Enhancing Care

TEODORA MANEA

> In the sense in which a man can be ever said to be at home in the world, he is at home not through dominating, or explaining, or appreciating, but through caring and being cared for. (M. Mayeroff, *On Caring*).[1]

Abstract
If moral enhancement is possible, the caring capacity of human beings should be considered one of the first and most important traits for augmentation. To assess the plausibility of enhancing care, I will explore how the concept and its associated human dispositions are socially constructed, and identify some of the critical points and complexities. Scientific advances regarding neuro-enhancing substances that allegedly make humans more caring will be considered and assessed against the main principles that govern the ethics of care approach. I argue that given the relational and contextual nature of care, its enhancement, if targeted at the individual level, can be more disadvantageous than helpful, by overlooking the "webs of care" people are situated in, and the role of social institutions in shaping behaviours, duties, attitudes, and principles.

1. Care as a Moral Category: Semantics, Discourse, Principles, and Webs of Care

The philosophical discourse promoting moral enhancement is difficult to align with the ethics of care perspective. The former tries to match technological developments with individuals' interests, insisting on the necessity of embracing and creating better humans. After the extensive debate around cognitive enhancement,[2] and the various critiques stating that more intelligence does not necessarily make humans better,[3] the field of neuroethics and the possibilities of moral enhancement have attracted increased attention. Moral enhancement arguments are constructed around individuals and

[1] M. Mayeroff, *On Caring* (New York: Harper Collins, 1971), 2–3.

[2] I. Persson and J. Savulescu, 'The Perils of Cognitive Enhancement and the Urgent Imperative to Enhance the Moral Character of Humanity', *Journal of Applied Philosophy* **25**:3 (2008), 162–176.

[3] M. Hauskeller, *Better Humans? Understanding the Enhancement Project* (Durham: Acumen, 2013).

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their brains, infused with elements of evolutionary biology[4] and abstract ethical scenarios – like the ultimatum game[5] or the trolley experiment – and highly simplified models of moral decision making.[6]

The ethics of care, by contrast, adopts a 'different voice' to offer an alternative to the ethical discourse of rights and abstract principles.[7] This perspective focusses on contexts and relationships, and looks closer at social realities in a sustained attempt to make marginal voices heard and to reveal existing vulnerabilities. The obvious question is then how and why these two perspectives – the ethics of care and moral enhancement – intersect. I would argue that although they approach morality from different points of view, both discourses offer a central role to values like *trust* and *altruism*, and so their object of reflection seems to be similar. For this reason, the ethics of care might be able to shed light on any social complexities that are overlooked in the current moral enhancement debate. Looked at from the other angle, one might ask whether the ethics of care would benefit from engaging with the moral enhancement perspective. Although we might be sceptical that it could generate a direct methodological benefit, the idea of enhancing care is *prima facie* worthy of consideration.

The necessity of enhancement has been a constant cultural and philosophical problem. In Greek mythology, human beings came

[4] J. Savulescu, 'Unfit for Life: Genetically Enhance Humanity or Face Extinction', 2009: https://vimeo.com/7515623. Savulescu presented an argument about deficient human nature by invoking *love*. He deplored the rate of divorce in contemporary societies, and used evolutionary theories to provide an explanation for our failed monogamy, thereby ignoring socio-economic factors that have empowered women to exit no longer wanted marital relationships.

[5] P. J. Zak, R. Kurzban, S. Ahmadi, R. S. Swerdloff, J. Park, L. Efremidze, K. Redwine, K. Morgan, and W. Matzner, 'Testosterone Administration Decreases Generosity in the Ultimatum Game', *PLoS One* **4**:12 (2009), 1–7.

[6] According to Molly Crockett, an influential neuroscientist, '[t]he science of moral bioenhancement is in its infancy. Laboratory studies of human morality usually employ highly simplified models aimed at measuring just one facet of a cognitive process that is relevant for morality'. M. Crockett, 'Moral Bioenhancement: A Neuroscientific Perspective', *Journal of Medical Ethics* **40**:6 (2014), 370–371, 370.

[7] C. Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge, MA: Harvard University Press, 1984).

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into existence in a somewhat imperfect condition. Their survival and flourishing was made possible only by a constant enhancement in the form of learning and the acquisition of different arts and crafts, which enabled humans to protect a feeble body, to fight, to better organise, and to keep away all kinds of danger.[8] From this perspective, *enhancement* and humanity are inseparable.

Let us imagine for a moment that there were either a good god or a brave Prometheus to give us a last gift, a last *enhancement* to humans. If there were the possibility to choose one and only one type of enhancement, I would want to make a case for enhancing the human capacity of *care*. Humans are, generally speaking, intelligent enough for all human purposes and have created technologies that assist memory and expand knowledge, from writing to computers. However, we could certainly do with more *care*, in the form of better healthcare, better education, better programmes for the most vulnerable members of society, and greater concern for animals and the environment. At the global level, we should be able to extend our moral feelings and redefine the scope of our responsibilities to accommodate both people in distant countries and ecosystems affected by technological developments and our current lifestyle. At the domestic level, the *relocation of care* in contemporary societies[9] – from the private to the public realm – has generated new structural problems. Institutions entrusted to care often fail in their task: fields of care like health and education are increasingly commodified and marketised as goods designed for economic profit (e.g., universities, private schools).[10]

At the same time as public care is becoming so precarious, often undermined by right-wing governments, private care retains a low social status (e.g., cleaning, nursing the elderly) traditionally associated with women and their domestic "duties". Finally, not only have contemporary societies and globalisation created new types of vulnerability and injustice[11] – like refugees, migrants, or homeless people that cannot afford medical care or education – but, in

[8] Plato, *Protagoras*, 320b–323a, in B. Jowett (ed.), *The Dialogues of Plato in Five Volumes*, 3rd edn (Oxford: Oxford University Press, 1892).

[9] S. Sevenhuijsen, 'The Place of Care: The Relevance of the Ethics of Care for Social Policy', in S. Sevenhuijsen and A. Svab (eds), *Labyrinth of Care: The Relevance of the Ethics of Care Perspective for Social Policy* (Ljubljana: Mirovni Institut, 2003), 14–20.

[10] M. Barnes, *Care in Everyday Life: An Ethic of Care in Practice* (Bristol: Policy Press, 2012).

[11] V. Held, *The Ethics of Care: Personal, Political and Global* (New York and Oxford: Oxford University Press, 2006).

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tandem with this, it is possible that our capacity to care is affected by a type of 'moral myopia' restricting our feeling of responsibility to very small groups or communities.[12]

Clearly, then, it looks as though societies stand to benefit, both nationally and internationally, from programmes aiming to enhance care. Enhancements, however, are not gifts from God, or from science. They are complex processes of negotiation, trial and error, and sacrifice, and many achievements so far – such as improvements to health, sanitation, education, and human rights – have been brought about through institutions created to protect them. Furthermore, there is a methodological question to be considered: should we enhance care by aiming to change individual *dispositions* or *traits*, or should we create better institutional frameworks that encourage and sustain caring *actions*? The answer to this question depends on how care is best understood, and therefore some conceptual analysis courtesy of the ethics of care literature is required.

1.1. Semantic Considerations

Care is a broad notion, starting with the *existential* understanding of care as a fundamental human disposition to engage with others and the world.[13] Accordingly, care is more than a practice between a care giver and a care receiver; it is a way of *understanding* and *positioning* ourselves within relationships.[14] Secondly, from a *sociological* point of view care characterises social relationships, and defines different roles and interactions between individuals, as carer and cared for. These roles, however, are in a constant state of change, and societal understandings of care duties are constantly renegotiated at the individual and institutional levels. If an institution cannot foster caring relationships, the practice of care is compromised. Thirdly, at a *political* level care reflects policy that defines social vulnerability and designs interventions to diminish or end poverty, inequality, or discrimination. With the advent of neoliberalism as an ideological force, care has been *relocated*[15] from the private to the public

[12] I. Persson and J. Savulescu, *Unfit for the Future: The Need for Moral Enhancement*, (Oxford: Oxford University Press, 2012), 100–134.

[13] M. Heidegger, *Being and Time*, trans. by J. Stambaugh (New York: SUNY Press, 2010), 174–221.

[14] Barnes, *Care in Everyday Life*.

[15] S. Sevenhuijsen, 'The Place of Care'.

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sector, *marketised*[16] – increasing social inequalities – and *dislocated*, in the case of migrants and asylum seekers.[17]

These three levels capture the main dimensions of care. They show at the same time that care as an individual virtue is intrinsically connected and defined by relationships and socio-political context. We care *for* and *about* people and the environment, and we care *about* human rights. Every activity or being that captures our attention and enters our world can benefit from our care; as a fundamental human disposition we identify and recognise things, ideas, or beings in *need* of care. But this very broad definition can lead us into error: sometimes words containing "care" make us rashly assume the existence of it, as, for example, in institutionalised care – health*care*, or *care* homes. Even though those institutions were designed in accordance with what we felt to be right at a certain point, they require constant analysis and evaluation.[18] Money "saved" on social care can compromise meaningful care practices and negatively affect the vulnerable. At the same time, those measures put more pressure on carers, generating wide social discussions about doctors and nurses having to work long shifts, teachers with overcrowded classes, and care workers who are abused and underpaid.[19]

The precise meaning of "enhancing care" also needs to be clarified. For the purpose of this chapter – namely, to engage with the moral enhancement debate – my focus will be more on what happens when we enhance care at an individual level. There are at least two ways to enhance care in this sense: by 1) making more acute our capacity to *recognise* and *assess* vulnerabilities or care needs, or by 2) improving our present ability to *perform* care (e.g., continuing to care without sleep, or having an increased physical and emotional strength to cope with difficult situations). Regarding the latter, such enhancement already exists: targeting the ability to focus on a task for a long time is used by pilots and the military. Although this form of

[16] Held, *The Ethics of Care*.

[17] T. Manea, 'Medical Bribery and the Ethics of Trust: The Romanian Case', *Journal of Medicine and Philosophy* **40**:1 (2015), 26–43.

[18] M. Barnes, *Care in Everyday Life*, and J. C. Tronto, *Caring Democracy: Markets, Equality, and Justice* (New York and London: New York University Press, 2013).

[19] Alexandra Ricard-Guay and Thanos Maroukis, 'Human Trafficking in Domestic Work in the EU: A Special Case or a Learning Ground for the Anti-Trafficking Field?', *Journal of Immigrant & Refugee Studies* **15**:2 (2017), 109–121.

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enhancing care seems to be desirable (in the health service for example), often it can lead to the exploitation of people, making them work long hours and damaging their well-being.[20]

For the purpose of this chapter I will focus more on care as an *activity*, although it is hard to separate it from the *dispositions* that make people care for others. I understand care as a personal capability that can be expressed and realised only as part of a complex *life-sustaining web* that maintains, repairs, and consolidates our *world*.[21] My central point is that in isolation care has no meaning. It is an interpersonal activity, needing the other for its existence. It is worth mentioning that although care presupposes a certain degree of altruism – especially at the dispositional level – altruism and care as activities can be different. Altruism, even if is done with the other in mind, does not necessarily depend on the feedback of another person. Someone can offer money to a charity, or build a school for a poor village from an altruistic disposition. Their action is deeply moral, no doubt. But care would entail direct engagement by teaching the children, or by implementing the charity programme into the community. Care involves a personal engagement, whereas altruism can be remote and impersonal.

My overall argument is that aiming to enhance care at the individual level, and ignoring the web of care a person is in, can be detrimental for society and for individuals. A meaningful enhancement of care should rather aim at revealing the webs, examining them so that we could better understand which social practices are able to generate and sustain care.

1.2. The Ethics of Care Discourse

Care and caring have received a lot of attention from feminist philosophy, starting with Nell Noddings and Carol Gilligan and continuing in the present with writers like Joan Tronto, Virginia Held, Marian Barnes, and others. Generally, this field focusses on relationships, emotions, contexts, vulnerabilities, and needs. A common criticism is that the contextual character of this perspective compromises the

[20] John Temple, 'Resident Duty Hours Around the Globe: Where Are We Now?', *BMC Medical Education* **14**:Suppl. 1 (2014).

[21] J. C. Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care* (London and New York: Routledge, 1993), 103; B. Fisher and J. C. Tronto, 'Toward a Feminist Theory of Caring', in E. K. Abel and M. Nelson (eds), *Circles of Care* (Albany: SUNY Press, 1990) 35–62.

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universality and applicability of ethics.[22] However, it is by no means clear whether the aim of ethics is to prescribe general rules for the decontextualised individual, or rather to bind together local communities. The recognition of contextual problems, beliefs, attitudes, and specificities is attuned to postmodern thought,[23] and can generate a flexible framework that should be adapted to the needs of different communities. Only the rejection of a totalising metaphysics can ensure that we avoid othering and the danger of what Rorty calls *final vocabularies*.[24] General ideas and principles of action – often being the content of dangerous ideologies – can lead to overlooking individual suffering or minority interests. Ethics should instead be understood as embedded and analysed together with societal constructions that regulate particular social interactions. An Inuit community and a Central African village function in different ways: there are correspondingly different models of care and relationships. It is hard to say from the comfort of a Western office what problems and vulnerabilities people there face. Thus, the focus on context is more than legitimate and presupposes a general recognition of human diversity, because 'morality does not come in one homogeneous and internally consistent chunk, but in various bits and pieces. It is, in one word, multidimensional'.[25]

Caring is also a personal virtue and a normative concept: for example, when a relationship is classified as being or not being *caring*. Is there something that we can say *a priori* about care, abstracted from all empirical content? What do caring relationships have in common – caring for a child, an elderly parent, or a patient? Is there an "Idea of care"? Certainly, we can trace our representations of care back to our memory and to previous experiences: we learn to care very early, as part of our socialisation, but care might also have an instinctive basis, something that we share with non-human animals.[26] Then again, some authors think that there is 'no recipe for good

[22] J. Rachels, *The Elements of Moral Philosophy* (San Francisco: McGraw-Hill, 1999).

[23] R. Rorty, *Contingency, Irony, and Solidarity* (Cambridge: Cambridge University Press, 1989).

[24] Rorty, *Contingency, Irony, and Solidarity*, 70–75.

[25] M. Hauskeller, 'The Art of Misunderstanding Critics: The Case of Persson and Savulescu's Defence of Moral Bioenhancement', *Cambridge Quarterly of Healthcare Ethics* **24**:1 (2015), 48–57.

[26] J. Donovan and C. J. Adams, *Beyond Animal Rights: A Feminist Caring Ethic for the Treatment of Animals* (New York: Colombia University Press, 1996).

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care'.[27] Arthur W. Frank, for instance, emphasises the subtle character of care and the fact that a proper 'job description' of care is impossible to give. Care surrounds humans and other animals throughout their life in a silent and unobtrusive way: only its failure is noticeable. The concept is not only broad, but it is also quite diffuse, informed by traditions, a multiplicity of associated practices, and the ambiguity of perceptions. Care has always been subtle, diffuse, disseminated between other activities, and somewhat elusive. It reflects and reproduces the characteristics and quiet voices of people involved in care practices.

1.3. On the Principles of Care

Let us imagine that we have deciphered all complicated hormonal codes in our brains and bodies, and can harness their potential. There would, then, be the possibility of moral enhancement, so that we might even be able to create more caring individuals. If there is a kind of recipe for creating *caring persons*, the main ingredients of it should accord with the following principles.

Joan Tronto identifies six principles[28] of care that reflect not only characteristics of actions, but also personal attributes: *attentiveness*, *responsibility*, *competence*, *responsiveness*, *trust*, and *respect*.[29] To this list I would add *commitment*. It is immediately clear that these involve our cognitive *and* emotional capacities, so that a respective moral enhancement would have to consider modifications in both senses.[30] I will describe these principles and examine whether some "moral molecules" (like oxytocine) can play a role in their enhancement.

Attentiveness is the practice of *caring about* ideas and beings. It is defined by Marion Barnes as: the *awareness* and *recognition* of the need for care.[31] Tronto emphasised that in order to recognise and be attentive to others, we should be able to *suspend* our own

[27] A. W. Frank, *At the Will of the Body: Reflections on Illness* (Chicago: University of Chicago Press, 1995), 42–50.

[28] The term "principle" is not entirely adequate here, but it is present in the care literature. As I have mentioned before, the ethics of care – with its focus on context and relationships – differs from principlism. A better term would be "characteristics".

[29] Tronto, *Moral Boundaries*.

[30] For the debate regarding the primacy of cognitive enhancement for enhancing morality, see: J. Harris, *How to Be Good* (Oxford: Oxford University Press, 2016).

[31] Barnes, *Care in Everyday Life*, 20; Sevenhuijsen, 'The Place of Care', 20.

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ambitions, life plans, and concerns.[32] Ethicists of care point out that our duty of care does not encompass only a private concern for known others, but also a broad recognition of social and cultural factors or circumstances that affect people that we do not know personally.[33]

From the ties of friendship, kinship, and other specific contexts, attentiveness for others has been progressively – but so far incompletely – implemented in international politics aiming towards global justice and responsibility. Global warming, refugee crises, and migration in general are just a few cases that show the efforts and the failure of our present caring activities. A capitalist and individualistic model of thinking might question the extent of our responsibility for the socio-economic disparities of the world. Recent political developments, including the denial of environmental responsibility[34] and halting of child refugee programmes,[35] remind us that decades of moral effort invested in caring about others are easily reversed. It is incontestable that the measure of our moral behaviour is given by the scope of our self-defined responsibility, but the two examples above have less to do with individual dispositions; they instead reflect questionable governmental policies. The role of democratic institutions – from parliament to the judiciary and a free press – is to react to those policies and eventually to inform them.

Responsibility means *taking care* of things, having the *willingness* and the *capacity* to address an identified need.[36] How can we make people more responsible? A traditional answer is through *education*. The more we know about the past, the deeper we understand the complexity of social and international relationships, and the more

[32] Tronto, *Moral Boundaries*, 128.

[33] Barnes *Care in Everyday Life*; Held, *The Ethics of Care*.

[34] In the USA the *Climate Action Plan* (2013) is set to be replaced by the *America First Energy Plan*: ‘President Trump is committed to eliminating harmful and unnecessary policies such as the Climate Action Plan and the Waters of the U.S. rule. Lifting these restrictions will greatly help American workers, increasing wages by more than $30 billion over the next 7 years’ (White House, 2017).

[35] E. Addley, ‘Why Has the UK Ended its “Dubs” Child Refugee Scheme?’, *The Guardian*, 10th February 2017: https://www.theguardian.com/uk-news/2017/feb/10/why-has-the-uk-ended-its-dubs-child-refugee-scheme.

[36] Sevenhuijsen, ‘The Place of Care’, 21.

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we might comprehend our position and role in the present historical moment.

It is hard to imagine a drug that increases responsibility, because responsibility deals with different types of emotions, sometimes even with contradictory feelings. Responsibility can take the form of providing constant care for someone, or it can drive people who suddenly identify with a cause or an acute need to take drastic action. Should we, therefore, enhance our *willingness* to take risks with testosterone? For instance, Suffragettes, or animal or human rights activists, put themselves in a great deal of danger trying to take care of the vulnerable beings they choose to speak for and to protect. But equally, responsibility can involve quiet and supportive love. The delicate balance of those two is decided predominantly by external circumstances and not so much by individual hormones. Some might suggest that the use of cognitive enhancement[37] represents a solution – however, intelligence alone is not a sufficient and sometimes not even a necessary condition of caring.[38]

Competence is an essential ingredient of *care giving*. It is not enough to provide care, but care should have a certain *quality*; it should properly address relevant needs. Examples from care homes, hospitals, and schools illustrate the necessity of this principle. The way competence is assessed directs the discourse towards what society designs as *caring institutions*.[39] They can be analysed from the community level (schools, hospitals) to the national (judiciary systems and national protection systems for workers or the disabled) and at the international level (international organisations, forums, unions). *Caring* institutions incorporate certain suppositions about needs, vulnerability, power, and responsibility. Even if the individual competence of a mother to take care of her baby seems to be regulated by oxytocin, creating *institutional competence* is a meta-individual, abstract, and bureaucratic procedure. Democratic institutions, for example, can be enhanced by having dedicated politicians, but those institutions will have to pass the Popperian test, meaning that they preserve their principles even if corrupt or bad politicians are in office.[40] Applying this to the present topic, caring institutions should be built in a way that careless individuals who might be

[37] Harris, *How to Be Good*.
[38] Tronto, *Caring Democracy*, 54–63.
[39] Tronto, *Moral Boundaries*.
[40] Karl R. Popper, *The Open Society and Its Enemies* (London: Routledge, 1945).

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employed there will not have any chance to derail the caring processes. Hospital and care home abuses revealed in recent years prove that there is still space for improving these institutions and thereby care competence.

Responsiveness pertains to *care-receiving*. There is a subtle dialectic between the care-giver and the receiver of care that is reflected in successful or unsuccessful caring processes. For one thing, we cannot force someone to accept care. The relationship between a care-giver and a care-receiver typically reflects an inequality of power.[41] The problem with this is that vulnerability is sometimes shameful and people are not always happy to recognise or accept it. We have to remember that every one of us can be and will be at certain times in a vulnerable position. By accepting the position of care-recipient, one submits to the power of the care-giver, responsiveness to which ideally takes the form of positive feedback to something both parties understand as care and caring. But sometimes being in the position of a care-receiver can be damaging to people who have constructed their identity (only) as independent and autonomous individuals. One suspects that the prevalence and pervasiveness of neoliberal ideology has encouraged people to think about themselves in this way. Regardless, to properly enhance care in this context means to change the present understanding of what we are. The phase of our lives marked by youth, as active, successful individuals, is for most of us a short one: illness, disability, age, and familial commitments have to be incorporated into our self-understanding, and with them an acceptance of care practices.

Trust was one of the principles of care underlined by Selma Sevenhuijsen,[42] and seems to be where oxytocin promises great things.[43] What is trust? Starting with the basic interpersonal level, we trust different people with different things, or even the same person to different degrees depending on the action or opinion in question. For example, someone can trust a friend to take care of their dog, but not trust their political judgement. A partner can be trusted with essential things – from fidelity, to children's education, finances, and provision for the family – but distrusted for other

[41] Barnes, *Care in Everyday Life*; Tronto, *Moral Boundaries*, 136.
[42] S. Sevenhuijsen, *Citizenship and the Ethics of Care*, trans. by L. Savage (London and New York: Routledge, 1998).
[43] H. Wiseman, *The Myth of Moral Brain: The Limits of Moral Enhancement* (Cambridge, MA: MIT Press, 2016), 88–93.

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activities such as cooking, choosing the right wine, or caring for plants. Relationships compartmentalise roles and responsibilities; negotiate permanently areas of "excellence". A successful relationship is not based on an *average* trust for *all* domains, but a *total* trust in *some* of those areas. Each partner might have a particular idea about priorities, or what necessary and sufficient care is. Should we use cognitive enhancement to change their epistemological capacity,[44] or should we use oxytocin ourselves to accept them unconditionally and enjoy a happier relationship? Some may argue that if we had the same degree of intelligence and knowledge – helped possibly by enhanced cognition (about politics, wine, and plants) – trusting someone might be easier. But still people have different interests and different past experiences, situations, and other ingredients that make them what they are. Trying to change someone implies a paternalistic attitude, a lack of *respect* for who and what that person is.[45]

Respect was added to the definition of care by Daniel Engster.[46] In caring, respect should be a reciprocal value. People in vulnerable situations need it and caring people usually deserve it as well. However, respect is shaped by different and complex factors, from early education to general societal attitudes. Respect for a patient, a child, or a homeless person cannot be taken for granted: there is a difference between the type of respect imposed by law, regarding individual rights, and the type of respect experienced even in situations when there are no rights to compel our attitudes. If the first type of respect can be connected with a certain type of authority, and even fear of being punished,[47] the second type relies on empathy, openness, and understanding. For example, there is no law that compels people to respect their pets. There are regulations regarding animal welfare and prohibiting cruelty, but not for respecting a dog's autonomy. I understand autonomy here not as an abstract ethical value, but a contextual manifestation of free will.[48] What I mean is that relationships are the condition of possibility for the manifestation of free will:

[44] As John Harris would presumably suggest.
[45] M. Hauskeller, *Better Humans?*
[46] D. Engster, *The Heart of Justice: Care Ethics and Political Theory* (Oxford: Oxford University Press, 2007).
[47] For example, when someone respects the speed limit in an area because of speed cameras, although accelerating will not put anybody immediately in danger because the road at this exact time is empty.
[48] M.A. Fineman, *The Autonomy Myth: A Theory of Dependency* (New York: The New Press, 2004).

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others are co-creators of our sense of liberty and entitlement. Regarding the dog example, the fact that an owner stops to allow her dog to sniff a wall or to eat a particular blade of grass leads the dog to have expect that her owner will support this particular preference. If a dog, or a human being, is consistently prevented in their relationships from realising certain interests, their behaviour and sense of liberty might well change. In other words, respect is a condition of liberty. But there are two different types of respect: respect for laws and rights, and respect for the other in a relationship. To chemically manipulate respect, we would most likely have to target totally different groups of "moral molecules" and it is questionable if science currently allows for this, or ever will.[49]

Commitment has so far not been theorised as a principle of care, but in analysing different types of moral enhancement interventions it becomes clear that they target generally moral *traits* or dispositions, and *actions*.[50] Discussing the structure of morality in order to identify at which level Persson and Savulescu's moral enhancement project is aiming, Nicholas Agar has drawn attention to the difference between moral *motivation*, moral *cognition* – knowing what is good – and moral *action*.[51] Reflection on the complexity of moral action involved in care reveals the necessity of adding to this structure another key element: moral *commitment*, which is a kind of "temporal test" for our moral actions.

Regarding climate change, Persson and Savulescu's key concern, it is clear that care for the future of the planet is insufficient if only ephemeral: it is not enough to now and then refrain from using the car. The disposition and the impulse to act – or not act – is necessary, but not sufficient for changing moral behaviour that has distant or unclear consequences. While commitment is generally recognised as an ethical value, it is pointless to demand commitment if society does not offer an institutional framework to harness and reward meaningful actions.

2. The Relevance of Care for Moral Enhancement

On the basis of the preceding, I shall summarise the main points where the ethics of care can contribute to the moral enhancement

[49] Crockett, 'Moral Bioenhancement', 370–371.
[50] M. Hauskeller, 'The Art of Misunderstanding Critics', 48–50.
[51] N. Agar, 'Moral Bioenhancement is Dangerous', *Journal of Medical Ethics* **41**:4 (2013), 343–354.

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debate. Firstly, it demonstrates the need to emphasise the role of *relationships* and *context*.[52] Secondly, the main characteristics of care illustrate that the idea of *autonomous individuals* needs to be fundamentally revised. With its revision, the whole project of targeting individuals with moral enhancement – for example by giving them the option to take it or not – becomes moot. Wider contexts, interests, relationships, family, and community structures need to be considered, and in doing so concerns about liberty gain a new immediacy. Thirdly, the ethics of care brings forward the relevance of *commitment* as an additional element to be considered alongside moral traits and actions. The final point I would like to make regards the distinction between *therapy* and *enhancement* in the case of care. The reason for invoking this somewhat "classic" distinction is that a lot of examples used in the moral enhancement debates which relate to caring, or contain components of care, are in fact therapy cases.

The distinction between therapy and enhancement is a pivotal one for the enhancement debate; it is better to keep it in place[53] than to replace it with that between soft and hard enhancement as Wiseman has suggested.[54] When applying this distinction to care some characteristics of care are made more prominent. The "therapy of care" should aim to restore care to a socially acceptable level. I specify a "socially acceptable level" and not "species normal-functioning" because for the moral domain biological standards are less relevant than in the question of enhancing physical traits. Socially acceptable standards of care differ from one society to the other. I will illustrate this with a straightforward and basic activity of care, the one of a mother for her baby. Even if there is a strong presence of biological factors in this case, what is expected from a mother as "acceptable care" differs between societies. Written and unwritten social norms define the optimal body shape of the mothers (e.g., how acceptable it is to be fat or not during pregnancy), whether breastfeeding is a must or not, the amount of maternity paid leave (determining for how long a mother should be home with her baby), the possibility of paternity leave, room and home arrange-

[52] Ideas already developed by other ethicists (e.g. R. Sparrow and M. Hauskeller), albeit from different perspectives.

[53] R. Sparrow, 'Better Living Through Chemistry? A Reply to Savulescu and Persson on "Moral Enhancement"', *Journal of Applied Philosophy* **31**:1 (2014), 23–32.

[54] H. Wiseman, *The Myth of the Moral Brain*, 8–9.

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ments, etc. A basic engagement between the mother and the baby is expected to happen: when it is absent, mental health issues, like post-partum depression, are explored and tackled (in the UK, at least). This is a case of "therapy of care". An *enhancement* of care would be to bring care *above* the socially-expected capacity: for example, creating "super-mums" that breastfeed their children for the exactly right amount of time – a topic which is still controversial across Western cultures – and never get tired, stressed, or depressed. Branching out from mothers, we can imagine creating housewives that are caring and loving, like Ira Levin's *Stepford Wives*:[55] perfect women 'without the flaws', 'perfectly usable, obedient and ready to serve'.[56] With the last example, it is easy to see how crossing the line between therapy and enhancement immediately causes alarms to ring regarding freedom, autonomy, and respect.

In the context of a care home, "enhanced carers" could mean: physically stronger, more perceptive, sleepless, and even immune to smells and disgust. For doctors, we can imagine enhancing their ability to perform long operations or long shifts without being tired or distracted. For teachers, perhaps more empathetic capacities, attention, and other cognitive abilities allowing them to understand and know every individual child – even in state schools with overcrowded classrooms! – and to find the best ways to motivate them. In all of these examples, regarding possible "care enhancements", the focus is on individuals. My main criticism is that this approach is not only hard to implement – why would anyone wish for it? – but also dangerous for individuals and for the social fabric. The social danger comes from keeping poor structures in place: overcrowded classrooms, long hospital shifts, low status and badly paid care work, gender inequalities, and asymmetries in parental obligations and duties. To agree that enhancing care at the individual level is the solution for our society's needs entails an acceptance of common social practices as morally just and to stop any social critique of or change in our present day institutions. It means stopping our efforts to recognise dysfunctional activities, abuses, and inequalities. On this basis, I suggest that our "natural" moral progress over time – perhaps the only consistent and safe "moral enhancement" – would cease. Chemical solutions targeting individual enhancements might lead to even more

[55] I. Levin, *The Stepford Wives* (London: Constable and Robinson, 2011).

[56] M. Hauskeller, *Sex and the Posthuman Condition* (Basingstoke: Palgrave Macmillan, 2014), 28, 40.

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inequalities, abuses, and further ignorance of the complexity of caring relationships and contexts.

3. Limitations and Worries

One might argue that care is just one aspect of our moral behaviour. This is true, but it is also true that early experiences of care might affect the way people develop and act later in life.[57] An analysis of care can only enrich the moral enhancement debate.

Another limitation follows from the very nature of care practices: long term commitment to care can lead to a feeling of overwhelming obligation at the expense of freedom. Taking care of children or elderly parents, no matter with how much love, dedication, or attentiveness, can be frustrating at times. Without institutions of care in place, and without social recognition of these practices, dedicated people can be at risk of abuse. Similarly, morally enhanced people can be subjects of abuse at the hands of other people or socio-political institutions. This shows that without pre-existing social structures for morality that are practically proven to be just and responsible, individual moral enhancement could even be dangerous.

Another concern is that moral enhancement conforms to 'the magic bullet syndrome'[58] of present Western societies: namely, where pharmaceutical companies and a broader paradigm characterised by 'biological materialism'[59] contribute to the 'magic solution' of problems themselves caused by certain lifestyles and social influences. These problems were quickly medicalised, pathologised, and associated with certain 'chemical deficiencies'.[60] For example, depression has been connected with low levels of serotonin, and schizophrenia

[57] J. A. Bartz, J. Zaki, K. N. Ochsner, N. Bolger, A. Kolevzon, N. Ludwig, J. E. Lydon, and S. E. Taylor, 'Effects of Oxytocin on Recollections of Maternal Care and Closeness', *Proceedings of the National Academy of Sciences of the United States of America*, **107**:50 (2010), 21371–21375.

[58] P. J. Zak, *The Moral Molecule: The New Science of What Makes Us Good or Evil* (London: Bantam Press 2012); P. J. Zak and A. Fakhar, 'Neuroactive Hormones and Interpersonal Trust: International Evidence', *Economics and Human Biology* **4**:3 (2006), 412–429.

[59] E. Martin, *Bipolar Expeditions: Mania and Depression in American Culture* (Princeton and Oxford: Princeton University Press, 2007).

[60] C. Elliott, *Better Than Well: American Medicine Meets the American Dream* (New York: W. W. Norton & Co., 2004).

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with dopamine malfunctions. Moncrieff's analysis showed that instead of addressing the socio-economic causes of depression, medicine was given as a quick fix.[61] Similarly, if the presence of *care* or trust are connected with increased levels of oxytocin, focussing on the connection between morality and bio-chemistry, then wider social contexts that determine the quality and quantity of care will be overlooked.[62]

4. Conclusion: Webs of Care

The complexity of the brain's networks and connections are mirrored in the complexity of our relationships. In *Unfit for the Future*, Persson and Savulescu argued for the urgent necessity of moral enhancement, given that our *technological power*, together with *liberal democratic* freedom and *moral myopia*, imperil human existence. Their observation is correct, at least at first glance. But as Hauskeller notes, humans have already considerably expanded their circles of moral concern, so that they do not relate only with their own 'kin and a small circle of acquaintances', but also with people from different countries, societies and races.[63]

With a full acknowledgment of people as situated in their webs of care, or by making visible the webs of care that surround us, we can no longer maintain an ethical concept of "individuals" as autonomous, independent, and abstract agents. Human life builds up in *clusters* of people and not in isolation.[64] Moral decisions are influenced by others, directly or indirectly, and the morality of an action has significance only with the other in mind. The tensions, relationships, and dynamics of those clusters go beyond biological or evolutionary explanations. Biological factors are present, of course, and the

[61] J. Moncrieff, *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment* (Basingstoke and New York: Palgrave Macmillan, 2008); and J. Moncrieff, *The Bitterest Pill* (Basingstoke and New York: Palgrave Macmillan, 2013).

[62] S. Vreko, 'Folk Neurology and the Remaking of Identity', *Molecular Interventions* **6**:6 (2006), 300–303.

[63] M. Hauskeller, 'Is it Desirable to Be Able to Do the Undesirable? Moral Bioenhancement and the Little Alex Problem', *Cambridge Quarterly of Healthcare Ethics* **26**:3 (2017), 365–375.

[64] T. Manea, 'Care for Carers: Care Issues in the Context of Medical Migration', in Marian Barnes, Tula Brannelly, Lizzie Ward, and Nicki Ward (eds), *Ethics of Care: Critical International Perspectives* (Bristol: Policy Press, 2015), 207–219.

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neurosciences can reveal and help us understand these aspects of morality. But seeing the complexity and the interconnectivity of our moral actions, it is clearly difficult, if not impossible, to isolate certain moral traits and declare them to be "good" or "bad" in themselves.[65] Ambition can be good and bad; aggression can sometimes be a lifesaver, or used to start a political protest against a pernicious law, or to fight against discrimination. Excessive care, too, can be damaging for a child who needs space to experiment in taking risks and in life in general. There are no optimal levels of alertness, aggression, love, care, or bonding. Rather, all are produced by subtle and constant feedback processes involving moral feelings and the actions triggered, defined, and provoked by our web of care.

Regarding our alleged "moral myopia", another question arises: why and how do we extend our web of care? Modern technology entails that our social networks extend far beyond the physical space that once defined a community. People have "friends" around the globe with whom they share common interests, affinities, and parts of their life. To connect with someone presupposes the acknowledgement of some sort of commonalities that can generate empathy, love, or other feelings. Those commonalities – the knots of the web – can be totally contingent, like past life events, similar cases, people that resemble other people we cared about, or even a certain type of atmospheric situation brought about by a book, a film, or some other experience. It will be hard to explain the hormonal changes triggered by *Guernica* or the *Moonlight Sonata*, partly because different people will have different reactions. Yet those differences make us what we are.

In order to be more caring, at least in the sense of cultivating our attentiveness, there is a need to extend our particular group in order to connect with people that are not normally part of it. Can we artificially create or trigger commonalities and make new *web knots*? The picture of a dead child washed to the shore changed Europe's attitude towards war refugees. What was it in the picture that made us care? Perhaps the response was based on the fact that most of us have children. But what made the knot stronger was the realisation of our cruelty, the same cruelty analysed by Rorty, which is not in a particular action or disposition, but rather the absence of both, the indifference. We begin to step out of our cruel indifference when we learn to recognise possible commonalities and train our attentiveness. Commonalities are strengthened by

[65] M. Hauskeller, 'Being Good Enough to Prevent the Worst', *Journal of Medical Ethics* **41**:4 (2014), 289–290.

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recognising the insecurity of our world, and a possible reversibility of our historical *situatedness*. The way we perceive refugees is different, because perception and understanding is designed by personal experience, history, memory, events, or even capacity of understanding. Analysing the *situatedness* of each of us and the situatedness of our *clusters of care*, though complicated, could be achieved through the better cultivation of moral sensitivity. Finding a neurochemical equivalent of it seems at best a very remote possibility. To conclude, if we could hope for a possibility to enhance care, the answer is not juggling hormones at the individual level, but revealing and mending our social webs of care.

University of Exeter
etm205@exeter.ac.uk

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