

# CareVisions Briefing 4

## Contestations in Care Ethics

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## Introduction

Critical engagement with concepts and ideas emerging from the feminist ethics of care has contributed to the further development of theoretical perspectives and their application in policy, practice and research approaches. While care ethics revealed power imbalances and inequality within care, the voices of those experiencing care and objecting to care abuses have provided greater critical insights. This briefing note reflects on three key contestations which seek to develop or extend debate in the on-going theorisation of care: critiques brought by those receiving care; intersectional analyses of the gendered, raced and classed nature of care; and a growing recognition of how inequality is exacerbated by the commodification and globalisation of care.

## Care Receiver Critiques

The theoretical grounding of the feminist ethics of care emerged from the perspectives of care providers with Tronto (1993) and Kittay (2020) among those who recognized how paternalism and power could shape care. Extensive critiques about the concept of care have been levelled at care ethicists by those *receiving* care, particularly people with disabilities. From a disability perspective care is a 'paradox' (Douglas, 2010) that is 'haunted by the specters of institutionalisation, medicalization and paternalistic charities which, in varying degrees past and present, systematically marginalize people with disabilities' (Kelly, 2011: 564). Tronto (2018: 23) herself acknowledges that the feminist ethics of care has not reconciled these concerns effectively and thus there is a 'strong distaste on the part of people with disabilities for care ethics; many have argued that care ethics errs against a more rights-based approach to disability and leaves people with disabilities in a state of being dependent'.

Disability rights activists have asserted disabled people's claims for equity, empowerment, choice and control and proposed a social model of disability to address disabled people's exclusion. Reflecting the social model, disability studies largely abandoned concepts of care, caring, family care-giving, formal and informal care as they were seen as 'conceptually contaminated' (Kröger, 2009, 399). Morris (1991), a disabled feminist scholar, found that disabled and older people's efforts to achieve better quality of care outside of residential care were compromised by feminists' rejection of community care given the burden on women. While Morris credited feminists for exposing the exploitation of women's unpaid care, she argued that disabled women's claims for the right to live in their own home must not be dismissed nor regarded as simply re-enacting oppressive

gender norms. Morris (1995) asserted that the feminist ethics of care reinforced social prejudice by framing older and disabled people as 'dependent people' and by not reflecting on the subjective reality of those who are 'cared for'. Thus, she stressed that research and policy should centre disabled people rather than the perspectives of care workers or informal carers (Kröger, 2009).

While disability perspectives on care rejects concepts of 'dependency' as oppressive and objectifying several authors have, however, proposed ways to work with tensions between care and calls for disabled people's autonomy and independence by emphasizing notions of interdependence. For example, Fine and Glendinning (2005) explored views on dependence, independence and interdependence and suggested that an emphasis on interdependence could be most useful if we are able to acknowledge dependency in caring relations. Kröger (2009: 416) embraces the utilisation of interdependence as it diminishes the sense of "'us' and 'them', that is between care givers and 'the dependent'". Nevertheless, Battalova (2019) cautions that mothering with a disability is not solely about dependence, nor is it fully interdependent as it involves 'adjustments' and supports that are inevitable in the context of responding to care needs. Williams (2001) suggested that we should emphasise self-determination rather than self-sufficiency given the vulnerabilities inherent in the human condition.

Kelly (2013) suggests that the dependency debate should be informed by feminist disability theorists' call for ambivalence. This would leave some care debates and contested terms unresolved which would allow people with disabilities to be independent while at the same time recognising that 'independence is not the sole indicator of personhood and success to which some people have access and others do not' (Kelly, 2013: 793). Furthermore, Kelly (2011) calls on disability activists and scholars to not condemn care outright while stressing that those engaging with both disability and feminist discourses shouldn't only concede to feminist viewpoints to shape accessible care.

It has been argued that certain groups have not been as able to assert their voices in the discourse on care ethics, including both older people and people with intellectual disabilities. In the context of older people, for example, Lloyd asserts that an ethics of care lens needs to take age into consideration, arguing 'how people live towards the end of their lives in old age is currently poorly understood by researchers, policy makers and service providers alike' (Lloyd, 2010: 198). Similarly, care discourse also needs to be alert to the missing voices of people with intellectual disabilities so that disability rights-driven care solutions do not attempt to 'bolt on' people with intellectual disabilities. For example, Kelly (2011: 577) found the model of independent living may be 'inadequate

in discussions of the needs of people with intellectual disabilities who may have difficulty making independent decisions about their lives, or in some cases expressing themselves verbally' (Kelly, 2011: 577). Drawing on Gilligan's (1982) theory of moral development, Ward (2015b) highlights how people with intellectual disabilities develop 'moral maturity', through being cared for. In turn they are able to apply moral development in order to understand and fulfil the needs of those that they care for, as well as to address their own needs as carers.

Feminist care ethics discourse must not ignore the dark side of care, spanning everyday abusive acts to structural violence embedded in institutions (Kelly, 2013). Empirical evidence of multiple forms of abuse reveals the reality that 'for many disabled people, the experience of violence is not separate from their experiences of care' (Kelly, 2017: 98). Physical violence is also a common experience for care workers and may be normalised as an expected part of the job. Kelly recommends that these realities be recognised and integrated into our understandings: 'care includes violence; violence is a part of care. The inclusion of violence in our definitions of care has the potential to disrupt and transform care relationships' (Kelly 2017: 107, emphasis in original). Feminist interrogation of gendered notions of selfless, empathic carers along with disability rights activists' challenges to stereotypes of passive, vulnerable care recipients can both be utilised when confronting these troubling realities.

## Intersectional Perspectives

Care ethics emerged from feminism's rejection of gendered notions of women's inherent altruism compassion, empathy and selflessness and challenged expectations that women should be responsible for enacting care at the expense of their own needs in order to be valued as a mother, wife or daughter (Pettersen, 2012). Early analysis embraced the focus on the under-valued private sphere, highlighting the oppressiveness of women's burden of caring as one manifestation of the feminist movement's emphasis on the 'personal as political' (Noddings, 1984; Ruddick, 1980). Critics of this approach warned against reinforcement of essentialist notions around gender differences which could undermine other feminist objectives (Held 1995; Hoagland, 1988; Tronto, 1993).

Tronto (2018) lamented that care ethics may have not been taken seriously by many scholars because it has been mistakenly labelled as form of 'cultural feminism' that valorises the feminine. Tronto (1987:650) also expressed concern that the formative care ethics research undertaken by Gilligan<sup>1</sup> could be perceived to have overlooked that 'the moral views of minority group

members... ..are much more likely to be characterized by an ethic of care than by an ethic of justice'. A number of commentators have also raised critiques of partiality in Gilligan's initial work including that it lacked relevance to Black women's experiences (Robinson, 1999; Hankivsky 2014; and Graham 2007). Ward (2015a) suggests that early work on care ethics is viewed as a 'product of its early time', reflecting how care is imbued with the social and cultural values, which may have been incomplete but remains valuable.

An intersectional lens that considers the compounding effects of multiple factors of inequality has been utilised to reveal experiences not previously featured within writing on the ethics of care. The transnational nature of care requires ongoing exploration of power imbalances which relate to gender as well as race, class and other forms of marginalisation (Hankivsky, 2014). Held (1995) acknowledged that the responsibility for both informal and institutionalized caring largely falls on working class and minority women. In responding to the need for intersectional analysis, Williams (2018) developed an analytical framework that 'synthesizes 'care' with an intersectional method and a political economy perspective' (Williams, 2018: 550).

Legacies of colonialism, slavery and racism have profoundly shaped the care sector and remain reflected in the racialised demographics of the care workforce. Narayan (1995) urges that care discourse continue to expose relationships of power and domination such as those between colonizers and colonized wherein the colonial project justified the enactment of paternalistic forms of 'care'. Recognising that the meaning and value of care has been deeply racialised, Raghuram (2019) calls on those writing on care ethics to think about how the theory intersects with race and other identities. Graham (2007) explored how Black women's historical exploitation as slaves and household servants in the British colonies, shaped recruitment practices in the National Health Service (NHS). In the NHS, Black women were assigned lower grade nursing positions and tied to the heavy end of caring in health settings and welfare provision, while white women had clearer routes to progress through labour hierarchies. Graham draws on the work of Hill Collins (2000) to explore how Black women adopt a spiritually inspired African-centred ethic to support their self-care and counteract the harmful stereotype of the 'strong Black woman' carer.

Akkan (2020) also considers how young female carers' experiences of multiple intersecting inequalities of class, gender, age and care giving during their childhood leads to the development of a subaltern gendered identity. Utilising a 'situated ethics of care' to examine intersections on gender and class, Faur and Tizziana (2018) found that the limited availability of public services results in

women struggling with the burden of care to varying degrees based on their socio-economic status. Such analysis remains crucial to expose conditions of work in care markets given that it is 'still gendered, and importantly it is heavily marked by intersectionalities such as class, ethnicity/race, religion and migration status...which necessitates a relational approach to pushing back against neoliberalism' (Lopez, 2019: 834-835).

## Contesting Commodification

Feminist care ethicists have contributed to the growing contestation to the commodification and globalisation of care, by revealing the inequalities that persist within neoliberal care markets. Critiques of the commodification of care recognise that paid care work may be a necessity but assert that it cannot substitute the 'primary care' enacted within our 'chosen dependencies or interdependencies' (Lynch and Walsh, 2009). Kittay (2009: 59) asserts that 'caring labor has properties that resist commodification'. Lynch and collaborators (Lynch et al 2021, Lynch and Walsh 2009) have used care theory to develop a concept of affective relations which stands as a challenge to commodified care provision, to justice-based attempts to overcome social inequality and to traditional sociological modes of thinking. The idea of commodifying 'primary care' is problematic because 'it is impossible to pay someone else to maintain your own relationship with someone you care for, but also because the trust, continuity and attachment characteristic of love labour cannot be secured by contract in contemporary labour markets' (Lynch and Walsh, 2009: 49).

Economic austerity measures in the Global North, such as public sector pay freezes or salary 'increases' that are not adjusted to rising cost of living, have hit paid care workers hard and made recruitment, into nursing in particular, less attractive. This impacts on ongoing reliance on health and care worker recruitment among workers from the Global South which in turn creates a 'brain drain'. While 'Global Care Chain' (GCC) scholarship has exposed the inequalities created through globalisation of care work, some have critiqued its limitations. An emphasis on care interactions in domestic and nursing care can evoke a normative view of the care needs of the most dependent and limit the transformative power of this analysis (Nguyen, Zavoretti and Tronto, 2017: 200).

Furthermore, GCC scholarship has frequently focused on migrant women workers which may reinforce perceptions of care as 'women's work'. Another concern is that by examining care which crosses state borders, GCC analysis may privilege aspects of transnationalisation and inadvertently reinforce the importance of borders (Yeates, 2012).

Tungohan (2019) urges that, in addition to GCC, we should adopt intersectional, decolonial and queer approaches in order to imagine just alternatives to transnational care (see also, Yeates, 2012). By paying attention to the particularities of situations and historical context, the complexity of transnational caregiving arrangements as sites of both joy and sadness can be documented in ways that overcome normative views of the migrant family (Tungohan, 2019). Using a more nuanced approach, Tungohan details experiences of children 'left behind' by migrants, the slipping identities of migrant carer as 'family member' and worker (see also Liang, 2018; Kittay, 2009) and the new definitions of 'family' for migrant carers whose family remains in their home country, which may provide freedom for women as well as sexual and gender diverse carers seeking to escape oppressive social norms. Liang's (2018) research among 'live-in' migrant workers in Taiwan demonstrates how care ethics can expand the rights-based analysis characteristic of migrant care studies in order to explore interdependency, emotional ties and power dynamics between care workers, care receivers and their families. While providing material benefits to their families, migrant workers are also engaged in a 'global heart transplant' (Ehrenreich and Hochschild, 2006) which may come with significant emotional costs to themselves and strain relationships within their families (Fraser, 2016; Kittay, 2009).

## Conclusion

A range of contestations, debates and dilemmas have shaped the development of ideas emerging from the feminist ethics of care making it more responsive, representative and relevant to care research. This reflects maturation of an area of scholarship which provides new theories about the centrality of care which can offer 'suggestions for the radical transformation of society' (Held, 2006: 12). Theorists have also urged that we overcome the 'impoverishment of our vocabulary for discussing caring' (Tronto, 1995: 113). In our efforts to offer new theoretical and practical applications, CareVisions is cognisant of existing critiques and of the need to expand our vocabulary to devise new understandings of care in Ireland and in a post-pandemic society.

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