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article

Digging into care practices: the confrontation of care ethics with qualitative empirical and theoretical developments in the Low Countries, 2007–17

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The article starts with a brief sketch of the current state of care ethics in the Dutch-speaking Low Countries. It examines more closely the authors' approach to empirical research and its underlying argument, and sketches a theoretical development in care ethics that they deem promising. An oscillating movement is needed between empirical work and theory development, committing both to each other. The article concludes with some remarks on the need in care ethics for multisided international debates, the empirical grounding of normative claims and the radicalisation of care ethics, loyal to its critical insights and dedicated to its transformational aim.

key words care ethics • empirical research • theory development • the Low Countries

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Introduction

What is happening with regard to care ethics in the Dutch-speaking part of the Low Countries? Both Flanders and the Netherlands are welfare states in which neoliberal ideas have gained prominence. What does this mean for the Dutch traditionally pragmatic – and also moralistic and faction-based – approach to social problems (Brons, 2014), and especially for Flanders, which simultaneously prospers economically, longs for independence, battles Salafism and flourishes culturally (Brans and Aubin, 2017)?

First, we give a brief sketch of the current state of care ethics in the Low Countries.[1] In doing so, we address the relationship between conceptual and qualitative empirical

research. We contend that empirical research is a crucial element in fostering a viable care ethics that can analyse practices of care in a methodologically sound manner and develop a political-ethical theory on care that has 'bite'. This bite, the critical character of a political ethics, implies taking into account the late-modern stage in which this complex society finds itself. Care ethics in the two countries is explicitly reacting to some of the social issues marked by late modernity, for example, the issue of how caregivers and care receivers relate to each other. Care ethics does not suggest that the normativity *inherent to modernity* has resolving power when this normativity fails to understand its limitations and the contradictions within modernity (Bröckling, 2015: 10). It is, for example, worrying to continue to advocate relationality when, in the systemic environment of health care, relationality is received and absorbed in the social technology of a conversation protocol that provides scripted reactions to the caregiver according to an algorithm that deals with the probability that the answer given leads to patient satisfaction. Thus, the strain (for caregivers) of reflecting, under stressful conditions, is relieved and behaviours desired by management are installed. Insisting that this is not 'real dialogue' would be a rather ineffective kind of normativity as it does not address the substratum of late modernity that always seeks to avoid uncertainty in action (Foster, 2016: 86). The adversary of care ethics is not only rationalist, rights-based or (distributive) 'justice' reasoning. A complex (and diffuse) approach is also problematic: an approach that has imported care-like ideas about relationality and creativity as welcome, 'freely available' gifts, and embedded them in a systemic approach. The resulting ambivalence with regard to the call on relationality, while 'reclaiming' relational care from 'a toxic terrain' (Puig de la Bellacasa, 2017: 11), is indeed frustrating (Schmidt, 2017: 313), yet it cannot be overcome simply by restating the original insight that relationality is a humanising kind of normativity. This implies that we need to remain true to relationality, a decisive care-ethical insight, but to radicalise its expressiveness.

In the second section, we examine more closely our approach to empirical research and its underlying argument, after which, in the third section, we sketch a theoretical development in care ethics that seems promising. In our view, there is an oscillating movement between empirical work and theory development, committing both to each other. It is through enquiry into the complex practices of care that we are able to focus on the political character of care ethics as we have come to understand it. We conclude, in the last section, with some brief remarks on the need in care ethics for multi-sided international debates, for the empirical grounding of normative claims and for the radicalisation of care ethics. It is a radicalisation loyal to the critical insights of care ethics on relationality, vulnerability and so on, but one also dedicated to its aim of transforming both ethics and political theory. Tronto, among others, has shown how valuing care can take place only by politicising it. This also implies a transformation of both ethics (Laugier, 2011: 360) and political theory. In our view, this politicisation can be achieved not only through critical theorising, but also by looking empirically at care from within caring practices. When care ethics becomes a matter of 'putting practice into theory' (Mol et al, 2010), we need a bottom-up approach that starts with close scrutiny of caring practices themselves. When embedding care-ethical reflection in practices of care (as advocated, among others, by Tronto, 2013: 19), we concentrate here on practices of health care and welfare. We take them as nested in broader societal caring practices, as outlined in the often-cited Fisher–Tronto description of care (Tronto, 2013: 21). This focus on health care and

welfare functions as a prism through which general issues (like care labour) arise even more urgently – and not as a distraction.[2] The emphasis on empirical research, and the resulting conceptual 'talk back' to care-ethical insights, is, we believe, the main contribution of research in the Low Countries to contemporary theorising within care ethics; however, to compare care-ethical empirical research and its theoretical strategy in other countries is beyond the scope of this article.

Care-ethical groups in the Low Countries

In the Low Countries, there are presently four centres of academic care ethics.[3] In Belgium, there is a Louvain-based group, led by Chris Gastmans. In the Netherlands, there are three groups: one in Amsterdam and two in Utrecht. The group at the Amsterdam Free University is led by Tineke Abma (Visse et al, 2015). One of the Utrecht-based groups is seated at the University of Humanistic Studies chaired by Carlo Leget and offers a master's programme in care ethics (Leget et al, 2017). This research and the master's programme were, until 2013, located at Tilburg University. Finally, there is the Critical Ethics of Care (CEC) research network (founded in 2016), in which the authors participate, also based in Utrecht.[4] Different as their approaches to care ethics may be, a common characteristic of these groups is the intense traffic between care as carried out by health care and welfare organisations and municipal services, and academia. Related to this is another shared, although differently elaborated, feature: all groups recognise the need to undertake qualitative empirical research as well as theoretical conceptual work.

Each of these groups has its own characteristic focus within care ethics and the domains of care, its own theoretical approaches and views on interdisciplinarity and research methods, and its own social engagement and loyalties to the feminist roots of care ethics. Some of the groups have set out to combine care ethics with bioethical approaches (Abma et al, 2010; Tadd et al, 2010) or to have an orientation towards virtue ethics (Vanlaere and Burggraeve, 2013); others opt for care ethics as critically applied ethics (Leget et al, 2009; Leget and Borry, 2010) or combine it with personalist approaches (Vanlaere and Gastmans, 2011). The CEC network aims to develop a political theory using critical sociologies and political phenomenology.

Engagements

At face value, this seems like a rich picture. Yet, we are worried about care ethics losing its critical impact, in the Low Countries at least, but probably also beyond. As we understand care ethics, assessing it critically from its history, we think that it should continue to be committed to three forms of engagement: innovative power, ongoing intellectual inquisitiveness and theoretically interesting contributions to fundamental care-ethical controversies. *Innovative power* not only relates to a critical approach towards neoliberal politics, dominant concepts in practices of care and welfare, and mainstream ethics; it is also about constructively voicing different perspectives on practices of care and welfare, introducing new load-bearing concepts, and proposing innovative ways of perceiving and thinking about these practices (eg by introducing practice theory instead of an individualising theory of action). The latter means, in our view, that care ethics is well advised in rebutting the scheme often used in ethics: of an individual, acting in circumstances, in a specific manner (how), with an object

of action (what), with an intention, and with foreseeable consequences, in which cooperation with other individuals is taken only as an addition that does not change the substance of the act. Practice theory recasts this scheme into an interplay of co-acting people and materiality.

Intellectual inquisitiveness is closely related to burning social issues; as care ethicists, we are intellectually challenged by probing issues that are not invented by us, but felt by participants in the practice of care. The urgency of these issues, as felt by decisive others – for example, troubled professionals, care and welfare organisations, and their 'client' citizens – is a criterion for initiating and designing care-ethical research. Ongoing inquisitiveness implies testing old concepts (care-ethical ones included) and developing new concepts rather than simply applying established care-ethical 'principles'. This is induced and governed by the 'problematic' (Dorothy Smith), which care ethicists dig out. Third, as care ethics has developed over 35 years, several controversies have arisen. One of many possible examples of this is the characterisation of vulnerability: what does it mean for political theory when vulnerability is depicted as 'existential', 'ontological' or 'intersubjective'? Many answers are possible, but we think the controversy should be taken to the next level, in which (1) the insights of fellow travellers in other disciplines and (2) the worries and insights of people engaged in caring practice and caring organisations are taken into account.

The subsoil for these three criteria is our concern about a stalemate in care ethics: the amount of care-ethical research is increasing (albeit limited, compared to large health-care and welfare research programmes), but it is unclear what is 'political' about it.

Troubled by what we came to see as the under-theorised character of care ethics as a political-ethical endeavour, the authors, with about 20 other scholars, have created the aforementioned CEC research network to address what we see as the need to radicalise care-ethical insights by reflecting on which kinds of qualitative empirical methodology (see the second section) and philosophical (political phenomenology) and critical sociological theories (see the third section) are most apt for care ethics. 'Under-theorised' relates not only to recognising the late-modern character of problems in care practices, but also to the lack of consciousness on how to dig into practices in such a way that participants and their actual concerns in that practice are acknowledged (and not their imagined position, 'needs', etc). Participants in the CEC network are researchers, teachers and professionals working in universities, universities of applied sciences and civil society organisations in the domains of care, social work, education and governance. The CEC network is oriented towards care ethics as political ethics, burning social issues, the theory of presence, multidisciplinarity and intense interactions between empirical and theoretical research. It is from this stance that, in the next sections, we examine the contribution of different views on care ethics in the Low Countries, including our own position.[5] In addition, we will briefly indicate how we try to relate to contributions from other disciplines and other European, especially French and German, scholars.

Fostering care ethics by means of empirical research

In being engaged in research for over 20 years, we came to see, by critical observation and research into *actual* practices of care, that it is the practice that orients normatively, not the ethical categories. Without empirical research, there is a risk that ethicists

reflect only on their own assumptions, perceptions and experiences (Walker, 1998); situations and practices are observed and interpreted by inadequate theoretical concepts, and modes of acting are promoted that are inappropriate. Moreover, theorists who work with purely epistemological theories risk being paternalistic insofar as they suggest that they are more adequately able to determine the well-being of vulnerable or injured people than those people themselves, or than the professionals who work with them, discovering what actually works for them (Fricker, 2007). That is why we are interested in the practical knowledge and wisdom of participants in the practices studied.

Our position: empirically grounded care ethics

We advocate a qualitative empirical research process that is accompanied by ethical reflection while, at the same time, being oriented to theory development. The origin of this method of qualitative empirical research lies in Andries Baart's long-term grounded theory study into a specific practice of care, namely, a form of outreach pastoral care in deprived urban neighbourhoods (Baart, 2001; Baart and Vosman, 2011; Timmerman and Baart, 2016b). Since Baart and Frans Vosman started collaborating in 1998, they have supervised, together, separately or with others, several doctoral theses in empirical (care) ethics (Keinemans, 2010; Timmermann, 2010; Wilken, 2010; Timmerman, 2011; Klaver, 2016; Kolen, 2017; Boonen, 2017; Schaftenaar, 2018). During 2009–14, Baart and Vosman, together with Gert Olthuis, carried out a major transition and research project in a general hospital under the title 'Professional loving care' (Baart and Vosman, 2015). That period gave rise to the questioning of ethical theories, parts of care ethics included. Practices disenchant ethics and substantiate what is actually good for fragile participants.

While giving an account of our approach to empirical research in the framework of normative care ethics, we have learned to elaborate on: (1) the interaction between empirical research and ethical reflection; (2) the interaction between empirical research and theory development; and (3) the connection between these two interactions. This is still work in progress. Regarding these interactions, we take a position in which a particular insight and a specific way of acting are essential. Forced by the puzzles in researching caring practices, we have become more aware: first, that reality (and not just care) is morally laden, not neutral (cf Taylor, 1989); and, second, that every perception and experience is theory-laden (cf Hirschauer, 2008). We are continuously developing, testing and adjusting ways of practising empirical care-ethical research that helps to articulate both the moral weight and the theoretical implications of the practice studied, rather than distorting it or even replacing it with ill-fitting moral ideas and inadequate theoretical concepts. An example of misrepresenting a practice is infusing it with the (wished for) notion of responsibility or dignity. What guides the morality of practices is not these moral 'values' or the lack of them, nor is it simply a matter of installing a moral idea like 'enhancing virtue' (of caregivers), as the complexity of caring practices is immense and not to be remedied by one-dimensional people. Ethical shortcuts conceal actual morality, the ethos of care, although it is actually an ethos that potentially enables a relational fine-tuning between participants in a practice. Our interest in political-ethical theory means that it is important for us to consider both interactions in connection with one another, as intertwined. This connection is situated in our political-phenomenological interest in the lived

experience of people who act and suffer, and their first-person perspectives, in the context of institutions and society as a whole. We call our stance 'empirically grounded care ethics' (Baart and Timmerman, 2016; Timmerman, 2010; Timmerman, 2018; Timmerman and Vosman, 2014; Timmerman et al, 2017). We will now elaborate on the three issues just mentioned.

Empirical research and ethical reflection

The first issue, the relationship or interaction between empirical research and ethical reflection, is the subject of much debate in bioethics (Gastmans et al, 2007; Christen et al, 2014; Davies et al, 2015), which has a bearing in care ethics on the development of different approaches to empirical research. This is especially the case in the Low Countries because of developments, since the mid-1990s, in empirical research into bioethics in the Netherlands and Flanders, where a great deal of such research has been undertaken due to government policy on funding medical research. Our interest in care ethics as a form of normative political theory means that we conceive of situations and practices as sites where one can find normative and ethical (ie theorising) insights, and not primarily as areas where normative and ethical insights should be applied. In bioethics, two varieties can be distinguished that take this position: 'critically applied ethics' and 'integrated empirical ethics' (Molewijk et al, 2004). In critical applied ethics, empirical and normative views on reality are complementary; in integrated empirical ethics, the empirical and the normative view are conceived of as mutually dependent.

Critical applied ethics and integrated empirical ethics

A specific kind of critical applied ethics has been advocated by Leget (Leget et al, 2009; Leget and Borry, 2010). In his conception, there is a 'two-way relation' between empirical research and care-ethical theory, which are thought of as two independent focuses of an ellipse. To describe their interaction, Leget et al presented critical applied ethics as a five-stage process that includes: (1) determination of the problem; (2) description of the problem; (3) empirical study of effects and alternatives; (4) normative weighing; and (5) evaluation of the effects of a decision. In all five stages, both poles are present, but at various stages, one is more prominent than the other. In the end, however, it is 'ethical theory (empirically informed) [that] renders moral judgment' (Leget et al, 2009: 233). Examples of empirical care-ethical research taking this position are the studies by Van der Meide (2015) and Van Wijngaarden (2016).

Recently, the Department of Care Ethics at the University of Humanistic Studies published its take on care ethics as an interdisciplinary field of enquiry driven by societal concerns (Leget et al, 2017). Its own contribution to this interdisciplinary field is intended to be an ethical one, the key question of which is: what is morally good from the perspective of care given this particular situation? To answer this question, it proposes using an open theoretical framework, which functions as a 'multifocal interpretative lens'. In this version of care ethics, conceptual and empirical research are thought of as being in a 'dialectical relation with each other' (Leget et al, 2017: 6). In its empirical research, this take on care ethics will 'focus on lived experiences, practices of care and the way society is organized' (Leget et al, 2017: 7). Its epistemological position is described as 'expressive-collaborative and embodied'

(Leget et al, 2017: 8). An example of this "'hybrid" kind of ethics that draws on theory and practices' is reported by Van Nistelrooij et al (2017: 637).

One specific kind of integrated empirical ethics is 'dialogical empirical research', based on hermeneutic philosophy and responsive evaluation as an empirical research method (Widdershoven et al, 2009; Abma et al, 2010; Landeweer et al, 2016; Visse and Abma, 2018). The term 'dialogical' refers both to a dialogue between practice, theory, research and ethics, and to an interaction between 'various people with various roles, both practitioners and researchers, jointly exploring what is morally right' (Landeweer et al, 2016: 140). Normativity in dialogical empirical research is not derived from an external normative framework, but originates in: (1) the normativity of the research aim and question; (2) the practical rationality of the participants in the practice studied (the 'stakeholders') about what is morally important and right; (3) the normativity of the researcher; and (4) the incorporating of external criticisms by the researchers into the moral enquiry with the participants. What is aimed at in dialogical empirical ethics research is 'the process of searching for new and better ways of dealing with normative issues in practice' (Landeweer et al, 2016: 155).

Empirically grounded ethics of care

Empirically grounded care ethics differs fundamentally from both critical applied ethics and integrated empirical ethics, as presented earlier. Unlike critical applied ethics, we aim to integrate empirical and ethical methods and not to resort to a two-phased model of first doing empirical research and then reflecting ethically upon it. By no means, to our mind, is care ethics a hybrid, that is, a mix of disparate elements, nor is it dialectical, that is, a movement leading from contradictions to a higher-level insight. Both the conceptual and the empirical work should meet the highest internal standards; an un-reflected mixing is not appropriate and the work should remain critical. However, unlike integrated empirical ethics, we see a difference between empirical research methods and ethical reflection, being aware of the risk of 'smuggling' morality into seemingly neutral descriptions (eg the equivocal term 'resilience'). In contrast to critical applied ethics, we are concerned with discerning and promoting practices of *good* care and not with establishing and describing a moral problem, nor with analysing alternative problem solutions and their consequences, and weighing them normatively. Unlike integrated empirical ethics, it is not intuitions and judgements about vignettes or fragments of cases, but an *actual practice as a whole* and the situational and practical *savoir faire* of the participants in this practice, which are the site of normative-ethical insights. Our position holds that the practical knowledge and wisdom of participants in the practice studied, and the proper empirical, theoretical and ethical capacities of the researcher(s), are both essential to perceive and discern what is morally relevant, to address what theoretical veil is alienating or obfuscating what is at stake, and to come up with feasible proposals for those participating in that practice.

Example: another take on end-of-life care by general practitioners

Our study into end-of-life (EoL) care by general practitioners (GPs) is an example of how empirical research leads to 'talk back' to care ethics (Timmerman and Baart, 2016a). We analysed six extensive cases with one patient each and fragments of about

80 further cases of six experienced GPs. The research process can be analytically divided into eight phases. Phases 3, 4 and 5, on the one hand, and 6, 7 and 8, on the other hand, partly overlapped: (1) interviews about one case, from beginning to end, resulting in six comprehensive and extensive case descriptions; (2) follow-up interviews about the cases; (3) thematic analysis of the interviews; (4) focus group interviews; (5) analysis of the focus group interviews; (6) synthesis – reconstruction of the EoL caring process; (7) focus group interviews; and (8) writing the research report. The analysis of the interviews resulted in 10 themes, among which were: 'focus and scope of attentiveness', 'metaphorical positioning', 'the physician has to act' and 'substantive ideas about parting, dying (for the patient) and continuing to live (for the relatives)'. To discern what EoL care by GPs is about, we had to reconstruct different, complementary ways for GPs to determine pain and suffering. To reconstruct the whole process of perceiving, reflecting upon, weighing, estimating, acting and evaluating in EoL care by GPs, we had to develop our own grammar and syntax. It led to a dynamic image that significantly deviates from the image we found in much of the literature. A GP is more than, and often different from, a rational choice actor performing separate, context-less actions in 'plan–do–check–adjust' cycles.

In reconstructing the complete EoL care process, we had to distinguish between the different components of the assessments that the GP is continuously making, we had to develop the idea of configuring and reconfiguring those components, and we had to differentiate them within the concept of attentiveness. To preserve the emergent dynamics of the process, we had to introduce the idea of continuously interpreting the actual situation and process by means of images and stories, references to lived reality, and an imagined synthesis ('What will be the final situation?'). Central to our interpretation of the process of EoL care by GPs is the metaphorical positioning of the GP. In the informal network around the patient GPs take upon themselves the metaphorical, morally guiding *position* of a father or mother, a friend, or a neighbour, without really becoming a father or mother, friend, or neighbour. We are alerted by the already-existing theoretical indication that positions are vital in a practice. However, it is only by digging into an actual practice that we could come up with these metaphors and test their validity. Trying to discern theoretically what a GP has to do, we developed an empirically enriched concept of practical wisdom. With such conceptually and empirically enriched concepts and reconstructions, professionals are helped to improve their work and engage in new moral issues. With regard to the insights of care ethics, this implies putting the issue of positions on the agenda, that is, the positions of people as they participate in a caring practice, and raising the question of an imagined position (possibly different from the actual position, but within reach) conducive to good care.

Empirical research and theory development

The empirically grounded ethics of care that we are proposing also involves an intertwining of empirical research, on the one hand, and concept and theory development, on the other. Theoretical and conceptual reflections are used to recognise details that are particularly relevant and saturated by complexity, to perceive more closely what has been perceived, to perceive what was not perceived before, and to give a plausible account of what has been discerned. Empirical research is carried out to operationalise and differentiate abstract concepts (relationality, vulnerability,

corporeality) and to repair and enlarge deficient concepts (autonomy, self-reliance, co-creation, shared decision-making). Empirical research makes it possible to 'talk back' to theory and to ask questions that stimulate further, relevant theory development; the position of a GP, as brought to light by our enquiry, is only one example of the kind of talking back that we have in mind. Going beyond mere descriptions of experiences, our aim is to develop concepts and theories grounded in our empirical research, connecting up with the grounded theory methodologies also used in nursing ethics (Grypdonck, 1997). In the oscillating movement between theory development and empirical research, research by other scholars in ethics and social science is also important, on both sides. Oscillating means swinging in an intended, methodological way, detecting what questions the observed practice raises, as well as what questions the theoretical notions used raise, rigorously enquiring into these questions, and updating the preliminary findings. The enquiry is fuelled by observations that do not make sense, and prepares the way for a different perspective, possibly also a different theoretical take on the practice, if the theory used does not fit, or ignores, the fine fabric of the care practice.

Example: another take on power

This enquiry involves not only postponing normative judgements, but also suspending the use of a determined theoretical grid. It may be that what is chafing is a matter of power not in the sense of domination (physicians over nurses, making profit from vulnerable citizens), but in the sense of allowing oneself to be 'used', when this seems desirable to the actor. Power then acquires a different meaning than outright domination. Power can acquire multiple meanings when looked at 'bottom-up' from within a caring practice. In our research, we saw nurses acknowledging with great clarity the strain that comes from directives to work more efficiently, while also acknowledging the estrangement that this brings. Such a directive does not respect nursing work as such, but regards it from a merely instrumental perspective (Boonen, 2017: 15). In spite of this, nurses took on the imposed task and made considerable changes in regard to efficiency, nevertheless using their creativity to make 'workarounds' where they thought patients should get priority, and elegantly withstanding the reprimand that they then received for the workaround. They did their 'talk back' with success, and got the respect they deserved. By taking on the task, they gained enormous strength.[6]

Practising this oscillating movement between the observed in empirical research and the perceiving capacity of theories (or lack of it, as the research puzzle proves), researchers can thus gradually gain a 'deeper' understanding of the situation or the practice, develop 'clearer' theoretical concepts, and avoid both empirical naivety and fact-free reasoning. The focus is always on a practice (Nicolini, 2012; Schmidt, 2012) and primarily on the acting and undergoing (or to put it phenomenologically, the *passibilité*) of living beings (Vosman et al, 2016), on the knowledge and the practical wisdom of those who offer professional care and help. At the same time, theoretical understanding is developed further, from concepts to grounded theories, to more comprehensive theories that point beyond the concrete situation or practice. Care ethics dives into the particular, yet is bound to develop *viable* generalisations as well.

The connection: political phenomenology

As care ethicists concerned with political ethical theory, we find that the connection between the interaction of empirical research and the development of concepts and theories, on the one hand, and the interaction between empirical research and ethical reflection, on the other, lies in a phenomenological enquiry into the lived experience of the persons who act and suffer (care receivers and caregivers), and their first-person perspectives. Considerations inspired by care ethics and extensive qualitative empirical research experience cause us to position ourselves not in the epistemological-egological tradition of phenomenology (Husserl), but in that of political phenomenology. Merleau-Ponty's phenomenology of people who come together primarily as embodied beings (Coole, 2007) and the 'responsive phenomenology of the alien' proposed by Bernhard Waldenfels (2011 [2006]) are constitutive of what we understand political phenomenology to be: the appearance of the phenomenon of embodied people being together, and of their practice of ordering relations, in a variety of ways, and with bearings ranging from understanding and love, through fundamental uncertainty and the opaque, to chafing, struggle, battle and war. The implication is, first, that we still have to face the original problem of phenomenology, that is, the contradictions and overstatements of modernity, with its emphasis on individual autonomy, on owning possessions as the subject's way of being and on the social contract (cf Vosman, 2018). Second, this political phenomenology enables us to have an open and fearless eye to chafing and conflict in relations, without having to refer to Romantic ideas of 'profound harmony' or to views based on an all-pervading basic pattern of struggle. In this sense, political phenomenology enables us to deal critically with the presuppositions of modernity (cf Vosman and Niemeijer, 2017; Vosman, 2018).

Theories in interaction with societal developments

From its origins, Dutch-speaking care ethics has had its own concerns: getting close to actual care practices, which are often multifaceted and highly complex, as organisations and policymaking permeate care (also at home). In the same period, US care ethics landed in the Low Countries, in the early 1990s, as a set of ideas inspired by neoliberalism became guiding principles in politics, health care and welfare policies, and leadership models. These changes in policies resulted in questions and critique from citizens who have to cope with strenuous care at home, from professional caregivers and patients, and from care and welfare organisations. This critique often resulted in institutional efforts to refocus caring practices. Not coinciding with neoliberal policy, but influential as well, are cultural trends in the Netherlands and Flanders, such as the widespread longing to live an autonomous life and be independent from any form of regulation, let alone coercion. This is quite paradoxical in a welfare state. Yet another such tendency is the creation of technical, procedural 'solutions' for any problem, moral problems included, thus avoiding the social heat, conflict and deep moral pluralism in society. Smoothing out explicit moral problems turns ethics, any ethics, into traffic control rather than a discipline that identifies moral issues. These tendencies have deeply pervaded civil society and policies, the implication being that reflection on care as an activity that enables us to live together in an ordered way cannot but engage in huge changes in actual care.

The challenge to care ethics is to upstream its insights and have them discussed in political theory and ethics rather than mainstreaming them so that they lose 'bite'.

Radicalising the practice claim

As in many other European countries, care ethics as developed in the US by first- and second-generation care ethicists had a remarkable influence. Their insights were welcomed in that small group of Dutch scholars who set out on the road of care ethics. Henk Manschot, Marian Verkerk, Selma Sevenhuijsen, Annelies van Heijst and Andries Baart were among those early adaptors.[7] Yet, each also initiated a theoretical development of their own. We limit ourselves to two scholars here. The direction in which they have moved can be seen as a radicalisation of care-ethical insights.

Different from one another in their primary academic discipline and approach were Selma Sevenhuijsen and Annelies van Heijst, who were both deeply rooted in feminism and prioritised caring practices. Political theorist Sevenhuijsen (1998 [1996]) took on actual political practices, not just political creeds, with a transformational intention, as she analysed the actual use of citizenship and justice talk. In one of her last care-ethical studies working with mixed groups, mainly women, of researchers, experts, policymakers and practitioners in Slovenia, she presented an analytical and transformational guideline to policymaking on care (Sevenhuijsen and Švab, 2004). It is a clear account of how to arrive at a care-ethical encounter with political practices. In *Professional loving care*, Annelies van Heijst (2011 [2005]), a moral theologian by training, has placed actual caring practices, mostly health care in a clinical setting, on the agenda of care-ethical reflection.[8] Caring practices are not just the object of reflection. Rather, they occasion the proper issues to be raised, such as: how can it happen that a care practice becomes self-referential and the good of the individual patient gets obfuscated? Van Heijst invented the expression 'added harm' as she analysed how health-care practices lose focus and become onerous to patients, not by intention, but through the actions themselves and the lack of space for reflection.

Digging further into practices

Later, in the Tilburg-based national research group Care and Contested Coherence (2007–14), the question of what a practice is, and how it can be properly conceptualised to reflect the *actual complexity* of caring practices, became central points of reflection – drawing on Robert Schmidt's (2012) and Davide Nicolini's (2012) empirical and conceptual work. Practice theories are a set of conceptual tools and methodologies for investigating, analysing and representing everyday practice through written text, language, images and behaviour (Nicolini, 2012: 214ff). We have explicitly broadened the idea of a practice, being about 'doings and sayings' (Theodore Schatzki) (and 'artefacts'), with 'undergoings': citizens like care receivers and caregivers are always also subjected to a situated care practice (Vosman et al, 2016).[9]

A rather radical step in Dutch and Flemish care ethics (ie in Amsterdam, Louvain and Tilburg) was that practices were empirically researched, that is, as a necessity. The mix of *ideas*, on for instance 'leadership', 'the turnaround of organisations', 'safety' and 'the quality of care', and *doings* in care practices, which are often inconsistent from a conceptual point of view, proved to be very decisive for the 'normative intent' of care ethics. If it wanted to provide some normative clarity for citizens and care

professionals, care ethics had to engage deeply with that mixed-up practice. This intellectual road led to analyses within caring practices of what is considered 'good care' – analyses made *together with* people, groups and institutions involved in those practices.

The move towards qualitative research in the Care and Contested Coherence (CCC) research group at Tilburg University was instigated by Andries Baart and Mieke Grypdonck, a Flemish professor in nursing. Both wanted not only to qualify their approach as care-ethical, but also to expand on care ethics (Baart, 2001; Baart and Grypdonck, 2008). This engagement with empirical research also led to the critical interrogation of philosophical and social-scientific concepts. As existing care ethics did not provide sufficiently incisive tools, CCC members studied critical sociology, such as: François Dubet's (2002) apparatus on the deinstitutionalisation of institutions, in which he draws on his research on the professionalisation of nurses and teachers; critical forms of phenomenology, like Bernard Waldenfels's (2004) idea of attentiveness; and practice theory, which extended a concept of action that Tronto called for in *Moral boundaries*. Thus, not only is the urgency of, among others, 'vulnerability', that is, the concept as it was developed in feminist philosophy, highlighted; the concept is also corrected as it proves to be too imprecise, remaining rooted in an idealistic world. An example of this practice-induced interrogation was the empirical and conceptual study by Jean Pierre Wilken on the lifeworld of psychiatric patients. Autonomy 'floats on the layer' of vulnerability, which, in turn, floats on the layer of frailty as a basic human condition (Wilken, 2010: 191–2). Part of the CCC Tilburg heritage lives on in the current research network of the CEC. Many CEC members engage in qualitative empirical research while, at the same time, enquiring, with great thoroughness, into associated conceptual issues as this proved to be a necessary condition for creating a heuristic framework for analyses of care practices. While care ethicists of the first and second generation have provided critical insights of utmost importance, we believe that the time has now come, while being loyal to these insights, to radicalise them. Relationality, context, the political, all need a conceptualisation that is far more exact with regard to political theory but also one grounded in actual caring practices, institutional ones included.

Strategy for linking care ethics to practices

The authors of this article opt for care ethics as a political theory of caring,[10] using specific ethical insights and distinctions, and systematically raising questions like 'What is good care?' and 'What good emerges from it?' (see the second section). Such questions attract criticism, such as a critique of the category of the 'good', a category that defies moral pluralism (MacIntyre, 1990). 'Emergent good' means: that which, in a practice, turns out to be good from the perspective of the citizen, patient or resident, and always in relation to others. Upfront, the moral orientation, the appreciation, was a particular one. For example, before it is actually the case, someone can say 'If I cannot get around and go wherever I want, life is not worth living anymore' However, having being thrown into an unwanted situation of vulnerability and dependency, something different can prove to be unequivocally good. For example, when incisive interdependency is actually the case, the person can say: 'I wanted to be alone but actually being together with R. (= another patient) has helped me to see things differently'. There is strategy behind these substantial ethical questions.

They head for the social 'heat' as it is felt by the participants in a caring practice. Asking for the good, instead of asking for the application of value preferences and accepting, even presupposing, deeply plural 'appreciations', is provocative. This does not imply denying plurality. On the contrary, it takes the actual trajectory of the citizen in a care practice more seriously than leaving someone alone with her or his sense of what is good. Asking for the good also links with the language that people actually use: an action is 'good', a caring posture is 'loving'. It thus removes the 'fat' layer of inadequate 'care talk', phrases like 'improving the quality of the health experience', which are ultimately a form of alienation, as people report when space for an enquiry into the moral and political dimension of care has opened up. Engaging with questions as they are raised by participants in a care practice is a fundamental and necessary step for care ethics.

A second step in our strategy is to *question the questions* of people in a practice, with utmost loyalty to the people and issues in that practice. Our question to care practitioners is: does the conceptualisation, the language and the change approach you take bring you something good? In this strategy, it is not permitted (for the researchers) to withdraw from the heat of the issue and come up with 'solutions', moulded in the form of an easy formula. A third step in the strategy, all in all, affixing care ethics to care practices, is to contribute to a fitting, non-alienating, re-categorisation of the original question. In care practices, we observed that any kind of chafing and potential conflict was framed as a matter of 'communication': communication should be enhanced (between patients and physicians, nurses and physicians, management and workforce, etc). It turns out to be very helpful to ask whether practitioners actually benefit from using such a general frame as the solution ('more communication!') was given over and over again for many years, yet nothing changed for the better. Eventually, together with practitioners, gathered in a learning community, we developed another categorisation: acknowledge the chafing, sort out different perspectives and frame chafing as a matter to curate.

However, if care ethics is to survive, and possibly thrive, there is an urgent need to work together and to discuss research strategies, as well as the choice of what type of philosophy and social science is helpful to care ethics. Which non-care-ethical authors should we acknowledge as fellow travellers as they are engaged in marvellous similar enquiries? As many issues in care ethics remain under-theorised, and scholars tend to operate in isolation, affected not only by language barriers, but also by intellectual traditions, 'not necessarily aware of each other's voice', as Maria Puig de la Bellacasa (2017: 2) elegantly articulates it, there is the risk of a standstill. If care ethics, drawing on US predecessors, develops in different directions, this can be seen as a beneficial development. However, the *lack of discussion*, while mandatory as care-ethical voices from different continents with different issues of their own emerge, is a threat to the intellectual soundness of care ethics and to the political-ethical impact of the radical critical insights of care ethics.

Conclusions

For meaningful and relevant further developments in accordance with the options indicated in this article, we think these 'road markings' are relevant:

1. We take a European perspective and think that more high-level, continental, trans-cultural exchanges of ideas and theories between countries (like France, Germany, the UK, Norway, Finland, Italy, Belgium and the Netherlands) could be promising, defeating language boundaries and local horizons (eg see Barnes et al, 2015; Conradi and Vosman, 2016).
2. In our view, an intense engagement with critical social theories, relational ethics and political philosophy, on the one hand, and solid empirical research, on the other hand, is necessary to radicalise care ethics. In the end, this radicalisation is about pointing out, and giving theoretical support in understanding, the actual fragility and precarity of many lives.
3. In the Low Countries, we have at least four explicitly care-ethical research groups. The common task is digging into caring practices and developing theory from there. For the research network we participate in, thinking through the connection between care ethics and empirical research is fundamental, and a means to nurture care ethics with insights from critical social sciences and political philosophy.

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Notes

[1.] With the term 'care ethics', we refer to the insights that came from first- and second-generation frontrunners like Gilligan, Noddings, Held, Tronto and Walker, to name only a few scholars, but also to the theory developed by European care ethicists (eg Brugère, Laugier, Paperman, Van Heijst and Conradi), including empirical work (eg Barnes). In this article, we do not engage in the debate about nomenclature – 'care ethic', 'care ethics' or 'ethics of care' – or with the important contributions from South Africa, Asia and Latin America.

[2.] Elsewhere, we have specified how the empirical scrutiny of care practices relates to that broader definition (Vosman and Baart, 2011; Baart and Timmerman, 2016).

[3.] We consider these groups and their differences with regard to their stance on empirical and theoretical research. As some scholars in these groups are prolific writers, we only mention single publications characteristic of their take on care ethics.

[4.] Both Utrecht-based groups have an internationally oriented website. The Department of Care Ethics at the University of Humanistic Studies runs the site of the Care Ethics Research Consortium (CERC), founded in 2016 by Joan Tronto and Carlo Leget (see: www.careethics.org). The CEC network has its own website, run by an independent editorial team (see: www.ethicsofcare.org).

[5.] The position presented here is that of the three authors and not necessarily that of the entire CEC network.

[6.] In Vosman and Niemeijer (2017), the authors experimented with such a heuristic use of the notion of power, rather than a defining use.

[7.] For example, Verkerk (1997), which contained, among others, Baart (1997).

[8.] Van Heijst's analysis was built on three pillars: care ethics, Arendt's thought about the human condition and Baart's theory of presence.

[9.] For the affinities between care ethics and practice theory, see Nicolini (2012: 3–5, 220).

[10] We are as hopeful, but not yet as convinced, as D. Engster and M. Hamington that – despite the important contributions by Held, Tronto, Engster, Brugère, Conradi and others – care ethics has already reached the stage of 'a robust political theory' (Engster and Hamington, 2015: 6), as the discussion with full-blown political theories is still limited, as is its infusion with insights from caring practices.

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