CareVisions Briefing 3

Approaches to care within the Feminist Ethics of Care

Cliona Loughnane

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The feminist ethics of care has developed as a theoretical perspective which accounts for the importance of care for individuals and society and to suggest ways to resist the social inequities which undervalue caring. The ethics of care cannot be necessarily understood as a coherent, bounded, set of ideas; rather, care ethics developed since the 1980's from the contributions of a diverse range of theorists in different disciplinary contexts (see CareVisions Briefing Note 1, 2022). This briefing focuses on three approaches to care evident within the feminist ethics of care perspective: care as value; care as relational; and care as practice.

Care as value

Care as value describes the values displayed in undertaking, receiving, and thinking about care and the caring moral lens which can notice, evaluate, and renew caring values. Care values described across the care literature include reciprocity, mutuality, trust, understanding, relationship, solidarity, sensitivity, and compassion.

The ethics of care sees humans as dependent upon each other, connected by pressing moral claims by those who require and give care. As a result, care ethics seeks to address moral dilemmas experienced in care to develop good caring relations and enable human flourishing (Held, 2007). Care decision-making requires particular values and ethical judgement. While some may care more 'naturally', the maintenance of caring requires a moral commitment, an ethics of care (Held, 2007). Further, caring is sometimes difficult (Barnes, 2012) because care is a practice situated in power differences between care givers and receivers. As requirements or situations change, caring can become a site of conflict.

Caring is a practical morality, which arises directly from our life dilemmas (rather than abstract moral questions) and relates to particular contexts and caring relationships (Casalini, 2020). Care ethics developed in opposition to the dominance of Kantian or utilitarian moral theories built on contractual, rule-based public lives which ignored concern for relationships and caring activity in the so-called 'private' sphere (Held, 2006, 2007, 2014; Kittay, 2020; Tronto, 1993, 2013). Historically, an ethic of justice, concerned with fairness, equality, individual rights, abstract reasoning and non-interference has been emphasised in society and our institutions. These perspectives are inadequate to understand

human interdependence and care, which requires an ethic focused on the development of caring relations, of attentiveness, solidarity and trust (Held, 2007).

Virginia Held (2007) discerns a number of features within care ethics. Firstly, care ethics is centrally focused on taking responsibility for meeting the needs of particular others. Secondly, in the making of moral judgements – as in how and to whom to provide care – care ethics recognises how emotions and relational capabilities help us arrive at good moral decisions. Thirdly, care ethics rejects abstract, universal reasoning, in favour of noticing and responding to the specific context and the needs of those seeking our care. Fourthly, it rejects the public/private life separation of independent, unencumbered individuals, instead drawing attention to the power differentials and enmeshed nature of human relationships. The fifth, related, feature is how care ethics understands people as relational and interdependent, valuing actual ties and connections with others.

By caring we identify and demonstrate caring values and can use this caring knowledge to evaluate whether particular relations (familial, institutional, or political) are capable of the caring needed to live well in this world (Barnes, 2012). Considering care as a value enables us to consider the moral implications of caring not just in one-to-one care situations, but also how caring is supported across social, political, and economic life (Lynch, 2022; Tronto, 2013).

Care as relational

A second outlook within the feminist ethics of care is that caring relations connect all those giving and receiving care. Perceiving of humans as relational has significant ontological effects: we identify that people are able to act on their own only through their interdependent development with others; we recognise human vulnerability and fragility; and we recognise that we all – regardless of ability or infirmity – receive and give care (Tronto, 2017). Thus, the autonomy care ethics promotes is not to live apart from all others, rather it is the ability to create and develop caring relations, (Held, 2006, 2007).

A relational approach to care foregrounds the multiplicity of caring roles and conditions people experience over lifetimes (e.g., the child who received care becomes an adult caring for their parent with dementia (Guest and Corrigan, 2018)) and undermines the possibility of defining people in a binary of either care giver or care receiver (Barnes, 2012). Understanding care as a relational activity

reveals the complexity of care relations (Fine and Glendinning, 2005; Ward, 2015) and the varied ways care is provided – in groups and to groups, by multiple carers, outside of personal relationships, the web of supports needed to sustain care relations and to deliberate care through social policy – overturning the carer/cared-for binary with an understanding of networks of care and collective care (Barnes, 2015).

Human interdependence means that everyone will experience the positions of caregiver and care receiver, sometimes simultaneously. While the lazy image of the care receiver conjures up the old and infirm, all people rely on care (Tronto, 2013). An employee is 'free' to work and earn because of the sustaining meals and clean clothes organised at home, the caring community that provides the public transport she needs to get to work, and so on. The feminist ethics of care assists us to recognise the caring relations we live within *and* supports us as caring persons to adjudicate whether relations are caring, so that we can remake them, or, when necessary, throw them off (Held, 2006). Thus, while we are embedded in care relations, we retain our moral agency to assess and potentially withdraw from relations which are uncaring.

'Relational thinking' (Robinson, 1997: 130) based on our mutual dependence provides a critical lens to question inequality and power operating in and across societies (Tronto, 2018). Care ethicists illustrate that human relationality expands beyond our closest relations into the social and political context in which needs are experienced and met, or ignored (Barnes, 2012). As the COVID-19 pandemic has exposed, we exist in relation to dependence – our own, and the dependency which arises when we care for others (Engster, 2005; Kittay, 2013). As feminists have continually highlighted, 'it is deficient social assistance that makes so many of the commitments of the relational person so burdensome and hard to fulfil' (Held, 2006: 50). To be equitable and sustaining, care relations require 'a response from public services to enable social justice' (Barnes, 2012: 59).

Care as practice

A third outlook in the feminist ethics of care is that care is a practice. Examining care as a practice illustrates the labour involved in caring, the variances of care in different contexts and cultures, as well as the features of 'good care'. As a practice, care relates directly to care values and care relations, which are displayed and improved in the undertaking of the tasks of caring (Held, 2006, 2007).

Seeing care solely as a value obscures care as work, and *who* undertakes most of that work (Held, 2006). Care ethicists emphasise both the paid and unpaid labour involved in caring because 'care of dependents is *work*' (Kittay, 2020: 35). Patriarchal perspectives belittle the labour involved in care work; thus, it is typically passed onto the least privileged (Lynch and Walsh, 2009; Robinson, 2018; Tronto, 1993, 2013). Analysing care as a form of labour brings into sharp focus the gendered, raced, and colonial histories which influence present care provision (Keller and Kittay, 2017) and emphasises the ruinous conditions of many paid and unpaid carers (Rummery and Fine, 2012). Most care work is undertaken by women and most paid care workers are women of colour, increasingly migrant women from the Global South (Robinson, 2006; Yeates, 2012). This is the 'vicious circle' (Tronto, 1993: 114) in which 'care is devalued and the people who do caring work are devalued'.

Uncaring social and political systems impact the experience of care work. Increasingly, in developed economies care provision has become more complex as paid care has been professionalised and specialised, care markets have been introduced into welfare provision and new service delivery models have resulted in complex governance arrangements (Barnes, 2012). The treatment of care as a commodity has led care ethics to analyse the actual conditions of care work, including the social and economic forces impacting care arrangements (Barnes, 2012). For many carers the oppressive experience of caring reflects the lack of attention and resources to support the paid or unpaid work of care (Kittay, 2020). Structural inequalities further impact care workers' and unpaid carers' time to participate in political life (Cantillon and Lynch, 2017; Tronto, 2013). Care has been theorised both as 'a labour of love, and as a commodified activity (paid labour)' (Rummery and Fine, 2012: 322), with significant debates as to whether it is possible, or acceptable to commodify care (see for example Claassen, 2011 and Lynch and Walsh, 2009). The shift of care from the family home to institutional care provided through the state, the market or not-for-profit organisations requires that elements of good care are made overt.

Identifying 'good care' is an integral motivation of care ethics (Barnes, 2012). Assessing care is a crucial practice to end deficiencies in care, whether because of paternalism on the part of the caregiver, failure to account for the actual needs of the receiver, or because care relations exist within gendered or raced hierarchies (Held, 2014). Tronto (2013) imagines the good care we would all hope to receive: care given by someone happy and rewarded in their caregiving; care which attended to our specific needs, rather than some standard sense of care; and that we are able to share our contentment and frustrations about care with people who understand. Good care applies not only to interpersonal care,

care ethics also draws attention to collective responsibility for ensuring the conditions for and the provision of good care (Barnes, 2012; Tronto, 2013).

Conclusion

In summary, examining care as value, the feminist ethics of care considers the values displayed in caring and the moral lens needed to evaluate and renew caring values and create a care-centred society. Approaching care as relational, it attends to the relations at the centre of all care and human interdependence. Recognising care as practice, care ethics examines the work involved in caring and the differences of caring practices in specific contexts.

The feminist ethics of care offers a conceptual approach which challenges many of the accepted societal constructions of care and related policy responses. In expanding our understandings of care as a value, as relational and as a practice, the feminist ethics of care draws attention to the ways in which we are all bound up in relations of care and rejects a binary categorisation of people as care givers *or* care receivers. By identifying the conditions for good care, care ethics aims to improve the experience of care for receivers and givers. Care ethics also contends with care as politics, revealing care relations as nested in their social and political contexts and exposes the challenges particular groups face in providing or receiving care.

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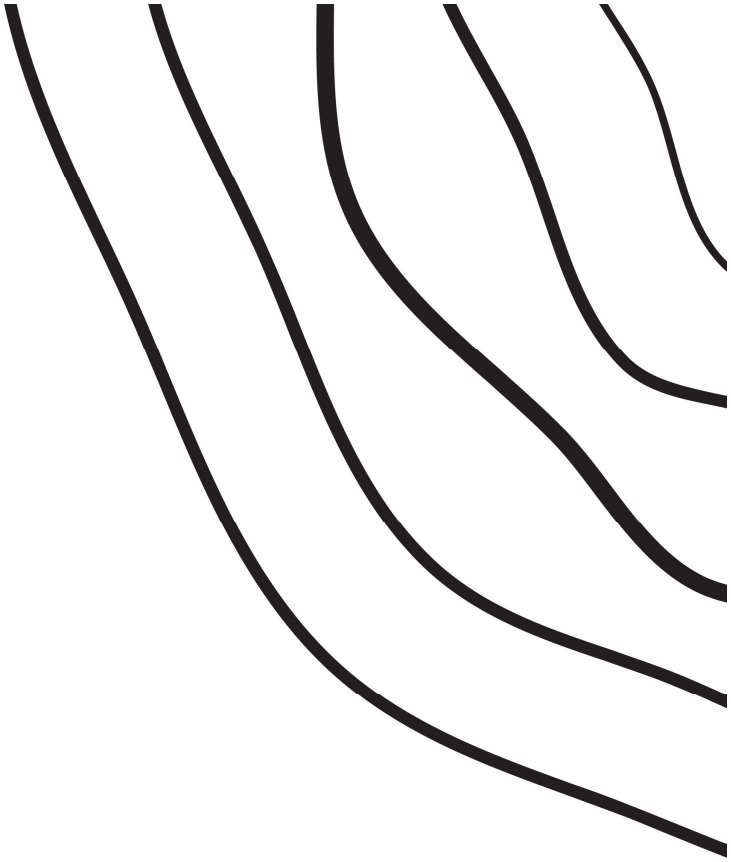

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Contact Details

www.carevisionsucc.ie | Twitter: @CareVisionsUCC | Email: Carevisions@ucc.ie

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