

Rethinking critical reflection on care: late modern uncertainty and the implications for care ethics

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Abstract Care ethics as initiated by Gilligan, Held, Tronto and others (in the nineteen eighties and nineties) has from its onset been critical towards ethical concepts established in modernity, like ‘autonomy’, alternatively proposing to think from within relationships and to pay attention to power. In this article the question is raised whether renewal in this same critical vein is necessary and possible as late modern circumstances require rethinking the care ethical inquiry. Two late modern realities that invite to rethink care ethics are complexity and precariousness. Late modern organizations, like the general hospital, codetermined by various (control-, information-, safety-, accountability-) systems are characterized by complexity and the need for complexity reduction, both permeating care practices. By means of a heuristic use of the concept of precariousness, taken as the installment of uncertainty, it is shown that relations and power in late modern care organizations have changed, precluding the use of a straightforward domination idea of power. In the final section a proposition is made how to rethink the care ethical inquiry in order to take late modern circumstances into account: inquiry should always be related to the concerns of people and practitioners from within care practices.

Keywords Care ethics · Late modernity · Precariousness · General hospital · Power

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Introduction

Should we rethink critical reflection on care, as it has developed within the still relatively young discipline of care ethics? Our current conceptualization of care ethics is reflective of the conditions of modernity in which it was invented. Accordingly, the conceptual frames of care ethics seem to fall short of taking into account late modern circumstances, which, as Anthony Giddens has demonstrated, take modernity to extremes (Giddens 1991). This article therefore proposes a rethinking of care ethics.

Characteristic for the ethics of care are insights about the importance of relationality, and of positions of power (Klaver et al. 2014; Collins 2015). However, we will argue that taking late modern circumstances into account implies that these categories should be altered. This article proposes a rethinking of care ethics. First generation care ethics was developed in the 1980s, but since then, the world has seen significant shifts and boosts in global social and economic dynamics. We wonder whether care ethics has remained adequate to these changing circumstances. In this article, we discuss the challenges that the changed social structures and conditions of late modernity pose to care ethics. Specifically, we discuss how late modernity challenges the ways in which ‘power’ and ‘relationality’ were conceptualized in care ethics at its conception. We will argue that taking late modern circumstances into account also implies that these categories should be altered. We focus our discussion through a specific institution changed by the conditions of late modernity—the hospital.

As we will argue, it is the late modern circumstances of precariousness and uncertainty through which relations and power in the context of care are ultimately formed. This perspective enables us to see that a dominant conceptualization of power in terms of oppression—previously a

central concern of care ethics—and along with it, clear-cut categorizations of people as oppressors or as oppressed, hinders us from seeing more complex and covert social positioning as they occur in caring practices in institutional settings, in late modernity. Using examples from French and Dutch general hospitals, in this article we show how the positions of patients are systemically produced and how managers, supposedly in positions of power, are also precarious - either worn out by their positions or suddenly falling from their esteemed positions completely. Through examining the implications of these forms of precariousness (or the unexpected re-positioning in care practices), we ultimately aim to introduce one of the necessary routes of inquiry that can explore the working of late modernity.

Late modern circumstances and care ethics

In order to get clarity about the late modern predicament we mainly draw on three sociological theories, of Giddens, Rosa and Ehrenberg, all three of them distinguishing between modern and late modern, but emphasizing that this shift is not chronological.¹ For instance, in *The consequences of Modernity* (1991) Anthony Giddens characterizes late modernity as ‘modernity over the top’ (Giddens 1991). And as Rosa states, Late Modernity is not a phase after Modernity: it is a phase inside Modernity (Rosa 2016, p. 519). Modernity hasn’t so much ended, as that it has taken on a new radicalized form, whilst also being in contradiction with itself. To expound this, two characteristics can be established. Firstly, if modernity can be characterized as being fast paced, then the ‘hyper pace’ is typical of late modern society: everyday work requires people to speed up constantly, with little opportunity to slow down. Even though we feel an increasing longing to do things at a slower pace, the pace of things in society has in fact only increased (Rosa 2013, 2016). Rosa characterizes this as “putting material, social and mental circumstances in motion in an ever faster way”; “In the meantime the logic of dynamization—other than the formula of the modernity project suggests—has become a structural constraint itself”. (Rosa 2016, p. 673). As Adorno has pointed out as early as in 1956: there is no such thing as the ‘moderation of modernity’ (In: Bürger 2001, p. 23).

Secondly, what was pursued and valued greatly in modernity, autonomy, i.e. the ability to lead a fully autonomous life, has become something that is at odds with itself

in late modernity. Wagner even characterizes autonomy as the very core of Modernity (Wagner 2009, 2012). Nowadays there exists social pressure to be(come) autonomous. French sociologist Alain Ehrenberg calls this ‘the paradox of autonomy’ (Ehrenberg 2010): citizens are socially molded by regulations, they are impacted by external rules of behavior, protocols or by being nudged. Indeed, society has never been so (over)regulated as it is now. At the very same time society also encourages us to be autonomous, which has actually become a moral imperative. If it is modern to view the surrounding world as a means to advance one’s own interest, then it is late modern for the surrounding world to draw up boundaries whilst at the same time dictating us to act autonomously, to act authentically and make one’s own choices. As Robert Castel, honing Ehrenberg’s characterization of the typical Modern creed of autonomy as being in contradiction with itself, writes: “Autonomy-on-command is not autonomy at all, but a new mode of dominance” (Castel 2010, p. 26). Both the ceaseless dynamization of society and autonomy turning into dominance have impact on how to conceptualize relations and power. One can observe these late modern features in care organizations.

Modernity of care ethics

According to sociologist Peter Wagner that what in Modernity was pursued and valued as its very core is autonomy, i.e. the ability to determine one’s own course of life (Wagner 2009, 2012). As Macpherson (1976) and Willms (1979) have shown, the social and political impact of this ‘turn to the subject’ has been enormous, pervading in human relations, production and the political order. It has also been pervasive in normative theory, where people were subsequently projected as individuals who are independent and self-sufficient, stipulating the ideal relationship in more or less contractual terms, where people act as equal citizens within a public realm.

Now, right from its onset care ethics was critical of this conceptualization. The first critical insights that provided the basis of care ethics, were gained through critical reflection on how American society depicted the learning of moral judgement during the seventies and eighties. First generation care ethicists put gender, race and power (in the Weberian sense of oppression) on the ethical agenda, thereby criticizing the inadequacy of existing ethical utilitarian and deontological theories (Hankivsky 2014). Standard ethical theories were critiqued as reliant upon supposedly ‘objective’ ethical categories such as autonomy, obscuring how much they were in fact predicated on an economically privileged form of white masculine selfhood. In these theories, gender, race, poverty and social power

¹ We differentiate this sociological attention for transformation in real life occurrences from mere philosophical and cultural theory approaches of Modernity. (Rosa 2016, 672) We restrict the argument to the western hemisphere and we do not enter, here, the debate on multiple modernities.

were simply domains to which ethics could be applied, rather than understood as constitutive of the very categories on which these theories depended. Care ethicists of the first generation such as Nel Noddings and others have therefore always been critical of the very idea of universal principles within the realm of ethics. First and second generation care ethicists did not intend to formulate principles independent of societal or contextual conditions, i.e. principles with a claim on universality, on the contrary. (Vosman 2016, p. 63; Engster 2015). The tendency to substantiate and generalize insights, gained through painstaking analysis, and make principles out of them runs completely counter to the freshly gained insight (Collins 2015).

Care ethics, then, explicitly emphasizes and privileges the relational, the local and the particular, over or often in rejection of concepts of the universal, the generalizable and the autonomous individual; and this critical stance was formulated as a deliberate critique of the foundational concepts of modernity. Where does that leave care ethics, in facing late modernity?.

Tronto and others have alerted us to reflect on care as practice rather than as the application of a theory or a set of principles which guide care activities. Caring gets its meaning from within the practices of care, i.e. from *the doings and sayings* of those on a field or site (Schatzki 1996). A practice theory approach of caring further paves the way for care ethics to deepen the insight that caring is a practice, as the representation in practice theory of how the actors, the specific materiality on the field (like the building, equipment etc.) and the lapse of time mold the action of caring allow for the differing complexities of practices.

Furthermore, practices of care can be conceived of as being much broader than one domain such as health care. The ensemble of caring practices constitutes the actual ordering of living together: caring enables living together. These important insights have significantly helped advance the discipline of care ethics and are still the basis of its conceptual categories. In substance care ethics is a critical endeavor to look at Modern societies from another angle, that is, bottom up, from the perspective of life lived. In itself care ethics is thus a critique of Modernity, offering an alternative, via its emphasis on relations as the locus to find out what is good, on the particular good of real and concrete people within a particular context and on emotions as intelligent strivings.

Entering the late modern mode

Although care ethics staged itself as a critical enterprise, it still remains largely under-theorized with regard to late modernity. As care ethicist Virginia Held stresses, “the ethics of care still has many weaknesses and lacunae, but

its development is an ongoing, cooperative project” (Held 2006, p. 6). In line with this, Joan Tronto has pointed to the opacity of one’s concepts: “Theories and frameworks exert a power over how we think; if we ignore this power then we are likely to misunderstand why our arguments seem ineffectual” (Tronto 1993, p. 4).

Our assumption is that care ethics has the capacity to develop itself into a next stage, discerning what late modernity implies and the urge to recast one’s modern categories, possibly even discarding oneself from concepts that are no longer adequate. Before we elaborate as to how care ethics as a critical enterprise might be further developed, we turn to a particular practice of care, on (a) site: the general hospital. A common critical insight of care ethics is the strategy of ‘thinking upwards’, from within practices of care. In doing so, we will stress the need to perceive what actually happens, what is both said and done, but also *undergone* on a site (Vosman 2016). This research is framed in an inquiry, a relational inquiry, by focusing on insecurity on the site as it develops under late modern conditions. We will specifically address a particular kind of uncertainty, namely precariousness, i.e. the insecurity about positions and ordering. After that in the third, last section we will zoom out and look again at the aims and mission of care ethics.

Discerning precariousness

Precariousness, as we term it initially, is about ongoing insecurity of one’s own position in the ordering of the community. In order to flesh out the concept, we are inspired by the insights of third generation French care ethicists such as Guillaume le Blanc, Fabienne Brugère and Sandra Laugier on precariousness. We will rely on recent conceptual research by the German sociologist Oliver Marchart (2013a, b) and French sociologist Alain Ehrenberg (2010). The main intention here is to use precariousness as a search term, rather than using a complete definition which can be applied to a particular site. In doing so, we utilize precariousness as a heuristic device, rather than as a hermeneutic or normative concept. Drawing on Marchart (2013a) we provide a comprehensive working definition of precariousness: *the lingering insecurity about one’s position in the future with regard to labor, income, status as it is depicted in the media and allocation (as a ‘citizen’, ‘client’)* (Kaplan 2010) *in institutions, produced in a society that provokes speeding as a means of its survival.* Again, we use it heuristically, not in a deductive way: we intend to discern what happens in health care practices, in a general hospital context, by making use of a ‘precariousness lens’ (cf. Nicolini 2013). What then becomes visible in practices of care when looking through such a precariousness lens? We will

present two observations of how practices of care reveal themselves.

At the emergency ward

The first observation comes from an Emergency ward in a French general hospital. In their book *L'Hôpital: un monde sans pitié* (2012), Claire Compagnon and Thomas Sannié, two French patients with a chronic condition, have researched what patients experience when they come to hospital for diagnosis and treatment. Compagnon and Sannié use two original perspectives on being ill. Firstly, they address what it means to be in the position of a *patient*. Being a patient implies not only to be in bodily condition but also implies having a social position. By being ill one becomes a patient when one relates to organized health care: when going to your GP, when undergoing diagnosis in hospital, when being on a therapeutic pathway for years, or when hearing bad news from an oncologist in the company of your sibling on the ward. The authors don't focus on how it feels to be ill nor on narratives about being ill. It is not about the emotions as such, but about what the refer to, e.g. anxiety referring to being left alone, by potent actors, with one's excruciating pain. Neither is it about the "self-fashioning" of a patient by means of his or her story (Jurecic 2012, p. 94), but about having a position amongst other actors on a site. Compagnon and Sannié concentrate on what a feeling (such as anxiety, indignation, relief) expresses about the position in which the patient finds him (or her) self, when relating to others and to the care organization.

Secondly, the authors also address the position of the *citizen*, by looking behind the scenes of the hospital which the patient is visiting. A patient has to *undergo* an order, as is (pre-) established within the care organization: there is a certain number of caregivers on duty, there is a certain capacity in the lab, there is a fixed hour during which a patient may call to hear the results of the test on his white blood cells. But the citizen patient also *reflects on* the order in which he (she) finds himself. Compagnon and Sannié thereby open up a political dimension. The patient is also the one who has his/her thoughts on how things are arranged, the one who is able to reflect and the one that can raise his voice in the political arena.

Position within a practice

The bifocal attention for the patient's position on the actual site of care and for the patient citizen, is rather

uncommon. There are many publications and websites dedicated to experiences of patients. There is ample reflection on being ill and—system related—on *becoming* a patient. It is however rare to find an inquiry into patient position(s), next to other positions in a very concrete site.

For care ethics, which owes its advancement in part to the ideas brought forward by Joan Tronto (1993) on the divide between public and private (in her game changing book *Moral Boundaries*), it seems imperative to adopt this bifocal view, thereby not accepting the division between care and illness as a reality defined in and confined to the private sphere. Being a patient is an elementary political category: it is about the ordering of relations. Reflecting in an inductive way, from within actual practices of care, relations materialize in an institutional setting that has a purpose (working on other people's living bodies in order to be of assistance, possibly cure). If we switch for a moment from the perspective of patients to that of professionals: professionals in care organization like a hospital do have their professional "propositional" knowledge (what the books, fixed protocols etc. tell) on what to do to relieve pain, what to do to get a valid diagnosis etc. They also have non-propositional knowledge: how to have some form of civilized contact with patients. That is not a matter of 'applying a moral value', such as respect. In line with Ogien (2014), it is within the actual situation (here: in a hospital) and thus with the actual knowledge of how things are, that people deal with "incompleteness" (Ogien 2014, pp. 83–84). They ignore the rules, or bend them, or opt out. The "situation has a weight of its own". The public character of the care practice means that participants can observe and know that they are observed as participants of that very practice (Ogien, *ibidem*). This means that there is a definitely non-romantic and non-idealistic approach of relations at work which fits with the care ethical idea of thinking bottom up. We would like to formulate it as an amendment to the care ethical notion of relations, because of the institutional setting: relational knowledge gives account of the weight of the situation (a) and is positional (b). With regard to positions in a field, we believe that marking out the positions relative to each other enables us to see the political character of the field. Discerning positions does not necessarily lead to division and antagonism. Rather it becomes clear how morally ambiguous positions are. Without them we cannot see where the actual good might emerge. For analytical reasons we advocate the switch from a philosophical ethical view on position to a mere sociological one (Keller 2011, p. 209; Vosman et al. 2016, pp. 126–127), i.e. to view subjects as social actors and at the same time beings that are impacted by others, materiality and time.

Box 1 Excerpt from: *L'Hôpital un monde sans pitié* (Compagnon and Sannié 2012, pp. 45–49), our translation

Observation made on February 15 2012, between 7.30 and 11 PM

While a patient is waiting at the Emergency ward, she is writing down her observations....The patient observes three nurses who are literally having a conversation over the head of another patient. They also talk about work related things such as: 'radiology has too much staff', whereas they feel they clearly have 'a lack of caregivers' at the Emergency ward. The patient observes how this other patient, a woman between 65 and 70, with what looks like a broken ankle, does not get any pain killers, or ice, for at least an hour and a half, as both of them, patient-observer and her fellow patient, are waiting for an X-ray

The woman with the broken ankle is obviously in pain and is getting tenser by the minute. Then the husband of the observer arrives. Confronted with the situation, the husband starts looking and subsequently finds a physician and asks her to pay attention to the woman who has been in pain. By coincidence the husband then overhears a phone call made by the physician the husband sought out, with another physician, the orthopedic surgeon, who gives the instruction to send the woman with the broken ankle to another hospital: he cannot operate, afterwards there is no bed available. By now she has been sitting there in pain for 3 h

Box 2 Excerpt from: *L'Hôpital un monde sans pitié*. Compagnon and Sannié 2012, p. 48, our translation

"being a physician in a hospital myself I know about the stress under which we have to respond to our patients. The various dysfunctionalities are not a matter of means, of personnel". The effect is that "patients can't do anything but endure the situation..."

Suffering

Compagnon and Sannié take an approach that is unusual in yet another sense: they frame the experiences of patients as *suffering*. In care discourse this is rare, as the modernist autonomous subject with his or her needs, preferences, and judgments on the quality of life is more frequently used to frame experiences. Although these terms do relate to suffering, suffering as such is hardly ever explicitly mentioned. Instead, Compagnon and Sannié's book raises questions such as: what does it mean to you as a citizen when you are waiting in an Emergency unit for 3 h, while in pain and in fear of having a broken collarbone? What does it mean for an elderly woman with Parkinson's disease when her knee operation is postponed by the planning department for the third time? Her daughter took time off twice in order to take care of her mother, but there is no chance that she can stay away from her job now. How do they view the postponement as citizens? Compagnon and Sannié thus focus on what we call the political dimension of being a patient, by opening up a different space of reflection: "I am ill, I am in pain, undergoing this situation in hospital. But how do I reflect on these realities in this site as a citizen?" Although Compagnon and Sannié would not identify themselves as care ethicists, they do however have a similar political and practice oriented stance. Consider the following excerpt in Box 1, taken from their book.

What makes this observation so interesting is that both the patient who is observing and her husband turn out to be physicians themselves, one of them in a different hospital. They realize they have a completely different position here, as they are not being recognized as doctors. Their professional position is of no importance here. They subsequently realize that their perspective has radically changed, shifting from a physician's perspective to a (fellow) patient's

perspective when sitting next to another patient in pain. In their report they indicate that they are perplexed and raise professional questions as to why the pain protocol was not observed (Box 2).

They also realize that patients have these experiences every day, and are positioned as 'endurers', not because caregivers have bad intentions, but because the care they provide has lost its focus. This focus, i.e. taking care of people who are suffering, is lost, as care becomes self-referential, preoccupied with its own organization and wellbeing. The observations of the two physicians also show that positions in practices of care are of the utmost importance: who stands where in the site (Delbridge and Edwards 2013).

Any (moral) indignation about the carelessness of the situation would then not be the most apt response to their observations. Although indignation does help to see what is morally at stake, remaining indignant could cloud further insight. It is in fact the *perplexity* of the two physicians that helps our reflection. They experience something that they previously could not have envisaged: they start to perceive in another manner, from another position on the site. As doctors they are upset about the organizational course of action. When they speak with one another about the question why rules are not being observed, they touch upon an issue that occurs in late modern professional organizations: the disappearance of rules, at a time where many complain of an excess of rules. Through the disappearance of a certain kind of rules, i.e. rules that were once constitutive of the profession, the organization loses not only its focus, but its *telos* as well. The physicians realize they have been superseded as physicians, not by means of an intentional act, not because of a disparaging attitude of the staff, or by any other, directly moral, point of view with regard to organizational realities. They have simply been displaced from their position. Although relationally engaged in the

Box 3 Empirical research on transition in a general hospital in the Netherlands (Baart and Vosman 2015)

During a 5 year period (2009–2014) Baart and Vosman, and a group of care ethics researchers from Tilburg University, undertook an effort to intervene in a general hospital in the Netherlands, in the transition process hospital care in The Netherlands is going through, by means of a program called Professional Loving Care. The underlying idea was that care practices tend to lose the patient's perspective from sight, focused as they are on professional standards and organizational preoccupations. The program wanted to develop a reflective culture, through learning communities and research accompanying this reflection. The central question was: what makes care to be good care, 'good' including proper medical and nursing quality of work, attitudes and moral orientations. The sub question was: how can the patients concerns play a more central role in care giving

The team of five researchers (two professors, one postdoc researcher and three Ph.D students) conducted observations (the shadowing of patients, nurses and physicians), interviews with middle and top level managers and interviews with physicians and nurses, combining qualitative empirical approaches with conceptual research, following a grounded theory approach. The level of generalization strived for was modest, the level of validity modelled on plausibility, via plural member checks

Publications in English up to now are on the trajectories of the very old in hospital, on what paying attention implies at the oncology ward, on the reflection and learning processes in learning communities, on caregivers getting seriously ill themselves, on medical complaints and ordinary life concerns of patients and on reframing hospital labor within a practice theory approach. Topics in hitherto Dutch publications are amongst others: a discourse analysis of letters of complaint (by patients or relatives) and an analysis of a key hole case (2, 5 month stay of an elderly lady in hospital with many, medically a-typical complications)

situation, the physicians become very uncertain about their own position as both physician and patient. If talking with the medical and nursing staff present does not yield any change, what does that imply about the position of patients? Remaining at the intersubjective level of relations means incapacitating further analysis of complex care practices within an organization.

The rise and fall of managers

We will continue our reflection with a second case, drawing on our own empirical research in a general hospital in the Netherlands (Baart and Vosman 2015) (see Box 3). Between 2009 and 2014, research was conducted at a hospital in the Netherlands. The main goal was to observe, interview and converse in groups about what both patients and caregivers conceive of good care and what kind of behaviors might be considered as good care. One of the striking features in such an organization was the high turnover of managers, team leaders and executives, which in fact can be observed in many care organizations. Initially we primarily regarded it as matter inconvenient to us. Gradually however we started to see what both the concern and purport of the labor of managers (at varying levels) was, instead of being quick to judge them as the new power, executing a neoliberal agenda of profit maximization. As soon as we as researchers started to observe from *within* these practices of care, the touselled action within the hospital became noticeable. We effectively bracketed our presuppositions (Tufford 2010). What suddenly became apparent was that caregivers constantly try to get things done through and for others: by phoning, emailing and leaving (written or recorded) messages for the next shift. They are busy 'knitting'. The underlying idea being that otherwise the whole care process would be stalled and your colleague

of the next shift would be left with the consequences. This process of information giving with the aim of subsequent action(s) turns out to be incredibly complex. Information sharing is just one of the strands of the complexity that the hospital had to deal with, as do many other care organizations, despite their inherent differences. An 365/24 organization with many disciplines and many part-timers is a problem to itself. Indeed, this late modern phenomenon of (organizational) complexity has been widely reported in varying disciplines such as organization studies (Amalberti 2013; Kernick 2004; Dekker 2004), psychology of labor but also within philosophy, in epistemology and ethics (Cilliers, Morin, Kunneman: "Ethical complexity"). Complexity is used in varied ways with regard to institutionalized care practices (Wilson et al. 2001; Innes et al. 2005; Sims et al. 2015). We use as a working definition of complexity, that emphasizes the working of complexity and working with it. We draw on Schmidt (2015) and Baecker (2011, 2013), who have studied the paradox of increasing and at the same time reducing complexity in an organization: *the ongoing confluence of different strivings, governed by different reasonings, all aiming at the sustainment of the organization by permanently changing it*. Managers use, often in a superb manner, the ability to "oscillate" (Schmidt 2015, p. 272) in this paradox of sustainment and change. The definition is strictly heuristic, as it tries to help discernment. Indeed we do, then, observe a feature of complexity like non-linearity: the organization does not respond proportionally to who and what comes into the organization. A large number of patients presenting themselves to ER while staff is small may lead to exponential, sudden and even stochastic changes (Kannampalli et al. 2014). Our aim here is not to theorize further, but rather we want to inquire into the actual recasting of the site and into the repositioning of participants on that site.

Of course, many kinds of (social) technological systems have been introduced into health care with the aim of making healthcare more efficient by eliminating all superfluous acts and means from those processes. These systems are brought into health care for a variety of reasons (Kaissi 2012): because of the (perceived) demands of society, such as the demand for (more) transparency; but also the demands springing from developments in medicine and demands from patient organizations.

These demands increase complexity, thus propelling management to reduce this ever increasing complexity (Kernick 2004). At the same time managers are also continuously contributing to this complexity, by increasing the pace of work, movements and fluidity in organizational processes. The German sociologist Dirk Baecker (2011) formulates it concisely when he points out that: “it is of importance that the organization never comes to rest”. In other words, management should never assume that everything is in order.

Part of the systems that are used to reduce complexity arises from the needs as they occur within the hospital, such as the need for correct and complete information on the condition of the patient, diagnosis, lab results and so on. Other systems are imported into the hospital, induced by national and EU policies. As researchers we observed that the actual use of systems such as the electronic patient record (EPR) and the electronic nursing file took between 26 and 31% of the time available to nurses during a shift. The introduction, maintenance and renewal of many systems consequently has several implications for the manner in which care is organized (Boonen et al. 2016). So caring practices are not only about attentive and competent nurses and physicians who know how to listen to patient concerns. Caring practices are also not simply about integrating different logics: i.e. the logic of caring with the logic of managing and the logic of the market and so on. Caring practices are (also) about combining completely different self-referential “materialities”, such as an EPR, or an electronic medication system. Caring practices are—also- about keeping together the introduction and maintenance of systems and social technologies such as the Lean approach, and of coming to grips with financial flows. The executive leadership of the hospital has to deal with government and insurance company policies which not only change rapidly, but can also be internally inconsistent or even contradictory with one another. Both the board and higher management spend vast amounts of time coping with these external policies. Although certain managers remain confident with regard to complexity reduction via systems, as some seem to entertain the phantasm that the insoluble can be grasped and managed, many however are critically aware of the feasible, the insoluble and the simply tragic.

For instance, certain managers we observed tried to give physicians and nurses a shared responsibility as ‘cooperators’ on a ward, rather than pursuing a hierarchical model of work, hierarchy that might lead to tensions and wouldn’t tap into the (different forms of) available knowledge. At the same time these managers were also busy contributing to the increase of complexity, e.g. by introducing three ‘renewals’ at the same time: (1) integrating two teams of nurses, of two completely different medical wards, into one single multi applicable team, (2) trying to introduce and manage the merger of two different hospitals whilst also (3) trying to intensify the Lean approach of working processes amongst employees. Thus as complexity reduction in the hospital reached a certain level of stability, this was paradoxically achieved through a state of constant renewal: all partakers accepted that they and all processes are ultimately, constantly on the move. One of the top managers of the hospital literally depicted this state: “as long as we keep the matter liquefied we are doing a good job”. No doubt this liquid state has its consequences, as all partakers seemed to remain at surface level, refraining from diving in too deeply into anything, instead preferring to resort to short description(s) and quick solutions, trying to stay on top of things, surfing the waves of transition. Apart from ‘knitting’, ‘surfing’ is also important for complexity reduction by managers. Our observations seemed to have encapsulated the late modern character of the organization, as the continuation of the hospital appeared to be grounded in its pace (i.e. being on the go), rather than in its aims, striving for its own particular (care-based) telos. This does *not* imply that physicians and nurses do not give good care on a daily basis. But the pursuit of that telos is overshadowed by complexity reduction via speeding.

Care ethics should look upon this managerial work as vital and necessary in organizationally embedded practices of care. Macintyre’s well known definition of practices (1984), oriented towards the telos of practices and the realization of moral goods inherent to that practice remains important. We would however claim that in a care ethical inquiry telos and moral goods should be conceived as being heuristic rather than normative categories. What is a hospital actually striving for, what actual care is given? Nobody can set moral standards for the hospital by simply pointing at its telos and the subsequent moral goods which are at stake. We can however, by means of qualitative empirical research, gain insight into which goals are actually pursued, what professionals and patients indicate as goals. We can also construe how these goals can be compared to goals for medicine, nursing and for organizations from ethical traditions, thereby noticing how the goals of medicine (to pick one of three main goal orientations) are lost from sight or are being obscured through quality jargon (Plsek and Greenhalgh 2001; Wilson et al. 2001). We could try

and refocus complexity and the messiness of care practices towards medical goals. However, then we would fail to understand late modernity, with its paradoxes. As much as we have to acknowledge the necessity of the medical reduction (the patients complaint is reduced to the examination of the causes, as the treatment is the intervention), likewise we also have to acknowledge the constant attendance to complexity reduction: there is nonstop labor of physicians, nurses and managers, undergoing and navigating the conditions of complexity. The labor of complexity reduction is not totalitarian, but as Crozier and Friedberg pointedly expressed it, ‘opportunistic’ (Crozier and Friedberg 1981). The complexity reduction may be accompanied by care professionals becoming overstretched. When for instance in the hospital a campaign is held to increase hygiene, there are small teams on the floor to distribute yellow and red cards, like in a soccer match. Those care professionals who are caught wearing their wedding band (unhygienic) will get a red card on the ward. The physician who does not wear a white coat can also get a reprimand. Interestingly, fluidity is the most important issue in the campaign. As a team member stated: “as long as their consciousness is raised, this is what counts”. Fluidity itself though does have its consequences: staff themselves will start surfing the waves of complexity.

Having drawn a picture of the context of the managerial labor, from a care ethical point of view we can now also observe something different in this ‘complexity traffic’, the flipside of their knitting and surfing capacities, namely the waste of managers. Because if managers do not show the ability to ‘keep things fluid’, that is to say, to change not only by achieving (short term) results but also complete cultures of a ward or a team, they will immediately be replaced. This capacity to generate change, the ability to liquefy, is thus a condition by which managers are judged. Although managers in hospital have to keep an overview, be stress resistant and play an exemplary role, being a liquefier is ultimately the most important.

The swift release of managers is not a matter of simple raw exclusion. Rather it is a subtle way of being removed from a position. Behind the scenes the removal may be harsh, to outsiders it is often framed in a soft manner, e.g. (from field notes) “*all parties have come to the shared decision that pursuing a career elsewhere is preferable...*”. Thus managers are constantly insecure about their position, not in the psychological sense, but in terms of the game that is being played. There is a humorous but also rather ominous sounding expression amongst managers: each manager has an *expiry date*, just like a carton of fresh milk. The managers will work somewhere, will play the game, but are also well aware that after a certain period of time their expiry date will come: the organization has taken on another course again and is thus in need of other people as

liquefiers. Managers are thus always placed in a finite position to function as a liquefier and to deliver, until recall.

Precariousness as a heuristic concept

Our proposal is to use the concept of precariousness as follows: strictly as a heuristic concept, as a lens to perceive (more), to see sharp and analyze what happens in organized, highly complex care. Thus we identify our inquiry as using an emergent method (Charmaz 2010, p. 156). We situate it at the brink of going from inductive to abductive reasoning, allowing “to account for surprises, anomalies or puzzles in the collected data” (Charmaz 2010, p. 157). Precariousness can then be a starting point for an inquiry, a journey through the organization during which we look closely at which movements in positions and relations are becoming visible. To remind our readers, we will use the following shortened version of our working definition of precariousness: *the insecurity about one’s own position within the order of society, both in the present and in the time to come*. But it isn’t just the top manager who is being laid off from the hospital in his fourth year, someone who up into his third year was described as “excellent in leadership”. One can also take into consideration those people who are continuously hired on temporary contracts (as is for instance the case at universities). Or those people who either have to take care of the very ill, or get severely ill themselves during the remainder of their contract, as the insecurity with regard to their position in the enterprise and in society increases, because they cannot perform ‘at the full 100% that is desirable in these important positions’. There is not only insecurity about the level at which they perform, but also with regard to their relationships, as research on ‘informal care’ shows (Bee et al. 2009). With regard to precariousness we might also point to the phenomenon of ‘othering’ of vulnerable people, including the elderly, meaning that people can be brought into a position of being ‘the other’, of a ‘them’ at the other side of an (active) ‘we’ that is being installed. This othering leads to grave insecurity about people’s (legitimate) position in their community or society, and whether there will be help when they need it.

These examples stretch the meaning of precariousness, which is often restricted to economic insecurity, to also include insecurity about positions and relationships on a societal level as we suggested in our working definition of precariousness. Next to this focus, precariousness is also about the powerlessness against that insecurity. Precariousness as heuristic concept visualizes positions and relations within a community, positions and relations as they are seated on the index of insecurity. When we say heuristic, we also imply: insecurity shall not be limited to a

psychological definition. It is not only about how it feels if you are laid off 10 months after you were promoted to lead the ward, i.e. ‘to clean up the mess’, because you were not able to ‘get things moving in the culture of this ward’. Of course it is important to take feelings into consideration. But we have to be aware of the fact that something has been done prior to those feelings: they have been turned into *private* feelings. To private emotions no relational and no organizational meaning may be given: the ex-team leader has to go in silence. Precariousness should thus not be reduced to private feelings, nor should it be stripped from its social meaning, as its heuristic value would then diminish. Precariousness therefore isn’t just about wages or about forming another social call of the socially insecure, as for instance Standing (2011) proposes. Precariousness encompasses a much larger domain, including the subtle removal of people using nudges and HR techniques. The language that is used moves away from harsh realities, as expressions are used such as ‘we decided to say goodbye to one another and go separate ways’ with this surprising use of ‘we’.

To sum up, precariousness is not just about the inner world of the person who is being “precaritized”. Le Blanc stresses that “precaritization” is about an “operation” on individuals, not primarily and essentially about a stigma of a feeling (Le Blanc 2007, p. 113). Precariousness is also not just about groups of people who are obviously marginalized, such as the ‘illegal’ *sans papiers*. Precariousness is about making people vulnerable in the polis, as they are taken from their position and brought into a “zone of insecurity” within the political order (Castel 2010, p. 26). This repositioning can involve large groups. Society installs insecurity of position and relations, positions such as those of the elderly which are seen as a large policy or public health problem. Precariousness is thus the lens through which we can see the insecurity of all in the polis with regard to partaking in the polis.

Two methodological pointers

We have been looking at two care practices in an institutional context, imbued by systems. Firstly, from a methodological point of view, the use of precariousness as a heuristic device is more interesting when looking at phenomena in the hospital, as opposed to using a more standard concept of power and oppression: thus we are able to *discern more*. Oppression, in the double sense of imposing one’s will to others, or getting other’s people will imposed, is actually a perspective from which less can be seen. With precariousness as a permeable concept we do not (pre)define, but rather stay close to what is urgent in care practices. However, using a broad idea of precariousness as sketched above certainly does not imply that every

uncertainty is suddenly precarious. Precariousness is about the uncertainty of one’s position when in and due to an institutional setting. It surfaces when looking for threshold-, joint-, and fracture phenomena that are related to the cohesion in the organization.

When emphasizing the installment of positions and relations, there is of course need of additional permeable concepts—preferably to include a complete political phenomenology of organizations and ‘communities’. So, secondly, the lever for this approach is: looking for *positions in a site* where an ensemble of care practices occurs. Only then will we be able to perceive both high and low positions, but also close by and distant, distended and latent positions, pulsating relationships (the in between of positions) and withdrawal in relationships. Phenomenology exercised in the right way might offer a large(r) number of distinctions which are ultimately essential when doing an inquiry into practices of care. For instance, stories of patients are not simply expressions of interiority or narratives detached from care practices—rather they are sayings that mark positions and relations (Jurecic 2012).

Thinking along, counter thinking, rethinking

We have been describing the episodes of a patient waiting in the ER and of managers who are dismissed. We have outlined the paradoxical phenomenon of complexity reduction and introduced precariousness as a heuristic concept. We also pointed to the methodological necessity of permeable concepts and a phenomenological approach of positions and relations on a site. Care ethics should use all these lines of thought in order to be loyal to the concerns of (relatives of) patients and care practitioners, including managers. This is intimately linked to repositioning care ethics. The epistemological issue of what in an inquiry is seen and what counts as knowledge is linked with the critical engagement of the inquirers with what is at stake for practitioners. Care ethics is not about giving normative prescriptions from the outside of a practice, it is rather about looking along with practitioners at what they see, looking at what is good and bad in a practice and discerning them in the ethos. Baart and Vosman (2015) have described care ethics as a three-step approach: thinking along, counter thinking and rethinking (Baart and Vosman 2015). *Thinking along* implies taking the perspectives of patients, nurses, physicians and managers seriously, as opposed to resorting in this phase to analytical, ‘objectifying’ reflective interventions (e.g. introducing a psychological cause effect explanation or moral principles). This first phase draws on phenomenology as a method and presupposes essential political ethical ideas about perception in the

political domain (opened up by the idea on positions and relations in the polis).

Counter thinking is the phase of critically looking at what the inquirer sees and hears, and searching for more fitting frames, testing popular but not necessarily helpful care formulas (e.g. ‘shared decision making’ which includes three under theorized components: sharing, deciding, making). These formulas may turn out to be cheap rides, without giving profound support to those who have to act and react. During this phase, remaining loyal to the concerns of the partakers of that practice, by means of critical thinking, is as important as in the first phase. In the first and second phase care ethics binds itself onto those on the site. It is not possible to discard off nor overrule what the concerns of the partakers in the practice are.

Rethinking, the third phase, implies recasting the ideas about what good care is about, developing a care imaginary that has legitimation and is therefore recognized by practitioners as adequate and helpful.

This care ethical program to our mind has far-reaching consequences. We question the idea brought forward by Joan Tronto (2013) that because of good care a ‘Gegenbild’ should be construed, i.e. a counter image or story against neoliberal versions of caring. That would be a counter story of what caring is fundamentally about compared to what actual practices of care show. Our argument is that practices of care, at least the practices of a highly complex hospital, consists of a myriad of highly skilled labor, systems, technologies, patients and their relatives. We refrain from determining the purposes of care practices in advance: from the point of view of an inquiry the what (is done and undergone) and the how precede a predetermined normative aim. By looking inside the ethos present in practices of care, we do in fact look for the telos within that ethos. What is more, we find such telos, be it rather far away from what the organization expresses as its aims. The actual doings and sayings turn out not to be a defective application of pre-given normativity. Rather they create an actual normativity, including the telos that the organization actually aims for. A counter story in which we do not think along with the issues nurses, physicians, patients, are dealing with, in which their concerns are not leading would be a story conceived far too early: its critical point of view would detach itself from issues and concerns within the practices. Indeed, our stance is a typical ethical one, namely ethics as a discipline wanting to be radically loyal to the partakers in a practice. We advocate an inquiry loyal to the partakers on positions where there is pressure to act. The very idea of pressure to act (i.e. ‘it is impossible not to act’) is a modern marching order. Not-acting is perceived as acting: one always acts, even by refraining from some act, then one ‘chooses’ to not act. Letting go is not part of the

ethical vocabulary in modernity: thou shalt (always) act. Within a late modern context however, the urge to always act comes in contradiction to itself. The postulate often accompanies the ideas of practitioners with regard to their own acting. In the end it would be normatively more fruitful if we were able to enlarge the space for reflection, together with partakers in a practice, including the dismantling of modern elements which in fact constrain the reflection of the practitioners and do not serve them well after all.

New ways for care ethics?

Let us turn back to the patients, the polyclinic assistants, the nurses, doctors and managers within the framework of the general hospital. The late modern organization is an ever more complex field that is not just subject of but produces uncertainty. As this complexity and uncertainty increases, at the same time the command to be creative arises, the command to take responsibility and show leadership, even for the non-achievable. The achievable and that what is not within reach of acting are insufficiently distinguished in late modernity: both are supposedly within the realm of intervention.

If we would follow Joan Tronto in *Caring democracy* (2013) and her presentation of responsibility, the most elementary ethical question to be asked would be: *who* is responsible for care? Tronto (2013) rightly advocates a political version of responsibility, contrary to an individualized responsibility. Tronto mobilizes the concept of responsibility as the normative analytical tool to discern how power actually works. But her concept of care practices seems to oversee late modern realities, as it does not take into account practices from within a complex organization, and how responsibility is assigned within—rather than against—that complexity. As soon as one acknowledges the more subtle working of power, not as mere subjugation of one group of people by others, but rather by means of spreading insecurity that can engulf the lives of many, the seemingly dominant people as well, the concept of responsibility has to be rethought as well. We therefore urgently need to rethink care ethics, using permeable heuristic concepts, in such a way that we can uncover localized political experience from within practices, whereby late modernity is placed into the heart of care ethics.

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