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A Need for Caring

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A NEED FOR CARING

Judith Areen*

AIDS AND THE LAW: A GUIDE FOR THE PUBLIC. Edited by *Harlon L. Dalton, Scott Burris*, and the *Yale AIDS Law Project*. New Haven: Yale University Press. 1987. Pp. vii, 382. \$7.95.

And I looked, and behold, a pale horse: and his name that sat on him was Death, and Hell followed with him. And power was given unto them over the fourth part of the earth, to kill with sword, and with hunger, and with death, and with the beasts of the earth.

Revelation 6:8

AIDS is the modern day equivalent of leprosy. AIDS, or a suspicion of AIDS, can lead to discrimination in employment, education, housing and even medical treatment.

*South Florida Blood Service, Inc. v. Rasmussen*¹

[O]n this earth there are pestilences and there are victims, and it's up to us, so far as possible, not to join forces with the pestilences.

Albert Camus, *The Plague*

Professor Harlon Dalton explains at the outset that this book, *AIDS and the Law: A Guide for the Public*, grew out of the desire of several law students and faculty members at the Yale Law School to "do something" about Acquired Immune Deficiency Syndrome (AIDS) (p. xi). The result is a distinguished compendium of essays by knowledgeable authors that addresses significant legal issues raised by AIDS. One of the real achievements of the book is that even complicated technical matters are discussed in language that is admirably free of jargon, in keeping with the espoused goal of reaching readers who are not "steeped in the law" (p. xi).

The scope of the overall project is refreshingly ambitious. There are the essays one would expect on such practical matters as *AIDS in the Workplace* and *Schoolchildren with AIDS*, but there are also essays that put the matter in a broader context, including a particularly illuminating chapter entitled *A Historical Perspective* by Allan Brandt, and a thoughtful look at professional differences, *Physicians versus Lawyers: A Conflict of Cultures*, by Daniel Fox. There is also a ground-breaking section on groups specially affected by AIDS that in-

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1. 467 So. 2d 798, 802 (1985).

cludes separate essays on intravenous drug users, on the black community, and on the lesbian and gay community.

The decision to isolate these last essays as a separate section, however, underscores one weakness of the collection — the absence of a unifying theme or commentary. In the end, the volume remains a collection of partial solutions rather than an integrated whole. This is, perhaps, understandable given the inconsistencies and discontinuities that have characterized our nation's response to the AIDS epidemic from the very beginning. But even if our society is not yet ready to resolve the myriad public policy issues raised by AIDS, it is unfortunate that this volume did not better integrate the individual essays or, failing that, generate some conversation among the invited authors. Donald Hermann, in the chapter, *Torts: Private Lawsuits about AIDS*, for example, catalogues the various legal doctrines that might be employed to make one person liable for transmitting the AIDS virus to another. No effort is made to reconcile this approach with the caution, voiced by Larry Gostin in his chapter, *Traditional Public Health Strategies*, that such legal strategies may "deter people vulnerable to HIV infection from being tested, seeking advice and treatment, and cooperating with public health programs" (p. 65).

The silence between chapters forces the reader (and reviewer) to grope for linkages, for an integrated perspective, for a sense of what *we* can do.

I. THE DISEASE

The facts about AIDS that bombard us almost daily are sobering. First recognized as a new disease in 1981, the number of AIDS cases initially doubled every six months.² By 1986, cases were doubling only every thirteen months, but as Dr. June Osborn, Dean of the School of Public Health at the University of Michigan, observes, this was of small comfort because more new cases of AIDS were diagnosed in that same year (28,000) than in the prior five years combined (p. 19). By the end of 1987, 49,793 cases of AIDS had been reported in the United States to the Centers for Disease Control (CDC), of whom 27,909 (56 percent) had died.³ The mortality rate is almost 80 percent for people in whom AIDS was diagnosed more than two years ago, and most experts assume it will approach 100 percent over time (p. 19).

2. A damning account of the many unnecessary delays that occurred prior to acknowledging the epidemic or warning potential victims is R. SHILTS, *AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC* (1987).

3. Curran, Jaffe, Hardy, Morgan, Selik & Dondero, *Epidemiology of HIV Infection and AIDS in the United States*, 239 *SCIENCE* 610 (1988) [hereinafter Curran]. The Public Health Service has projected that by 1991, there may be 323,000 reported patients with AIDS and that as many as 200,000 may be dead. Board of Trustees Report, *Prevention and Control of Acquired Immundeficiency Syndrome*, 258 *J. AM. MED. ASSN.* 2097 (1987).

Not everyone who has caught the AIDS virus, or Human Immunodeficiency Virus (HIV) as it has come to be called, has developed AIDS.⁴ Researchers still do not know how many of the people who carry HIV will ultimately develop AIDS. In the book, it is suggested that only 20 percent of gay men with HIV, and an even lower percentage of hemophiliacs, will ultimately develop AIDS (p. 24). Already, those statistics have been overtaken by far more pessimistic projections. The San Francisco City Clinic Cohort Study found that, as of September 30, 1987, after 88 months of infection, 36 percent of the men had developed AIDS, another group of more than 40 percent had other signs or symptoms of infection, and only 20 percent remained completely asymptomatic.⁵ Eyster, Gail, Ballard, Al-Mondhiry and Goedert have estimated that approximately 30 percent of adult hemophiliacs develop AIDS within six years after infection.⁶ Recently, Dr. M. Roy Schwarz, head of the AIDS task force of the American Medical Association, stated, "I see nothing in the immunology of this virus which indicates less than 100 percent expressivity."⁷

Researchers are also challenging the validity of drawing firm distinctions between having HIV and having AIDS. Many HIV carriers develop AIDS-related complex (ARC). ARC has made tens of thousands of Americans seriously ill, and killed many others; but, because the Centers for Disease Control does not include ARC within its definition of "AIDS," those who die from ARC are not normally included in the count of AIDS deaths.⁸ Other studies suggest that HIV causes a loss of mental function long before other symptoms of AIDS surface, and that most HIV carriers show immune system damage within five years of infection even if they have not developed other symptoms of ARC or AIDS.⁹

AIDS is not an easy way to die:

The clinical illness itself typically starts with vague, debilitating symptoms including drenching night sweats, sustained fevers, chronic diarrhea, and weight loss, sometimes associated with generalized enlargement of lymph nodes. . . . Some, but not all, of the individuals who start with that set of symptoms then experience oral "thrush" (yeast

4. HIV was the name chosen as a compromise by an international committee of virologists when Dr. Luc Montagnier of the Pasteur Institute and Dr. Robert Gallo of the National Cancer Institute, who were both claiming to have discovered the virus that causes AIDS, could not agree on a name. For an account that emphasizes the role played by two American lawyers, together with Dr. Jonas Salk, in negotiating a settlement of claims between the French and American researchers, see Judge, *Anatomy of a Settlement*, THE AM. LAW., June 1987, at 88.

5. Curran, *supra* note 3, at 615.

6. Eyster, Gail, Ballard, Al-Mondhiry & Goedert, *Natural History of Human Immunodeficiency Virus Infections in Hemophiliacs*, 107 ANNALS INTERNAL MED. 1 (1987).

7. *Special Report: AMA Forum Told That HIV May Always Lead to AIDS*, AIDS POLICY & LAW, May 6, 1987, at 6.

8. Specter, *View of AIDS Too Narrow, Scientists Say*, Wash. Post, Jan. 13, 1988, at A1, col. 6.

9. *Id.* at A16, col. 1.

infection of the mouth) or develop the purplish skin lesions of a previously rare kind of malignancy called Kaposi's sarcoma. Alternatively — or as well — strange chronic pneumonias develop, caused by microorganisms rarely seen and resistant to treatment. Over time, some AIDS patients also develop confusion and other signs of progressive neurologic degeneration. . . . [F]ull-blown AIDS means a relentlessly downhill clinical course¹⁰

Some people have reacted to these facts with panic and draconian proposals that reflect both fear of disease and hostility to gays. For once, however, more and better information can rebut some of the most offensive reactions.¹¹ Indeed, about the only good news concerning HIV is that it is not transmitted through casual contact. Not only is HIV spread exclusively through blood or semen, but the virus is fragile enough to be destroyed by standard solutions of almost all common disinfectants, such as hydrogen peroxide, bleach, Lysol, or alcohol (p. 33). The most comprehensive study of families of people with AIDS involved ninety-four people who had lived at least three months with a clinically ill AIDS patient, sharing toothbrushes, towels, eating utensils, dishes, drinking glasses, beds, toilets, baths, showers, and kitchens. Seventeen percent of the subjects kissed on the lips. Not one adult contracted the virus. One five-year-old child became ill, but she appeared to have contracted the virus from her mother during pregnancy (pp. 34-35).

These facts should put to rest the unwarranted fears of most co-workers, and of parents of children who have a classmate with HIV, unless the child with HIV is too young to avoid posing a risk of exposure to bodily fluids.¹²

One of the most important chapters in the book is *Education as Prevention*. As long as there is no vaccine or cure for AIDS, education will remain the primary weapon against the disease. There are now encouraging data that show that the virus has stopped spreading as

10. P. 19. One of the most devastating types of pneumonia is *Pneumocystis carinii* pneumonia (often confusingly abbreviated as PCP). Pneumocystis is caused by a microscopic protozoa normally held in check by people's immune systems. An average person has 300 million air pockets in his lungs where oxygen from inhaled breath eases into the blood stream. For some AIDS victims, these air pockets offer a warm, even tropical climate for the protozoa to grow by the millions, slowly suffocating the patient. R. SHILTS, *supra* note 2, at 34.

11. See, e.g., Hilts, *When Fear of AIDS Freezes an Agency*, Wash. Post, Feb. 4, 1988, at A21, col. 3. This article explains that the turning point for General Accounting Office AIDS task force members was reading the Surgeon General's report that made clear that casual contact would not spread the disease. Consensus soon followed on a policy that states: (1) being AIDS-free is not required for hiring or continued employment; (2) an employee with AIDS is not required to disclose his or her condition to a supervisor or other employees; and (3) efforts to help an employee with AIDS should be the same as efforts to help those with other life-threatening diseases.

12. Guidelines issued by the Centers for Disease Control in 1985 recommend that children with HIV should be permitted to attend school unless the children are preschool-aged, are neurologically handicapped and lacking control of bodily secretions, display behavior such as biting, or have uncoverable, oozing lesions. Pp. 69-70.

rapidly among gay men, although this change has come too late to prevent a substantial proportion of the male homosexual population in some areas from being exposed to the virus. Thus, unless a cure is found, thousands more Americans will become ill and die in the next few years.¹³

Nonetheless, some public officials are expressing cautious optimism on the ground that AIDS will not become an epidemic among the general population. In early 1988, for example, Dr. Otis R. Bowen, Secretary of Health and Human Services, in a striking shift in view, announced that "we do not expect any explosion into the heterosexual population."¹⁴ Only a year before, Dr. Bowen had warned that AIDS would make the Black Plague, which wiped out a third of the population in Western Europe in the fourteenth century, seem "pale by comparison."¹⁵

But HIV continues to infect black and Hispanic drug addicts, their sex partners, and their babies, at tragically high rates.¹⁶ Intravenous drug addicts are likely to be harder to reach and are less likely to change their behavior in response to education than the gay community has been. Worse, as the general public focuses on the new demographic projections for the disease, animosity toward drug users and gays may lessen public support for additional funding for the battle against AIDS.

Law has played an important role in protecting some HIV sufferers from the additional burden of losing a job, of being denied admission to a public school, or of becoming uninsurable (pp. 74-78, 120-21, 190-93). But, as Professor Dalton acknowledges in the introduction to the book, there is no guarantee that in the future law will not come to rest most heavily upon those who already suffer the most (p. xiv), particularly if some of the proposals for large-scale mandatory screening or quarantine of HIV carriers are enacted. He calls for a massive, purposeful, and broadly-supported effort by the whole society to rein in its worst impulses:

Such an effort requires healthy doses of what my former colleague Charles Black has labeled "humane imagination," the ability to comprehend, however dimly, how life is lived by people very different from ourselves. We must struggle to see through the eyes and feel with the hearts of those whom AIDS is most likely to fell. [p. xiv]

13. Boffey, *Spread of AIDS Abating, But Deaths Will Still Soar*, N.Y. Times, Feb. 14, 1988, at A1, col. 3.

14. *Id.*

15. *Id.*

16. Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, has described the epidemic as "catastrophic" in the male homosexual population and among intravenous drug users. *Id.* at A36, col. 3. AIDS is now the leading cause of death in New York among men 24 to 44 years old and among women 25 to 34. *Id.* at A36, col. 2. One in every 61 babies born in New York City now has the AIDS virus. Lambert, *Study Finds Antibodies for AIDS in 1 in 61 Babies in New York City*, N.Y. Times, Jan. 13, 1988, at A1, col. 2.

In a secular society whose central organizing political and economic image is that of a competitive struggle for survival in a marketplace, what ground can be found for such a set of public and private attitudes and policies? There is a place to turn. It begins with the family.

II. THE CARE PERSPECTIVE

The law's rationale for why (or when) the state is entitled to intrude on family relationships has long been inadequate. The absence of a rationale has particularly serious consequences for parents who must try to defend against having their children taken away by the courts on the basis of an allegation no more specific than parental "neglect" — whatever that means. Moral philosophy, until recently, has paid little attention to the parent-child relationship. Indeed, as Professor Seyla Benhabib has noted, the imaginary world of most moral philosophers is a strange world "in which individuals are grown up before they have been born; in which boys are men before they have been children; a world where neither mother, nor sister, nor wife exist."¹⁷ Perhaps the starkest formulation is that of Thomas Hobbes, who proclaimed: "Let us . . . consider men as if but even now sprung out of the earth, and suddenly, like mushrooms, come to full maturity, without all kind of engagement to each other."¹⁸

Contemporary criticism of philosophy for ignoring the family is not completely unprecedented. David Hume, in the mid-eighteenth century, criticized Hobbes's state-of-nature hypothesis for ignoring the fact that "[m]en are necessarily born in a family-society . . . and are trained up by their parents to some rule of conduct or behaviour."¹⁹ Yet the lack of concern with family or with the nurturing of children has continued in the writings of the principal moral and political philosophers of our time. John Rawls, for example, reserves the "original position" that is central to his theory of justice for fully grown, rational beings.²⁰ As Alasdair MacIntyre has noted, it is "as though we had been shipwrecked on an uninhabited island with a group of other individuals, each of whom is a stranger to me and to all the others."²¹

The moral disposition to be just presupposes not only that the agent is adult and rational and attached to certain abstract concepts or ideals, but, as Flanagan and Jackson have observed, also that the agent . . . is attached to and cares for his community, and that he has

17. Benhabib, *The Generalized and the Concrete Other*, in *WOMEN AND MORAL THEORY* 154, 162 (E. Kittay & D. Meyers eds. 1987).

18. T. HOBBS, *Philosophical Rudiments Concerning Government and Society*, in *2 THE ENGLISH WORKS OF THOMAS HOBBS* 108-09 (Molesworth ed. 1966).

19. D. HUME, *An Enquiry Concerning the Principles of Morals*, in *HUME'S MORAL AND POLITICAL PHILOSOPHY* 190 (H. Aiken ed. 1948).

20. J. RAWLS, *A THEORY OF JUSTICE* 19 (1971).

21. A. MACINTYRE, *AFTER VIRTUE: A STUDY IN MORAL THEORY* 250 (2d ed. 1984).

a sense that his own good and that of those he cares for most is associated with general adherence to these ideals. Without such cares and attachments, first to those one loves and secondarily to some wider community to which one's projects and prospects are intimately joined, the moral disposition to justice . . . has no place to take root.²²

These cares and attachments do not develop without a considerable investment of both time and care by parents or others *in loco parentis*. Thus, paradoxically, even the theory of a contractarian like Rawls rests to a considerable, albeit unacknowledged, extent on good parenting. Nonetheless, there has been almost no attention paid by Rawls or most moral or political philosophers to the nature of good parenting.

One probable explanation for the omission is that parenting has traditionally been viewed as women's work. But that is hardly an adequate justification for ignoring parenting. Annette Baier makes the point more bluntly: "A decent morality will *not* depend for its stability on forces to which it gives no moral recognition."²³

The possibility that there is another approach to moral issues, one that uses the parent-child relationship rather than the arm's length transactions of strangers as its fundamental paradigm is gaining currency among philosophers, in large part due to the work of psychologist Carol Gilligan.²⁴ In her studies of the relationship between moral judgment and action, Professor Gilligan found that men more often than women conceive of morality as substantively constituted by obligations and rights and as procedurally constituted by the demands of fairness and impartiality. Women more often than men see moral requirements as emerging from the particular needs of others in the context of particular relationships. Gilligan named the latter orientation the "care perspective" to contrast it with the more rights-oriented approach of the "justice perspective."²⁵

Attention to the parent-child bond has also focused renewed inter-

22. Flanagan & Jackson, *Justice, Care and Gender: The Kohlberg-Gilligan Debate Revisited*, 97 ETHICS 622, 630 (1987).

23. *Id.* at 631.

24. See generally C. GILLIGAN, IN A DIFFERENT VOICE (1982). The most comprehensive exploration of the implications of Gilligan's work for moral philosophy is WOMEN AND MORAL THEORY, *supra* note 17.

25. Critics have complained that Gilligan's data do not support the assertion that caring is biologically determined, see, e.g., Kerber, *Some Cautionary Words for Historians*, 11 SIGNS 304, 305 (1986), and have cautioned that, although women have a greater reputation for altruism and empathy than men, studies do not show that women are any more likely than men to offer help to strangers when given the opportunity. Greeno & Maccoby, *How Different is the "Different Voice"?*, 11 SIGNS 310, 313 (1986) (Whether there is a sex difference with respect to helpful acts directed toward friends and intimates "can be neither confirmed nor refuted."). *Id.* at 314. Gilligan has answered that her intent was to highlight different modes of thought rather than to generalize about either sex. Gilligan, *Reply*, 11 SIGNS 324, 327 (1986).

Women may well be more likely to exhibit a care perspective than men, but this phenomenon is probably due to the fact that society assigns women more of the caring roles, rather than because of differences between the x and y chromosomes. Indeed, Joan Tronto may well be right

est in Hume, who criticized what he termed the "selfish system of morals" of Hobbes and Locke²⁶ by invoking the parent-child relationship:

Tenderness to their offspring, in all sensible beings, is commonly able alone to counterbalance the strongest motives of self-love, and has no manner of dependence on that affection. What interest can a fond mother have in view, who loses her health by assiduous attendance on her sick child, and afterwards languishes and dies of grief when freed by its death from the slavery of that attendance?²⁷

Hume proceeded to use the parent-child bond as a paradigm for the benevolent feelings and acts we should extend not only to friends, but to humanity.

The parent-child relationship is an appealing relationship on which to ground a general moral theory because it is familiar to virtually all human beings. More importantly, it may be a useful model for reconciling dependence and autonomy because parents traditionally care for and about their children in a way that respects and even fosters autonomy in the children.

Consider the list of virtues Sara Ruddick has developed to characterize parenting:²⁸ "*A responsiveness to growth* (and acceptance of change) along with a . . . learning that recognizes change, development and the uniqueness of particular individuals and situations; *resilient good humor and cheerfulness*, even in the face of conflict, the fragility of life and the dangers inherent in the processes of physical and mental growth; *attentive love*, which is responsive to the reality of the child, and is also prepared to give up, let grow, accept detachment; and *humility*, a selfless respect for reality, a practical realism which involves understanding the child and respecting it as a person, without either 'seizing' or 'using' it."²⁹ One drawback of the Ruddick list is that it would be impossible for any parent to exemplify the listed vir-

to suggest that the care perspective is a product of social oppression rather than of gender. Toronto, *Beyond Gender Difference to a Theory of Care*, 12 SIGNS 644, 649 (1987).

26. D. HUME, *supra* note 19, at 271.

27. *Id.* at 274.

28. Ruddick describes them as maternal virtues, but they are virtues that parents of both sexes can, and do, exemplify.

29. J. GRIMSHAW, PHILOSOPHY AND FEMINIST THINKING, 240-41 (1986) (paraphrasing Ruddick, *Maternal Thinking*, 6 FEMINIST STUD. 342 (1980)) (emphasis in original); *cf.* the view of mothering offered by Julian of Norwich in the fourteenth century. Dame Julian was a recluse, or anchoress in St. Julian's Church, Norwich who was praising God by attributing to Him maternal virtues:

To the property of motherhood belong nature, love, wisdom and knowledge . . . The kind, loving mother who knows and sees the need of her child guards it very tenderly, as the nature and condition of motherhood will have. And always as the child grows in age and in stature, she acts differently, but she does not change her love. And when it is even older, she allows it to be chastised to destroy its faults, so as to make the child receive virtues and grace.

THE NORTON ANTHOLOGY OF LITERATURE BY WOMEN 16, 18 (S. Gilbert & S. Gubar eds. 1985).

tues in every interaction with a child. Indeed, to spend all of one's time caring for another in this way is likely to lead to exhaustion and even resentment of the one cared for. Ruddick, herself, had second thoughts about her initial list:

[A]ttentive love calls for a realistic *self*-preservation on the part of the mother, a mother-self that can be seen and identified by the child who is itself learning attentive love. . . . Maternal thinking identifies attentive love as the fulcrum, the foundation of maternal practice; at the same time it identifies chronic self-denial in its many forms as the characteristic temptation of mothers and the besetting vice of maternal work.³⁰

Caring thus has several central characteristics. First, a caring person is responsive to the reality of the person receiving care.³¹ Care is provided at such times and in such a way that the person cared for is assisted without being demeaned. Indeed, a central goal of caring is to respect and foster the autonomy of the person cared for. By contrast, altruism (or charity, its theological cousin) may be satisfied simply on the basis of what the actor believes is good for the other. Caring, properly understood, should avoid the potentially oppressive aspects of such paternalism.

Second, a caring person also cares about herself sufficiently to sustain the physical, mental, and emotional resources needed to care for others. Self-love is not a sufficient end from the care perspective, but neither should self be sacrificed to excessive self-denial. A corollary of this principle is that caring cannot be universalized; it is not possible to care for everyone as a parent cares for his or her child.³²

Third, caring does not always begin or end by choice. Adults in our society may choose when to marry or to divorce and thus begin or end this caring relationship, but parents normally cannot end their caring relationships with their children. Conversely, adult children may be obliged to care for their parents despite the fact that they never voluntarily assumed the obligation.³³ From the care perspective, one should be a good samaritan to a stranger in need if no other assistance

30. Ruddick, *Preservative Love and Military Destruction: Some Reflections on Mothering and Peace*, in *MOTHERING, ESSAYS IN FEMINIST THEORY* 238 (Trebilcot ed. 1984) (emphasis in original).

31. Cf. N. NODDINGS, *CARING, A FEMININE APPROACH TO ETHICS AND MORAL EDUCATION* 16 (1984) ("Apprehending the other's reality, feeling what he feels as nearly as possible, is the essential part of caring . . .").

32. Virginia Held has suggested that caring may provide a new way to resolve the tension between universal obligation and egoism:

Moral theories must pay attention to the neglected realm of particular others in actual contexts. In doing so, problems of egoism vs. the universal moral point of view appear very different, and may recede to the region of background insolubility or relative unimportance. The important problems may then be seen to be how we ought to guide or maintain or reshape the relationships, both close and more distant, that we have or might have with actual human beings.

Held, *Feminism and Moral Theory*, in *WOMEN AND MORAL THEORY*, *supra* note 17, at 118.

33. An excellent discussion of the obligations of adult children to their parents is Sommers, *Filial Morality*, in *WOMEN AND MORAL THEORY*, *supra* note 17, at 69.

is available and if the care provided will not be an undue burden.³⁴

Critics of the care perspective have derided it as mere sentimentality. Neuchterlein has also objected that caring (he uses the term "compassion") has no place in politics because it carries "the unmistakable implication of dependence and piteousness on the part of those on the receiving end of the sentiment."³⁵ His criticism is unfounded if caring is understood to be directed toward producing autonomy, not dependence. Even Neuchterlein concedes, moreover, that caring is a "noble" force and "those who do not participate in it on a community as well as individual basis are morally tone deaf."³⁶

Another common criticism of caring is that it is simply a weak version of virtue theory. This is a devastating criticism in the eyes of those philosophers who have consigned the entire notion of "virtue," and with it the notion of a virtue-based theory, to the scrap pile of outmoded concepts. Aristotle may have been comfortable with the notion that a virtuous actor will know what constitutes right action, but many modern philosophers consider his theory naive; they contend that the morality of particular acts can be determined only by reasoning from moral principles.

The philosophic analysis of caring is in its early stages, so this is not the time or place for a detailed reply. Caring, like justice, may prove to be not merely a virtue, but a source of principles.³⁷ Alternatively, even if caring is a virtue, the philosophic debate about the role of virtues in moral theory is by no means over. Alasdair MacIntyre, for example, one of the modern philosophers interested in revitalizing virtue theory, has defined "virtue" as an acquired human quality which enables us to achieve goods that are internal to practices.³⁸ By a "practice," he means a "complex form of socially established cooperative human activity through which goods internal to that form of activity are realized."³⁹ For MacIntyre, throwing a football is not a practice, but the game of football is; bricklaying is not a practice, but architecture is. Of most relevance, he believes that the sustaining of human communities — including households, cities and nations — is a practice. Caring may well be understood as a virtue as MacIntyre uses the term; indeed it may be the central virtue for sustaining human relationships and communities.

What, then, is the relationship between the caring perspective and

34. Accord Prentice, *Expanding the Duty to Rescue*, 19 SUFFOLK U. L. REV. 15 (1985); Weinrib, *The Case for a Duty to Rescue*, 90 YALE L.J. 247 (1980).

35. See, e.g., Neuchterlein, *The Feminization of the American Left*, COMMENTARY, Nov. 1987, at 46 (quoting Kaus, *Up From Altruism*, NEW REPUBLIC, Dec. 15, 1986, at 17).

36. *Id.* at 46 (emphasis omitted).

37. Cf. J. RAWLS, *supra* note 20.

38. A. MACINTYRE, *supra* note 21, at 191.

39. *Id.* at 187.

the justice perspective? Their potential incompatibility is an ancient theme. Consider the exchange between Antigone, who wants to fulfill her obligation to care for her family (by burying her brother, Polynices) and Creon, King of Thebes, who has ordered that Polynices not be buried because he was killed attacking Thebes:

Antigone: Even so, we have a duty to the dead.

Creon: Not to give equal honour to good and bad.

Antigone: Who knows? In the country of the dead that may be the law.

Creon: An enemy can't be a friend, even when dead.

Antigone: My way is to share my love, not share my hate.

Creon: Go then, and share your love among the dead. We'll have not woman's law here, while I live.⁴⁰

Gilligan, by contrast, has written that there may be a role for both caring and justice in morality:

Theoretically, the distinction between justice and care cuts across the familiar divisions between thinking and feeling, egoism and altruism, theoretical and practical reasoning. It calls attention to the fact that all human relationships, public and private, can be characterized *both* in terms of equality and in terms of attachment, and that both inequality and detachment constitute grounds for moral concern. Since everyone is vulnerable both to oppression and to abandonment, two moral visions — one of justice and one of care — recur in human experience. The moral injunctions, not to act unfairly toward others, and not to turn away from someone in need, capture these different concerns.⁴¹

A traditional way to resolve the relationship between justice and caring has been to confine caring to the family. Charles Dickens illustrated the dangers of a family life without caring in *Bleak House* through the character of Mrs. Jellyby, the mother who devoted all of her energy to the rights of the foreign poor. When her own son was injured falling down the stairs, "Mrs. Jellyby merely added, with the serene composure with which she said everything, 'Go along, you naughty Peepy!' and fixed her fine eyes on Africa again."⁴²

Excluding justice concerns from the family also creates problems, particularly for women. Women today perform most of the daily caring — for children, for the household, and for the elderly⁴³ despite the fact that more than 50 percent of the mothers with young children also work outside the home. A recent study of men and women between the ages of twenty-five and sixty-four found that the total hours worked by women has increased during the past quarter-century while

40. SOPHOCLES, *Antigone*, in *THE THEBAN PLAYS* 140 (E.F. Watling trans. 1947).

41. Gilligan, *Moral Orientation and Moral Development*, in *WOMEN AND MORAL THEORY* *supra* note 17, at 20 (emphasis in original).

42. C. DICKENS, *BLEAK HOUSE* 38 (Oxford Univ. Press 1948).

43. "More than 70 percent of those who provide free home care to disabled elderly people are women, usually wives or daughters . . ." Rich, *Study Says Women Provide Most Home Care for Elderly*, *Wash. Post*, Aug. 4, 1986, at A3, col. 5.

the total hours worked by men fell. In 1959, women on average spent 572 hours in market work, 1,423 hours on housework, and 266 hours on child care, for a total of 2,261 hours annually. By 1983, the hours spent in each category were 929, 1,252, and 201, for a total of 2,383. Men, by contrast, in 1983 spent 1,667 hours in market work, but only 560 on housework, and 59 on child care (down from 76 in 1959), for a total of 2286.⁴⁴ This imbalance is likely to change only when it is accepted that men as well as women can provide caring in the family.

If family life without caring seems impoverished, should we not be equally wary of a society without caring, a nation in which individuals feel no moral duty to one another other than to avoid harming each other? If a justice perspective might usefully supplement caring within the family,⁴⁵ might not caring be an important complement to justice outside of it? Caring and justice are best understood as mutually reinforcing perspectives. Each compensates for weaknesses in the other.

It is one thing to conclude that caring should be extended beyond family relationships, and quite another to know how to apply the caring perspective in the public sphere. A natural extension would encompass friendship.⁴⁶ Many of the ways we relate to friends parallel our family relationships. Indeed, friendship may be a particularly important context in which to develop a more complete account of caring because it is not characterized by the inequality which lies at the heart of the parent-child relationship. It is more difficult to know how to apply the care perspective beyond family and friends to issues in the larger community,⁴⁷ but AIDS presents an important reason to learn.

III. CARING AND AIDS

As Professor Dalton has suggested, society needs to find a way to

44. Fuchs, *Sex Differences in Economic Well-Being*, 232 *SCIENCE* 459 (1986).

45. Seasoning caring with justice within the family challenges the notion that caring should only be done by women; and, by emphasizing that self and other are equal, it enables care givers to avoid excessive self-sacrifice. Cf. C. GILLIGAN, *supra* note 24, at 149:

Among college students in the 1970s, the concept of rights entered into their thinking to challenge a morality of self-sacrificing and self-abnegation. . . . [T]he notion of care expands from the paralyzing injunction not to hurt others to an injunction to act responsively toward self and others and thus to sustain connection.

46. See generally L. BLUM, *FRIENDSHIP, ALTRUISM, AND MORALITY* (1980).

47. There has been a resurgence of interest in public virtue theory. See generally M. SANDEL, *LIBERALISM AND THE LIMITS OF JUSTICE* (1982); Gutmann, *Communitarian Critics of Liberalism*, 14 *PHIL. & PUB. AFF.* 308 (1985). As Professor Seidman has cautioned, however, there is a tension between the particularist ideal of relationships characterized by caring and intimacy and the universalist ideal of equal beneficence toward all members of a community. Seidman, *Public Principle and Private Choice: The Uneasy Case for a Boundary Maintenance Theory of Constitutional Law*, 96 *YALE L.J.* 1006, 1007 (1987). It is true that governments and institutions are by nature impersonal, and, therefore, incapable of caring in the way that members of families do, but public policies can be designed so as to foster caring human relationships. The deeper moral tension between any individual's duties to humanity in general and his or her duties toward those with whom he or she stands in a special relationship may well be a permanently unresolvable feature of the moral life.

rein in its worst impulses if the battle against AIDS is not to become a war against the people infected (p. xiv). In other words, what is needed is a change in attitude or perspective. Public policies, rules of law, patterns of institutional and group behavior will reflect the fundamental perspective adopted by society. Here is where the adoption of the care perspective can make a difference.

According to the care perspective, people who might have HIV ought to care enough for and about those not infected to ascertain their HIV status and, if it is positive, avoid transmitting it to others. Governments could assist them by providing voluntary screening and education programs. Conversely, people without HIV ought to care enough about those with HIV to protect them from discrimination (in housing, employment, insurance, etc.) and to provide adequate care (medical, financial, and emotional) when they become ill. There is a mutuality to the care analysis: people with HIV are most likely to be responsible enough to ascertain their HIV status if they know they will be cared for and about by those without HIV.

A care perspective does not mean that people without HIV must rely only on the altruism of those with HIV. Caring includes caring for oneself. Accordingly, anyone who has not been exposed to HIV should avoid unprotected encounters with HIV-contaminated bodily fluids. What is to be avoided, however, is the virus, not people infected with the virus. Here, too, governmental education programs can play an important role in facilitating the care perspective.

A justice perspective, by contrast, would ignore the need of people with HIV for care, beyond ensuring that they are not discriminated against in the provision of medical services or in other ways.⁴⁸ The focus would be on deterring such individuals from harming others by transmitting the virus. Public policy founded on a justice perspective, therefore, would emphasize punishing the knowing transmission of HIV. Repeat offenders might even be quarantined.

A major problem with a public policy preoccupied with punishing the deliberate transmission of HIV is that such a policy would probably discourage individuals at high risk for HIV from determining their antibody status. In response, the government might impose mandatory screening requirements, but such a step would likely be

48. The attribution of particular characteristics to the justice perspective is a risky endeavor because there are numerous accounts of what constitutes "justice." I have chosen to focus on equal treatment as the central characteristic of the justice perspective for purpose of comparing it to the care perspective. Supporters of particular versions of justice might well contend that their approach to justice demands more. A strict egalitarian like Robert Veatch, for example, argues that society ought to provide the retarded and others who have "lost in the natural lottery" (presumably including many of those with AIDS) with enough compensation to get them to the point that they have an opportunity for equality of outcomes; subject to the constraint that the compensation provided should not exceed "the point where others would be reduced to a level of well-being equal to the one being compensated." R. VEATCH, *THE FOUNDATIONS OF JUSTICE: WHY THE RETARDED AND THE REST OF US HAVE CLAIMS TO EQUALITY* 158-59 (1986).

both prohibitively expensive⁴⁹ and involve unacceptably intrusive governmental regulation of private conduct for a democratic society that has traditionally placed a high value on individual liberty.

Although critics have charged that the care perspective has no role outside the intimate confines of family relationships, a comparison of the care perspective and the justice perspective on AIDS reveals that the caring approach is likely to be the more effective of the two at stemming the spread of this deadly virus, as well as the more humane approach for those who do contract HIV.

The inadequacies of relying on a justice perspective without attention to caring can also be seen within the medical professions. When growing numbers of physicians, nurses, and other health care personnel began to refuse to care for AIDS patients, the deans of several major medical schools announced that, henceforth, offenders would be dismissed.⁵⁰ Their goal might be laudable from a care perspective, but punitive enforcement of caring policies is not the most effective way to encourage caring — particularly when the caring burden is not shared equitably because it falls more heavily on health care professionals than on other individuals, and more on some areas of the country than others. The apparent result of the punitive approach embraced by the deans has been a decrease in applications for internships and residencies at institutions in areas with a significant number of AIDS patients.⁵¹ Fear of contracting AIDS may also be contributing to the

49. See Cleary, Barry, Mayer, Brandt, Gostin & Fineberg, *Compulsory Premarital Screening for the Human Immunodeficiency Virus*, 258 J. AM. MED. ASSN. 1757 (1987) (“[M]andatory premarital screening in a population with a low prevalence of infection is a relatively ineffective and inefficient use of resources.”).

50. Sullivan, *13 Medical Colleges Say Staffs Must Treat AIDS*, N.Y. Times, Dec. 9, 1987, at B2, col. 1. Physician refusal to treat is not a new phenomenon. When the bubonic plague arrived in Europe in 1347, “writer after writer lamented the avarice and cowardice of doctors in times of plague. . . . Some of the doctors who did not actually leave the city locked themselves in their houses and refused to come out.” Zugar & Miles, *Physicians, AIDS and Occupational Risk*, 258 J. AM. MED. ASSN. 1924 (1987) (footnotes omitted). When yellow fever broke out in Philadelphia in the summer of 1793, three of the city’s best known physicians fled to the countryside. *Id.* at 1925.

Some are now arguing that although physicians today have no legal obligation to begin to treat any patient (unless they are employed in emergency departments or in public hospitals), they have a professional obligation that grows out of their commitment to the *profession* of healing. See, e.g., *id.* at 1927; Pellegrino, *Altruism, Self-interest, and Medical Ethics*, 258 J. AM. MED. ASSN. 1939 (1987); cf. Walters, *Ethical Issues in the Prevention and Treatment of HIV Infection and AIDS*, 239 SCIENCE 597, 600 (1988):

A reasonable ethic for health care workers will not require of them heroic self-sacrifice or works of supererogation. . . . On the other hand, a reasonable ethic will not allow people who are in need of care to be refused treatment or abandoned solely because they are infectious. Such refusal and abandonment would violate the principle of beneficence.

51. Avoidance of AIDS has been cited as the reason why some of the best physician training programs in the country failed to fill all their positions in 1987. Specter, *Medical Profession Confronts New Generation’s Fears of AIDS*, Wash. Post, Jan. 20, 1988, at A1, col. 1. One doctor in a Bronx hospital stated, “People will tell you it’s the quality of life in New York, or the long hours, or the facilities, but that’s not it at all. It’s just AIDS.” *Id.* at A6, col. 2.

continuing decline in applications to medical schools, generally.⁵²

A second problem with the justice perspective can be seen in physicians' attitudes toward patients with AIDS. Physicians have come to expect success in their battle against disease. Paradoxically, it is the enormous success that medicine has experienced in this century in fighting contagious disease (through the introduction of antibiotics and the development of vaccines to protect against such major childhood killers as whooping cough and polio) that has bred an expectation of success that approached hubris. Even for those health care professionals ready and willing to care for AIDS patients, the absence of a cure, or even of effective palliatives, has led many physicians to feel they are of no use to the patients.

It is time for them to remember that for most of history, physicians have provided more care than cure. Lewis Thomas in his autobiography documents how recently medicine developed the ability to cure that we now take for granted.⁵³ He recalls, for example, accompanying his physician father on house calls in 1918 when about the only thing a physician could do was to diagnose.⁵⁴ But his father, and many other dedicated physicians understood that they still provided something of great value to patients and their families:

[W]hen I was on the faculty at Tulane Medical School and totally involved in the science of medicine, . . . I [was] asked to come to the annual meeting of a county medical society in the center of Mississippi, to deliver on address on antibiotics. . . . [M]y host was the newly elected president of the society, a general practitioner in his forties, a successful physician whose career was to be capped that evening, after the banquet, by his inauguration; to be the president of the county medical society was a major honor in that part of the world. During the dinner he was called to the telephone and came back to the head table a few minutes later to apologize; he had an emergency call to make. The dinner progressed, the ceremony of his induction as president was conducted awkwardly in his absence, I made my speech, the evening ended, and just as people were going out the door he reappeared, looking harassed and tired. I asked him what the call had been. It was an old woman, he said, a patient he'd looked after for years; early that evening she had died, that was the telephone call. He knew the family was in distress and

52. In 1974 there were more than three applications for every space in an American medical school. Now the ratio is less than two to one. *Id.* at A1, col. 1.

53. L. THOMAS, *THE YOUNGEST SCIENCE: NOTES OF A MEDICINE-WATCHER* (1983).

54. I'm quite sure my father always hoped I would want to become a doctor, and that must have been part of the reason for taking me along on his visits. But the general drift of his conversation was intended to make clear to me, early on, the aspect of medicine that troubled him most all through his professional life; there were so many people needing help, and so little that he could do for any of them. It was necessary for him to be available, and to make all these calls at their homes, but I was not to have the idea that he could do anything much to change the course of their illnesses. It was important to my father that I understand this; it was a central feature of the profession, and a doctor should not only be prepared for it but be even more prepared to be honest with himself about it.

Id. at 13.

needed him, he said, so he had to go. He was sorry to have missed the evening, he had looked forward to it all year, but some things can't be helped, he said.

That was in the early 1950s, when medicine was turning into a science, but the old art was still in place.⁵⁵

Tens of thousands have already died of AIDS. Hundreds of thousands more will die in the United States alone.⁵⁶ The dying need justice, but they also need caring, both from physicians and other health care workers, and from the community.

One possible future was chosen in Arcadia, Florida, where the home of three boys with the AIDS virus was burned, presumably by frightened neighbors. Another has been pioneered in Denton, Maryland, population just under 2000, where the single mother of a boy with hemophilia learned that her son had been exposed to HIV by a blood transfusion. After she sent him to kindergarten at Denton Elementary School, rumors began to spread. When a PTA meeting was arranged to discuss the situation, almost five-hundred people showed up. The county health officer explained why school officials had decided it was safe to have the boy attend school. Others suggested that the assembled parents should think about how they would feel if the boy were their own child. In the end, reason and calm have prevailed in Denton.⁵⁷

AIDS, like the plagues of the past, presents an opportunity for heroism or for scapegoating. As we decide whether Arcadia or Denton will serve as our national model, the need for caring as well as justice is clear.

55. *Id.* at 10-11.

56. For an estimate of world incidence see Pio, Plummer, Mhalu, Lamboray, Chin & Mann, *AIDS: An International Perspective*, 239 *SCIENCE* 573 (1988).

57. Kastor, *The Town That Wouldn't Give in to Fear*, *Wash. Post*, Dec. 21, 1987, at B1, col. 1.