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The Ethics of Care: the State of the Art

Frans Vosman, Andries Baart, Jaco Hoffman (Eds.)



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The Disenchantment of Care Ethics

A Critical Cartography

Frans Vosman

Introduction: a Different Kind of Ethics

The ethics of care is a relatively *young* discipline in ethics and political theory. It emerged within feminism in the early 1980s and is therefore approximately 40 years old. Care ethics has active feminist roots, but is not coterminous with “care feminism” (Cantillon & Lynch, 2017; Marsico, 2007, p. 100; Wolf, 1996, p. 9).

There are several *commonalities* that span the increasingly wide field of care ethics. Fabienne Brugère (2019) in her introduction to the ethics of care has identified one characteristic: compared with other types of ethics care ethics “is a theoretical and practical revolution” (p. 7). “This ethics is anchored simultaneously in receptivity, relatedness, and responsiveness” (p. 12).

The approach is called *interdisciplinary*, but also multidisciplinary, i.e. having a lower degree of aggregation than interdisciplinarity (Elst, Klaver, & Baart, 2014; Leget, Van Nistelrooij, & Visse, 2019, p. 5). This epithet of multidisciplinary is intended first and foremost as a statement of fact. It turns out that scholars come to care ethics from a variety of backgrounds: psychology, sociology, political science, various philosophical disciplines (anthropology, phenomenology, ethics), moral theology, qualitative-empirical researchers, themselves hailing from several backgrounds (public administration, nursing). Some care ethicists, it must be said, pay little to no attention to how the various disciplines of origin (psychology, philosophy, political theory, sociology etc.) could work together meaningfully.

Care ethics is *polyphonic* (Engster, 2015, pp. 18-19), there are several different views within care ethics. In fact it is possible to speak of care ethics in the plural (Vosman, 2016), to such an extent that the Wittgensteinian metaphor of family resemblances is perhaps no longer adequate. This blurring has been problematized in very different ways (Klaver et al., 2014; Collins, 2015; Leget et al., 2019; Vosman, Timmerman, & Baart, 2018). The polyphonic character of care ethics is evident for instance in the rejection, or, on the contrary, the fostering of connections with religious and cultural sources. Held (2006b) has rejected religion as a source of knowing what care is and what good care is, because people who do not adhere to the religion in question will find such an approach “non persuasive” (p. 22). Essentially that is an emic notion deriving from Religious Studies, and in many ways it is counterfactual: the perspective of people in the Democratic Republic of Congo will be very different, because the only form of sound health care and social care there is provided by churches (which, incidentally, are also the only force for democracy there); people in India have no difficulties availing of church-facilitated health care that is open to all if they have to, and are pleased with the results, even though India is being riven by disastrous religionization. Practices of care of their own weight. By contrast, other scholars purposefully seek to establish connections between care ethics and religions or philosophies of life, such as Confucianism (Sander-Staudt, 2015), Buddhism and Hinduism (McWeeny & Butnor, 2014), the Jewish faith (Conradi, 2018), and Christianity (Van Heijst, 2011).

Elements from care ethics are being developed *in many different directions*, from care at home to international relations, from birth care to the “care” provided by NGOs. Michael Slote has called this expansion a “wildfire” (Slote, 2013, p. 6). The “burgeoning” literature on the proliferation of topics is such as to defy attempts at synthesis, according to Hamington (2018, p. 312).

The approach of care ethics, which not only arose in the USA but is also strongly colored by American debates, has since its emergence been adopted *across the globe*: “care ethics has matured into an international and multidisciplinary intellectual phenomenon” (Hamington,

2018, p. 309). At the same time it must be observed that care ethics is to a large degree a “white” affair (cf. Bilge, 2015, p. 24). A standpoint approach, which rigorously takes the scholar’s own position (i.e. the often strained intersections between “identities” such as white (a color as well), colored, female, male, gay, lesbian, straight, trans, working-class or middle-class, ethnicity etc.) as the point of departure for reflection on care, as it is used in sections of feminism, is rare in care ethics.

From its inception, the ethics of care has been a different form of ethics than the usual ethical schools: it is not concerned with principles, nor does it focus on generalizing rules of action or calculating consequences of action, or indeed on individual virtuousness. At the same time, care ethics has from the start been an intensification of the epistemological question: whose experience-based knowledge of, or insight into what is good counts? Which groups’ knowledge is being elided? To put it differently: epistemology and power are subjects that most in care ethics regard as important. Another characteristic feature of the approach is that – in my words – providing care and being cared for are considered to be constitutive of society. “Care sustains and repairs society” (Williams, 2018, p. 557). Care itself is a political reality, a practice that institutes the possibility of living together in an ordered way. We have the work of the care ethicist Joan Tronto to thank, not only for drawing attention to the political character of care ethics, but also for ensuring that this has become the received view (Tronto, 1993/2009a).

Parallel developments

A number of complicated issues with regard to care and practices of care are currently more clearly seen than they were in the early 1980s. Care ethics has been joined in the field of inquiry by other approaches; I restrict myself to five of these parallel approaches.

Other, partially related approaches are cutting across the debates initiated by care ethics, fueled by the recognition of how important care is politically: the commoning movement is establishing connections between commoning, economic theory, and care (for instance

Bauhardt & Harcourt, 2018). The transhumanistic ecological movement is establishing connections between care and a sense of solidarity between all living beings (including for instance the caring activity of plants; De la Bellacasa, 2017). The postcolonial movement is establishing connections between care labor and categories of thought “occupied” by colonial thought, such as the controversial “we, women” (Montanaro 2018; Raghuram, 2016) movement. Finally, the precarity movement (including the EuroMayDay movement) is establishing connections between precarization, social insecurity, solidarity, and care labor (Brunner, Casalini, Kubaczek, Mulvaney, & Raunig, 2017; Sahraoui, 2018; Zechner, 2015). In the meantime, an awareness has grown that care itself is much more problematic than was realized before (De la Bellacasa, 2017; Dorlin, 2017; Raghuram, 2016: “trouble care”). Care ethics has been slow to respond to these recent approaches. Given that care ethics arose from women’s movements, and that it regards itself as political ethics and places itself within a democratic model, it should interest itself in these approaches like the commoning and precarization approaches, as they are closely connected to movements. If afflicted democracy is to survive, autonomous movements are required that can offer resistance to managerial practices, and corresponding inquiry is needed. Could care ethics be this inquiry? Could it come to view its work as the accompaniment of people, groups, and organizations that know what it is to struggle with “wicked problems”?

Structure of this article

In this three-part article I will firstly briefly address the substantive features of care ethics, and single out one feature in particular, responsibility. Then, in part two, I will give the disciplinary outlines: what kind of approach is the ethics of care? In the last, third part, I will discuss three points of concern somewhat more extensively. I believe that care ethics may well continue to expand, but that this does not necessarily mean that it will retain its force. I believe it is losing the critical force that has been its distinctive attribute from the start.

I will describe examples of a *frozen conversation*, a *lacuna*, i.e. a blind spot, and an *aporia* in care ethics. I will discuss the strategy of intersectionality as an example of a frozen conversation about complexity of treatment issues. Then I will examine “community” as a lacuna in care ethical thought. Finally, I will address an aporia, the problematic use of “we,” involving the use of ontology, in the ethics of care. I will conclude the article by returning to the question whether care ethics is tied to social movements.

Raising the problem

I believe forces will have to stand up in care ethics that are willing to engage in uncomfortable conversations. These conversations will have to involve people who regard themselves as part of care ethics, as well as fellow travelers, those scholars who also reflect critically on ethics, epistemology, and care, like critical sociologists. Why is it important to look at the weak points of care ethics? The number of complex issues to which care ethics is being “applied” continues to grow. The ethics of care is also undergoing a process of professionalization, with its own journal and conferences, as is usual for scholarly approaches that are seeking to become established and are seeking legitimacy. At the same time, however, there are theoretical weaknesses that are partially being identified from within care ethics and are subsequently being addressed according to the usual academic customs. An existing insight is then amended, and a sharper or much sharper definition of vulnerability or relationality is proposed. But the weaknesses also consist in part of *lacunas*: theoretical blind spots that are not perceived as such, instances of “not knowing what you don’t know.” One example of such a lacuna is the – ambivalent – need for community.

There are also aporias. I use the word aporia to mean a certain cognitive embarrassment that is related to the nature of the enterprise itself; a cognitive embarrassment that blocks further critical expansion of care ethics. Stacy Simplican (2015) has pointed to such an aporia in Eva Feder Kittay’s – extremely important – insight into shared vulnerability as the foundation for providing and receiving

care. Simplican has demonstrated the ambiguity of vulnerability, as a result of which it also becomes something that conceals. In the context of care for people with a severe disability: what if such people are not only vulnerable but also aggressive, where does that leave vulnerability? Can the violence of those who rely on care be immediately incorporated in the reflection? In contrast to idealizing-as-abstraction, care ethics is liable to idealize by romanticizing. To romanticize is “to make (something) seem better or more appealing than it really is” (Cooper, 2007, quoted in Simplican, 2015, p. 220). Simplican (2015) quotes Davina Cooper¹, who, arguing against a normative reading of care, concluded a decade ago that care theorists harbor a similar “gravitational pull of an ideal conception of care” (Simplican, 2015, p. 220, see also Petherbridge (2016) and Gilson (2013)). The strong tendency to perform analyses in normative terms (instead of an analytical or – preferably – heuristic use of terms) creates this kind of aporetic thought. To the extent that the ethics of care consists of saying out loud what care as a society-constituting practice implies, i.e. including the hidden realities, and to the extent that care ethics is a form of thinking that unveils practice, it is the task of care ethics to address these aporias that it has created itself.

A third problem is that care ethical discourse is losing its edge. The idiom of care ethics is now being used widely, but in an entirely different sense: relational care has become the language of the market. This means that the ethics of care is being dulled down. I think a parallel can be drawn with the way critical theory has been used. Edward Said (2000) observed that the theory on reification which his mentor György Lukács propounded lost much of its critical meaning in the frequent use that was made of it (pp. 436-452, p. 181). It became a “travelling theory: popularized, tamed and domesticated” (p. 438). He describes that the first time human experience is recorded and then given a theoretical formulation, its force comes into being directly connected to and organically provoked by real historical circumstances. Later versions of the theory cannot replicate its original power, because the situation has quieted down and changed, the theory is degraded and subdued, made into a relatively tame academic

substitute for the real thing, whose purpose in the work he analyzed was political change (Said, 2000, p. 436).

Has something similar not happened to care ethics, which in its inception was a critical enterprise? The situation with regard to exploited care labor has not quieted down, but it has changed: what is being exploited is not just the labor of specific groups, but all human experiences. What is being smothered are not just the voices of women, but the voices of all who are neglected go off course. This is not only true for reification, but also for the concepts of inclusion and groups. At the same time care ethics is becoming increasingly popular. Does this not mean that its critical character is evaporating? Even once critical concepts can go off course. This is not only true for reification, but also for the concepts of inclusion and empowerment that have been incorporated and transesterified in government thinking (Maynard, Gilson, & Mathieu, 2012; McLaughlin, 2016; Slee, 2009, pp. 177-189). Elements of care ethics, like the insistence on listening and the importance of the voice of those who care and are cared for have become travelling elements, to be found in other approaches to care, for instance in commercial or managerial care formulas. The result is that care ethical concepts such as relationality and vulnerability have gone off course. I believe care ethics partly bears responsibility for this, to the extent that it weakens itself and loses its perspicacity by continuing to base its two-tier approach on a pre-political, “universal,” “existential” relationality and vulnerability on the one hand, and a “political” version built upon this on the other. A clear and positive exception to this double-decker approach is Sandra Laugier’s (2009), who with her version of the concept of life form (indebted to Veena Das, Stanley Cavell and Wittgenstein) emphasizes ordinary life and its deeply political nature. A double-decker approach leaves the so-called existential layer of relationality up for grabs. Care ethical concepts are defenseless, easy victims for use in “care formulas” in health care (Fred Lee’s Disney approach to care, Blue Ocean, Value-Based Health Care, etc.). If the ethics of care conceptually permits relationality to be interpreted as a *value* – instead of a *pre-normative actuality* that is resistant against desired

normativity and instead of *an ever-shifting relationship between physical, material beings* – then we should not be surprised that the value of relationality is eagerly adopted elsewhere; but its meaning is substantially changed in the process. Thus care ethical thoughts can be integrated into governmental care policies, and thus go off course. Brugère (2019) has pointed to the adoption of care ethical discourse by the French government under Hollande, and Marian Barnes to the same process in the United Kingdom under Blair (Barnes, 2007). Cecilia Güemes (2019) is currently researching similar developments in Latin America. This casts doubt on the position of care ethics as a political theory and as a form of ethics. Is the ethics of care truly suited to be a theory for political change, or is it squandering this opportunity by insisting on being highly normative (Cooper, 2007; Vosman, 2018)? As far as care ethics as ethics is concerned, Fiona Robinson (2016) has categorized the ethics of care as part of the ethical turn (pp. 636-637). Does this not mean that there is an urgent need to determine once again *whether the ethics of care is a kind of ethics, and if so, to what extent, and what kind of ethics it is?*

1. Care Ethics and Its Critical Insights

What can a first exploration reveal? Whether – as many believe – it was Carol Gilligan's book *In a Different Voice* (1982) or – as the prominent care ethicist Virginia Held (2006a) has contended – Sara Ruddick's book *Maternal Thinking* (1980) that should be seen as the birth of care ethics, in both cases the impetus was recent. Now approximately forty years old, the ethics of care is currently the scene of important developments. According to the Canadian scholar Olena Hankivsky (2005, pp. 11-40; 2014), a third generation of care ethicists is currently active: after a first generation including Carol Gilligan, Nel Noddings, Virginia Held, Eva Feder Kittay, and Margaret Urban Walker (all of them American), there was a second generation to which Joan Tronto (US), Selma Sevenhuijsen (Dutch), and Marian Barnes (British) belong. There is now also a third generation, which includes Hankivsky herself, as well as Fiona Robinson (Canadian), but also Daniel Engster and Maurice Hamington (US). Other scholars,

including some from Europe, can also be counted among this third generation, for instance Elisabeth Conradi, who introduced care ethics to the German-speaking world, and Fabienne Brugère and Sandra Laugier, whose work has had great significance for the French-speaking world. I would suggest there is also a fourth generation, which includes such scholars as Marie Garrau, Alice Le Goff, Sophie Bourgault, Jorma Heier, Brunella Casalini and Flavia Biroli (cfr. Sander-Staudt, 2007; Vosman, 2016).

The first generation worked on the premise that women present a different moral approach than men (Gilligan, 1982/2003): an approach that is relational, and contextual in its orientation, which takes seriously the practitioner's own emotions and those of others; emotions are intelligent and telling. A characteristic feature of this first phase of care ethics is "the recognition that humans are concrete beings, who exist in mutually interconnected, interdependent, and often unequal relations with each other" (Hankivsky, 2014, p. 253). "Care ethicists begin with the premise that humans are fundamentally social beings enmeshed in a web of relationships" (Hamington & Miller, 2006, p. xii). Noddings (1984) and Ruddick (1980) based their approach on the nurturing way in which mothers care, presenting mothering as a model for care. "The significance of nascent articulations of care is that they made visible an alternative from of moral reasoning and its potential to affect the public realm" (Hankivsky, 2015, p. 13). At the same time this represents a form of substantialization of femininity, and this in turn disadvantages women, fixing them in a nurturing role. Hankivsky, quoting Monique Deveaux, calls this the "reification of femininity" (Hankivsky, 2005, p. 13).

There is also a debate here about the relationship between care and justice, in which Gilligan (1982/2003) places care over and against justice: care is an alternative moral approach that stands in opposition to the wish to view and solve moral questions through the lens of distributive justice. Noddings (1984) placed care above justice, thus creating a hierarchy. The first generation, for instance Held and Kittay, primarily attempted to devise a new relationship

between care and justice and to carve out a space for care as ethically relevant rather than as an ethical non-issue. This has turned out to be a lengthy and still-ongoing debate in which various proposals have been made, including a proposal to think justice from care (Kittay, 2015) or to see care as the wider context, part of a “revolutionary programme,” to think through a transformation of society; justice can be situated only within this wider framework (Held, 2006b, p. 66). Responsiveness to the needs of others is the most important alternative orientation, i.e. observing and attuning oneself to the needs of others (conceived in relational terms) instead of distribution from a position “above,” outside the relationship. In any case, this clashes with theories on justice, more specifically on *distributive* justice, like those of Robert Nozick, John Rawls, and Wil Kymlicka.²

The second generation of care ethicists, with Joan Tronto at the forefront, resisted the confining of care to femininity, and placed the fundamentally political aspect of care centre stage. In addition to Tronto, Selma Sevenhuijsen must be mentioned in this context, as well as for instance Annelies van Heijst, Elisabeth Conradi, and Sandra Laugier. I will limit myself here to the first two scholars. “An ethic of care remains incomplete without a political theory of care” (Tronto, 1993/2009a, p. 155). Tronto has demonstrated in *Moral Boundaries* that binary distinctions, including that of private vs. public, are deleterious. When care is not relegated to the private sphere, but is – in my words – constitutive of social life, then this is the beginnings of a care ethical political theory. Tronto is an important voice in care ethics in large part because she has proven adept at ethical code cracking: refuting concepts fixed in codes such as private-public. To put it differently, Tronto has broken through the “containment” of care in the private sphere. Among the second generation, it was Selma Sevenhuijsen (1998) who demonstrated that care as such is not good but multivocal (p. 20) and that “good mothering” is not simply *the* model for good care. Care as constitutive of the public sphere refers to the position that caregivers and care recipients occupy there: they are citizens. It is from the basis of citizenship

that the perception of needs should take place, but also “judging with care,” because that is part of citizenship: introducing insights about care to political debates by and about citizens (p. 15).

What is “care” about?

What is care (e.g. Pettersen, 2012; Lynch, 2016)? Is it “to nurture” (Noddings), “to repair” (Tronto), or is it the survival of individuals (Engster)?

At least nominally there is a great deal of consensus in care ethics about what care is, in the sense that *practices of care* are regarded as the point of departure, and in the sense that Joan Tronto’s and Berenice Fisher’s descriptions of care are frequently quoted, but at the same time there is in fact a variety of opinions on what care is. Likewise there are differences of opinion on whether the needs, preferences, or concerns of people who demand care should be the central issue.

There are authors who have attempted to give an emphatic description of care (Tronto 1993/2009a, p. 103; Baart & Vosman, 2011; Baart & Timmerman, 2016). Tronto has offered a broad definition: “a species activity . . . everything we do . . .” (Tronto 1993/2009a, p. 103). Engster (2015) has limited care to an activity focused on “vital needs” (p. 19). Is the reflection on care oriented also on values as well as on practices of care? Held sees care as “a cluster of practices” and “a cluster of values” (Held 2006b, p. 29-30). Slote (2013) has emphatically opted for a different approach by contending that “caring is clearly a feeling or an emotion of some kind . . . a certain kind of benign motivation . . . a kind of benevolence” (p. 5). Pascale Molinier (2013) has pointed out yet another approach: care is not simply a disposition or an ethic, it is mainly about labor (p. 340). Diemut Bubeck (discussed by Sander-Staudt, 2018, pp. 194-196) has unequivocally distinguished care from personal service; it is characteristic of service that another provides a service that the person could herself also perform. I think it may be questioned whether this last attribute is indeed sufficient to distinguish care. However, there are authors who, partly on the basis of the principle that practices of

care are the source of reflection, have rejected any all too restrictive description, let alone definition (Held, 2006a; Mol, Moser, & Pols (2010) strongly reject definitions). This last standpoint could be characterized as: practices will show what care is. Parvati Raghuram (2019, p. 14) has described this position in a, to my mind, precise manner:

If care is theorized as a practice, then we should also recognize that practices are indelibly inflected by . . . complex geohistories of existing practices of care. The definition of care does not precede its practice but arises from geographically variegated practices of care.

According to her the “instability of care” refers to care as “open ended and therefore risky because its quality can’t be known in advance” (pp. 15-16).

Is care ethics ethics?

There are various clear markers with regard to other, mainstream forms of ethics. The ethics of care is indeed a different voice, but it is certainly not unison.

Reflection on care starts with practices of care (Tronto 1993/2009a, p. 108, pp. 118-119³), and not therefore with attitudes (cf. Noddings, 1984) or virtues. Attempts have been made to establish such connections (McLaren, 2001; Halwani, 2009; Vanlaere & Burggraeve, 2015; Slote, 2007; Mocellin, 2007; Steyl, 2019), but the connection with virtues has also been criticized (Held 2006b, pp. 19-20, pp. 34-35; Sander-Staudt, 2006). From the perspective of one specific version of virtue ethics, the argument has been made that care ethics is superfluous: both virtue ethics and care ethics are “internally diverse”; “ethics of care as a view with no distinctive ethical content of its own” (Thomas, 2011, p. 144).

Nor does reflection on care begin with rights and duties (Nordhaug, 2011; see however Engster (2005) and Sander-Staudt (2006)), although Engster (2015) has called the care ethical position with regard to the more common ethical concepts of virtue and duty a “hybrid of these different moral traditions” (p. 24). Edwards (2009, 2011) and Paley (2011), who are critical about care ethics, think it is incoherent and superfluous.

There are forms of care ethics that orient themselves on a classical idea from ethics, the *telos* of human life, for instance “the good life” (Leget, 2013, p. 949). But the care ethicist Engster (2015) has embraced a more modest *telos*, namely “basic wellbeing”: “living and functioning as well as reasonably possible without significant blights (pain, suffering, unmet basic needs, underdeveloped capabilities)” (pp. 19-20, cfr. Engster, 2005, p. 53). I have criticized the bourgeois variant of the classical philosophical final goal, “the good life” – precisely as an implication of care ethics – and have instead pointed to surviving as a form of life (Vosman, 2018).

The ethics of care is characterized by the distance at which it stands to existing ethical categories, such as habit and virtue, as I have outlined above. But it also keeps its distance from reasoning through fictitious dilemmas and decision making. In the type of ethics that regards game theory as important, and also in popularizations of ethics, dilemmas as thought experiments play a prominent role. Gilligan (1982/2003) has characterized the emphasis on dilemmas as follows: “Hypothetical dilemmas, in the abstraction of their presentation, divest moral actors from the history and psychology of their individual lives and separate the moral problem from the social contingencies of its possible occurrence” (p. 100). The Heinz dilemma that is often used to illustrate Gilligan’s ethics is essentially such a hypothetical dilemma (p. 24 ff.). The focus that care ethics attempts to foster is on actual issues that arise in practices of care. Sander-Staudt (2018) has formulated this as follows: care ethics “shows a preference for exploring ethics through actual rather than hypothetical examples because of the detailed relational richness that is lost when situations are imagined and individuals are construed as abstract characters” (p. 193). Gilligan (1982/2003) has expressed this situational aspect very pointedly: “It depends . . . Well, it really depends on the situation” (p. 35).

A new terminology is replacing the usual ethical categories. Hamington (2014) has used the term “liminality” to describe this. Care ethics is “operating between ethical categories” and the reason for developing such a radically different “betwixt and between” approach was and continues to be that there is in fact an approach which seeks

ways of taking account of others with their needs and concerns on the basis of relationships, and in a situational way (Hamington, pp. 198-199). Engster (2015) has approvingly called this “fairly commonsensical” (p. 4), “meeting needs and not harming others” (p. 19). Daryl Koehn (2001) has convincingly shown how actual relationships are at least fluid (better perhaps is: always multivocal) and are at the same time the place where normativity emerges: “These relations are quite fluid and often both presuppose and require a trust and imaginative engagement for which there are no rules” (p. 1). Molinier (2013), who empirically studies care practices from a care ethical perspective, has described the relationship of care as follows: the relationship is not a combination of marketable tricks and by definition it is unique, unpredictable, high-risk, exhilarating, nauseating (p. 177).

This contrasts with an ethical approach which privileges, first, (a certain type of) rationality, and, second, the following of a generalizable rule of action, and which, third, regards easily communicable and codifiable communication about considerations and decisions as necessary for the validity of an ethical perspective (cf. for instance the emphasis on rational argument in Jürgen Habermas). Finally, there is an insistence on clearly defined and exhaustively refined ethical categories: what is or is not an “act,” what can and cannot be ascribed to an “actor,” etc.

The psychologist Carol Gilligan, in her still gripping book *In a Different Voice* (1982), described the factually existing alternative approach as that representing the voice of women: women in fact think differently. She regards having voice as a relational thing: speaking is inextricably linked to listening. At the same time, Gilligan regards voice as something that is present unless it is smothered or killed due to self-control. “By voice I mean voice . . . Listen . . . and then I will remember how it felt to speak when there was no resonance . . . Speaking depends on listening and being heard; it is an intensely relational act” (Gilligan, 1982/2003, p. xvi). She herself already broadened this concept: this relational and contextual way of thinking is a women’s voice that is being suppressed and that women suppress within themselves, thus alienating themselves from them-

selves: “the hand over the mouth and at the throat, the suffocation of voice” (p. xix). The alternative that Gilligan began to outline in “Letter to Readers, 1993” in one of the many new printings of *In a Different Voice* consists of the voice of women who seek resonance (p. ix-xxvii) and who focus on “repairing ruptures” (Gilligan & Snyder, 2018, p. 119 ff.). But this approach can also be seen in men. Much later, Gilligan would identify paternalism as the root question (Gilligan, 2008, 2011; Gilligan & Snyder (2018) in reference to Trumpism).

A decisive conceptual step was taken by the second-generation care ethicist Joan Tronto in her book *Moral Boundaries* (1993). She demonstrated that care ethics should become conscious of the boundaries that are imposed upon the alternative voice in ethics. The muffling of this voice sometimes happens unwittingly, by using ostensibly self-evident distinctions, and sometimes by employing rhetorical violence. In much existing ethical thinking, divisions are made between personal and political ethics, between the necessarily objectivizing and generalizing approach and the subjective approach, and between public and private life. These distinctions function as separations, and care can thus be safely relegated to the private sphere. The voice of women and of racialized groups who perform heavy care labor is excluded from the public limelight. This remains a highly relevant topic even after forty years of care ethical analyses (see for instance Biroli (2019), in this book, on Brazil). Laugier (2015) has pointed out that it is not simply a matter of voicing, of seeking out the voices of women and of other groups and of making them heard, but that it is always also about the equality of voices (Laugier, 2015) in the public forum. It is another matter whether this means that contemporary care ethics actually pays due regard to systemic injustice, to the way in which voices are dubbed in and through systems, up to and including the issue of women speaking for other women, black people speaking for other black people, and gays speaking for other gays (West, 1993/2001).

What goals does care ethics have now, after 40 years, in relation to voicing? Does it aim to provide policy support? But if so, what about the voices of people engaged in a social struggle, like the self-advocacy

of people with a disability? Simpican (2019) has pointed out that these people are not necessarily focused on influencing policy: self-advocacy that turns away from influencing policy-makers and instead focuses on creating “self-authored” spaces. These groups have the experience that their voice, whenever it is heard, is often “seized” by others.

The idea of “all the voices at the table” (Tronto, 2013) is unrealistic, because the idea of domination-free communication is a chimera in a democracy. And what about the voices of groups who are in fact unheard, but who *do not wish* to participate in the parliament of voices, as the French feminist philosopher Elsa Dorlin (2017) has courteously but firmly reminded care ethics. A dark part should be added to care ethics, an ethics of powerlessness, for there are groups that are experts in caring for others just to ensure their own bare survival (pp. 176-177). Those who provide care to avoid becoming the victims of violence do so according to “a totally different ethic than that of affective nearness, love, compassionate attention” (p. 175); instead, such groups seek “a refuge to defend themselves” (p. 175). The last thing they want is for their voice to be heard, because that involves even less safety. Of course this engages the very idea of democracy, with its assumption, its premise, that all are equal, and its programme of representing all people as equals, with the same right to speak according to the customs of democracy.

Zooming in on one particular concept: responsibility

Generally speaking, responsibility is regarded as a core concept in the ethics of care. In this section I will address in greater detail the way care ethicists have interpreted this prominent concept. I will also describe the problems that arise when responsibility is emphasized.

For Tronto (2013), responsibility is a key concept in her variant of care ethics (for the substance, see pp. 17-64). The concept has been adopted and modulated by many care ethicists (e.g. Van Nistelrooij & Visse, 2018). The underlying idea (why responsibility?) does differ, however. One underlying thought is: anyone who has the capacity to care must care – responsibility is a duty incumbent upon the position of a person who has the capacity, responsibility arises from “consistent

dependency” (Engster, 2007, pp. 46-54, 2015, pp. 21-22). Kittay (2009) sees care as a moral duty in relations of dependency, if the needs are basic, the vulnerability is major, and the previous relationship justifies the responsibility, even if the burden is high (pp. 49-73). Or: responsibility is self-evident when and in so far a relationship has value to us (Collins, 2015, p. 40). Walker (2007) also affords a central place to responsibility (pp. 83-106), on the basis of the idea that to care is a moral practice and that responsibilities are characteristic of moral practices. “I propose that it is fruitful to locate morality in practices of responsibility that implement commonly shared understandings about who gets to do what to whom and who is supposed to do what for whom” (p. 16). Ultimately she regards care ethics as a “narrative ethics of responsibility, even though these narratives are very modest and insignificant” (p. 155). She has also spoken of a geography of responsibilities. Another notion, however, is that responsibility must be thought as responsiveness, i.e. subjects respond to needs on the basis of some commitment that happens to exist. According to Kittay (1999), people simply exist in the context of a web of linked and nested social relations (pp. 66-70), or, as Engster (2007) puts it, “in our empirically verifiable dependency upon others and other’s dependency upon us” (p. 51). This is sometimes represented as natural care, “a primitive good” (referring to Noddings). Responsibility has also been analyzed from the perspective of forms of phenomenology: through a primary connection, subjects increasingly learn, so to speak, what responsibility in this connection evokes or which reaction grows into responsibility (Visse (2016), drawing on Urban Walker and Van Heijst). Elena Pulcini (2013), largely following Hans Jonas, has proposed another foundation for responsibility, which closely resembles the theme of responsiveness:

The ethics of responsibility is deemed to originate in the imperative to preserve humankind and life (“that there be a mankind”), which in turn derives from a meta-principle that states the intrinsic value of being over not being. Therefore the ought-to-be is deduced from being, ethics from ontology, responsibility from the superiority of what is good (being) compared to what is evil (nothingness). (p. 167)⁴

Tronto (2013) has confronted responsibility with societal power relations, and thus uses “privileged irresponsibility” as a distinction: there are groups that are able to abnegate their responsibilities very comfortably, thus also concealing care as a practice that is constitutive of society (p. 68 ff., but, much earlier, also in *Moral Boundaries* (1993/2009a, pp. 120-122, pp. 146-147). They have the power to ignore a part of the experience that becomes evident in the process of making a society livable (Casalini, 2018, p. 184).

Contested responsibility

Responsibility is not just a core theme for authors from care ethics. The Italian care ethicist Casalini (2018) has explicitly confronted the neoliberal emphasis on individual responsibility, on self-care and care for those who are dependent on you with caring responsibility arising from responsiveness. The idealistic and constructive care ethical idea of responsibility, responding to another person’s vulnerability, is being contested by other, actually existing and very influential discourses on responsibility (Trnka & Trundle, 2014, p. 141: “coexist . . . intersect . . . contest”). Responsibility is a thoroughly Modern concept, welded to Modernity (Hochmann & Pfriem, 2018, p. 127: “erstaunlich Modern” [astonishingly Modern]; cfr. Trnka & Trundle, 2014, p. 138). Hochmann and Pfriem (2018) have pointed out how important it is to have regard to the pre-moral character of responsibility, i.e. to responsibility as responding. They have also shown how the pre-moral is subsequently politically and morally “charged.” This charging happens both by the ethics of care and by other approaches, including the neoliberal approach (p. 31). This indicates that caregivers and care recipients are twice given a normative instruction in the public sphere, a care ethical and a neoliberal one.

On the basis of postcolonial theory, Pat Noxolo, Parvati Raghuram and Clare Madge (2012), whose thinking is close to care ethics, have drawn attention to the unsettled nature of responsibility. They have identified the various discourses about responsibility that are current in (political) ethics, and how problematic it is to

reason with responsibility (pp. 419-420). “It is difficult for well-meaning western academics to talk about responsibility, even reformulated as intersubjectivity, whilst the conditions that allow us to do so are so very complicit in . . . exploitative relationships.” What is important is that anyone who makes an argument for responsibility, even for caring responsibility, should account for the position from which they speak: “to fully face up to and accept their ‘contaminated’ position” (p. 422).

The ethics of care should be much more critical and political in its reflection on the intersection between discourses of responsibility and the protagonists’ own position, something which, to my knowledge, has not yet happened in a sufficiently radical way. In fact, the opposite is happening: there has been a shift away from the political. Care, responsiveness and responsibility are being ontologized or presented as apolitical phenomena (Van Nistelrooij & Visse, 2018, p. 10: “a call grounded in the being of the situation”). This idea of grounding clashes with the idea that “care ethics favors concrete considerations over abstract ones” (Hamington & Miller, 2006, p. xii).

Moreover, the feminist philosopher Dorlin (2017), who has engaged in a dialogue with care ethics, has demonstrated that care practices are characterized by forced responsibility. She has shifted the perspective: it is not about power (in the sense of oppression, obvious or subtle domination) but it can also be about – barely concealed – pure violence (p. 7). Enforced care is care, it is even very attentive care. But it differs from care through mere affective proximity, love, compassionate attention, affective concern, or self-sacrifice while giving very demanding care (p. 175). There is certainly a relationship at play, but this relationship is one between the “hunter” and the caregivers who are the prey (p. 163: “phenomenology of prey”). The caregivers are constantly engaged in thinking about what others want from them, and they give care to prevent further violence. According to Dorlin, the shift from power to violence can only be effected if care ethics is refashioned into “an ethics of powerlessness” (p. 177). What is at stake is whether care is viewed primarily as a moral activity that must be perceived

ethically and that is liable to receive normative instructions, or as a mixed practice, marked from the start not only by moral aspects and the directly physical, technical, material, and institutional aspects, but also by violence, which cannot simply be controlled through “high morality” or “relational ontology” or non-politically located phenomenology.

Given the enormous emphasis on responsibility in the ethics of care, it is perhaps a good idea to think again about responsiveness, with, as a subsequent step, not morally charged responsibility, but schooling in more refined observation and in how to begin and maintain relationships, amid friction, violence, and multivocal meanings, and this always on the basis of practices. This context can also be designated as “the political.” The step from the pre-moral to the moral requires renewed attention. Similarly, collective but also institutional and practice-generated responsibility require separate attention. Contextuality is not the problem, but the high moral connotation of the concept of responsibility within care ethics is, and the lack of true reflection on the context: the context of practices, collectives, and institutions.

Summarizing the core ideas

Relationality (1), contextuality (2) in observation and appreciation (up to and including the particularity of what is good; Sander-Staudt, 2018, p. 193), the normative importance of emotions (3), and the political nature of giving and receiving care (4), those are the four insights that care ethics has initially offered (Held, 2006a, pp. 538-541; Engster & Hamington, 2015, pp. 3-4). Responsibility (5), portrayed above, is a fifth key concept. Two further insights should also be mentioned: bodiliness in all relations (6), and vulnerability (7) as the common denominator through which people can recognize each other (instead of rationality). Kittay (1999) has observed that this vulnerability belongs to those who receive care, but equally to those who provide care. To her vulnerability is not a negative reality, not a weakness that should be phased out or diminished; recognizing it has a humanizing effect.

One observation that must be made is that each of these seven insights clearly testify of its feminist roots, both substantively-ethically and epistemologically. It was from feminism that the idea was developed to move from actual relations to the functioning of those relations, from related to responsiveness (Visse, 2016; Van Nistelrooij & Visse, 2018). Patricia Paperman (2015) has articulated this very clearly:

What counts and what is important cannot be understood as the result of preferences, values, or sentimental attachments, but as the result of engagement in the social world, engagements that are certainly assigned, but that allow for a different version of “reality” or a world that is social in a different way. (p. 63)

“Different” here means different from traditional ethics. Another typically feminist feature is the question (in many different formats) whose knowledge of problems of action that people face, counts. Often, very often, the knowledge of women and other marginalized groups is regarded as unimportant or non-existent within existing (powerful, often violently upheld) power structures.

Insights or principles

In this overview, I have spoken of critical insights that care ethics has developed. I would like to add a few words on this expression “critical insights” and their groundedness. This is not just a matter of words, but the form of care ethics as such is at stake. In 2012, I purposefully began to speak in terms of “critical insights” instead of “principles” or “concepts” to characterize the insights care ethics has brought (Vosman & Niemeijer, 2017; Vosman & Baart, 2018). What are critical insights in this sense? I have just indicated that the insights in question relate to relationality, the functioning of contextuality, the vulnerability of all participants – although this does not apply to all participants in the same way – and that vulnerability is always linked to physicality; and this is not an exhaustive list. These insights were acquired by care ethics through analyses of specific issues in care practices. They are not metaphysical or ontological “conclusions” on

who “man” is, but on how practices of care work and how participants in those practices fare. Handling critical insights also means that it is necessary to continue working on them, insofar as the issues and care practices continue to give rise to reflection or renewed reflection.

It is the opposite of critical insights to turn care ethical ideas into principles. Codification into principles that are subsequently applied in fact takes place, and some scholars advocate this process (Collins, 2015). To me, this is not the right way. It is understandable that people should seek something to hold onto, especially as care ethical principles are regarded as too vague and too little directive. Vanlaere and Gastmans (2005) have asked: “What precisely does care represent as a normative-ethical principle? The vagueness of the moral presuppositions underlying care ethics has sometimes led to this approach not being taken very seriously in the literature” (p. 200). And yet codification of principles which are then applied in practice is misguided. The remedy against presumed vagueness is to maintain the openness of the insights (for instance in respect of vulnerability) and to use them heuristically instead of as material for definitions. In view of the accusation of vagueness, it seems right to me to expect that care ethics should ensure the traceability of general statements about the normative significance of particularity: to what extent can statements on the basis of relationality and context be reproduced? The critical insights were acquired through induction and abduction and are not a matter of applying principles. This stance with regard to critical insights is linked to radically attuning inquiry to care practices. This is not to say that the objection of vagueness is nonsense. After almost forty years of the ethics of care, I believe care ethicists are ready to “work through” the past of care ethics. Do its insights fit or do they lack focus, as Simplican (2018) has argued? But it is also time to bind care ethics more radically to inquiries of practices and to the questions participants in those practices ask. To the extent that care ethics is ethics, this can make it more robust and more self-critical.

2. Contours of Care Ethics

In this section I will address the contours of the ethics of care, as an element of a critical cartography. I will use two approaches to do this. What is the aim of care ethics, and what is this approach trying to leave behind (programme and anti-programme)? There are various overviews of care ethics; does it help to know what kind of overviews these are and what kinds of overview are still lacking (types of overviews)?

Programme and anti-programme

What approaches (in ethics, in political theory) is care ethics attempting to get away from? *Where is it going*, and *what is it attempting to leave behind*? I am addressing these questions, because researchers always have issues that they are preoccupied about, they have proper *concerns*. The process of forming ideas that they undergo revolves around this concern. When the psychologist Carol Gilligan (1982/2003) invented the name “ethics of care” for an approach that would fully respect the voice of women, this means she also had an anti-programme: combating the neo-Kantianism of her fellow researcher Laurence Kohlberg with his requirement of general validity for any valid, mature moral statement. As an alternative to “self-defined through separation” she posited “self-defined through connection” (p. 35).

For many care ethicists, one burning issue that is connected to (although it is not coterminous with) the suppressed voice of women, was and is care labor: the caring labor that is often heavy and unpleasant, that is performed by specific groups without public recognition or appropriate remuneration: women of color, immigrants, women without much formal education. Much later, Gilligan (2008; Gilligan & Snyder, 2018) even more explicitly identified paternalism and patriarchal political culture as that which had to be combated. Tronto (1993/2009a, p. 11) has stated explicitly that the anti-programme of her own version of care ethics is:

to end sexism, to face up to racism, to liberate sexuality, to end domestic violence, to conceptualize domestic and medical services appropriately, to confirm the right of women and men to physical integrity, and to promote peace rather than war.

Another example of programme and anti-programme is the emphasis on vulnerability or on the interdependency of all human beings, as a form of realism, but also as an alternative for and critique of autonomy and the claim of rationality. Slote (2013) has – fairly succinctly – positioned care ethics in opposition to the Enlightenment; a view in which Romanticism is not seen as a second Enlightenment (Slote 2013, p. 7). To put it briefly, people are all equal because they are all vulnerable and interdependent; it is not their rationality and their autarky or autonomy that makes them human. Care ethics' elementary anti-programme is directed against obscuring caring activities as activities that are constitutive of the *polis* (see Paperman, 2013, p. 51: “invisibilisation et méconnaissance” [making invisible and lack of understanding]).

The distinction between programme and anti-programme can help to recognize the vector of care ethics, but also to keep it on course and to question the precision of the critique it offers.

Types of overviews

There are a number of overviews of care ethics that address the concepts, including the development of the arguments offered (e.g. Sander-Staudt, 2011; Garrau & Le Goff, 2011; Kohlen & Kumbruck, (2008), interwoven with nursing; Vosman, 2016; Keller & Kittay, 2017). These are mainly concerned with concepts and the history of ideas. In addition, there are several often short historical overviews in articles (for instance Hankisvky (2014), who distinguishes three generations of care ethicists) and in books (Held, 2006b), sometimes also when the background of one specific concept is being investigated (for instance care in Lynch (2016); or vulnerability in Bernardini, Casalini, Giolo, & Re, 2018). There are also surveys of the reception of care ethics, mainly of American care ethics, in other political or cultural fields: care ethics as received by French-speaking political culture (for instance Brugère, 2019), and Spanish (Lopez de la Vieja, 2006), Italian (Brotto, 2013; an overview in Casalini, 2018, pp. 148-149), Japanese (Okano, 2012⁵; Sugimoto, 2018), Canadian political culture (Bourgault & Perreault, 2015). The reverse, i.e. the reception of foreign work in the USA, is rare and I am not aware of

any overview; Bourgault and Perreault have courteously but no less clearly spoken of “isolation” and “loneliness twice over” (Bourgault & Perreault, 2015, p. 16).

There are also overviews that offer new arguments and their own distinct systematizations, for instance by Collins and Brugère. Collins’ (2015) interest is in the codification of care ethics, turning emerging insights into principles which can then be applied, but the book can also be read as an overview. Fabienne Brugère’s (2019) aim was to highlight the political nature of care ethics, but in doing so she has also provided an outline of the major developments.

What is lacking – and this is important in view of the burning issues that have been identified – is an overview that situates care ethics historically, socially and economically. It is abundantly clear that care ethicists are responding to social conditions. Barnes and Tronto, for instance, responded to what were observed to be the effects of neoliberal policies. At the same time the involvement with complex social problems is not always appositely expressed. Hankivsky (2014) has pointed to the debate about the great feminist concerns (color, gender, class, as well as sexism and ageism) with which the ethics of care is engaging in a methodically very limited way: “Care theorists tend to mask the historically rooted ties and mutually constituting processes and patterns of a broader range of oppressions, thus obscuring the full range of possible forces of power that shape difference” (Hankivsky, 2014, p. 253).

As far as I am aware, there is no overview of care ethics that is conceptually sociological, that is: an overview of the ethics of care conceived from the perspective of the various social problems, and of how and to what extent care ethics is responding to these through theory formation. Such an overview would be fully suited to care ethics and would at the same time be part of a social condition and of major shifts in the social and cultural situation in which care ethics operates. Nor is there – to mention yet another possibility – any materialistic overview, which could demonstrate how the private sphere is continually inflated and how social problems are relegated to this sphere in a very different way (Casalini, 2017, p. 501)⁶.

Such overviews would also be able to show how a critical insight, for instance the value of attentiveness within relationships (Brugère, 2019) and the demolition of the boundaries between public and private (one of Tronto's "moral boundaries"), is itself a historical phenomenon that can also be overtaken by social development and by political change. As Andreas Reckwitz (2017) has demonstrated, the cultural emphasis on attentiveness, on the personal and the relational ("singularity") in Late Modernity has in the meantime become a general social programme and is no longer an "alternative" approach. I think the critical insights that care ethics provides are not at risk of losing their value, but they should be rethought and placed in a new framework.

3. The Future of Care Ethics: Uncomfortable Conversations

In this last part, I will address the necessity of having a rigorous conversation within the ethics of care about unresolved issues that are frustrating the development of care ethics. I will look at one particular such issue, intersectionality, to explain that care ethics has not yet found an answer on how to inquire into the *complexity* of social issues (Vosman & Niemeijer (2017) on complexity and complexity theory). Furthermore, as I announced in the introduction, I will briefly discuss a lacuna and an aporia in care ethics.

It is time for care ethics to engage in a rigorous conversation about its future and about the design of care ethical research. My take on this design is that care ethics should study what has proven to be possible in practices when it comes to developing good care, with care interpreted in a very broad sense. It is important to achieve a greater degree of consensus on which issues remain undertheorized and why. These conversations are surely uncomfortable, but if these debates are not held, my suspicion is that care ethics will stagnate. These uncomfortable conversations are not about hostility. Tronto has pointed to the danger of "horizontal hostility" (Tronto 1993/2009a, p. 16). This is a risk that must be acknowledged and faced. Nor am I arguing for permanent "dissensus" (Bröckling, 2013, p. 319). But the growth of care ethics must not lull us into ignoring its considerable theoretical weaknesses.

It is inevitable that uncomfortable questions will be asked during the type of conversation I am advocating, such as why conversations with black women themselves and with black feminism are not a fixed feature of care ethical research. To formulate it more broadly: with which kinds of feminism is care ethics, itself rooted so strongly in feminism, engaging in dialogue (Casalini, 2018; Robinson, 2015)? How can it be that care ethics is multidisciplinary, possibly even interdisciplinary, but has no fixed strategy on bringing the various disciplines into dialogue with each other? I will first ask a number of wide-ranging questions, and will subsequently discuss the various points more specifically.

Is it possible to have philosophy without sociology, or without an explicit political theory; and are there valid forms of care ethics that have no empirical reference? Is it possible to critique neoliberalism without thoroughly studying the many faces of neoliberalism? Kangas and Salmenniemi (2016) have observed a “multiplicity, complexity, and variegation of neoliberalism, that is, its hybridity” (p. 215). Is it possible to have an ethics of care without incorporating findings from critical economic theory? Interdisciplinarity is a worthwhile but laborious programme.

In addition to the issues of who one’s interlocutors are and of interdisciplinarity, what is at stake is also research of and conversations about foundational categories. Why, for instance, are presuppositions concerning what the political and politics are, what democracy is, not developed further, while many within care ethics at the same time profess to believe that care ethics is political in nature? Can care ethics neglect the task of finding out what methods can be used to study complexity while the complexity of action questions is such a pressing issue? One final example of an uncomfortable question is what the “Mappa Mundi” of care ethics would look like if voices from South Africa, Brazil, Korea, and Japan were equal, or, for that matter, voices from France, Canada, or Germany.

A frozen conversation: intersectionality

I will now focus the argument outlined above by describing the example of a frozen conversation that is necessary, a conversation about

an issue that causes friction, and that involves the possibility and the requirement of speaking with fellow travelers. There are three relevant issues. Firstly, it is a conversation that directly involves that which care ethics stands for, making the voice of those who are suppressed heard. Secondly, it is also an example of the kind of epistemology and ethics that are relevant to care ethics. What is assumed and what is left out within the conceptual framings of care ethics? Thirdly, the issue at stake is whether care ethics has a differentiated sensorium for intersections of multiple nature, amidst of growing societal complexity. A sensorium means receptivity for complexity. These would be the topics for such a conversation, which is likely to be uncomfortable, but also fruitful.

On the basis of the feminist roots of care ethics, the connections between gender, color used to racialize, and economic, social, and cultural class is an important issue. Intersectionality, a term introduced by Kimberlé Crenshaw in 1989 (cfr. Crenshaw, 2017), has since been used within sections of feminism as the method par excellence to investigate these connections. Sirma Bilge (2015) has characterized intersectionality as a form of power analysis: of the mixing, structuring, and organization of power, of the interaction between vectors of power and of the domains in which power is exercised (p. 15). It has also become increasingly clear how complex it is to work with intersectionality (Lutz, Vivar, & Supik, 2016; McCall, 2005): the aim of intersectionality is that it should be applied to complexity, but it is itself also a complex strategy (Hankivsky & Grace, 2015). “The paradoxes, promises, and perils of deployments of intersectionality” have become clearer (Thomson & Finley, 2019, p. 155). Among its protagonists, various distinct views on intersectionality have arisen, ranging from relatively open – a method to ask critical research questions (Davis, 2014), to very detailed – 12 categories must be investigated (Lutz, 2015).

The fact that intersectionality-based research has gone off course has been strongly criticized (Bilge (2014): “depoliticized”, Bilge (2015, p. 20): intersectionality at the same time has been applauded and neutralized; Wekker: “interrupted and displaced,” as cited in Colpani & Isenia, 2018, p. 225). At the same time, a strong

plea has been made to use intersectionality within care ethics “as a robust method for understanding the significance of difference and their relationship to power” (Hankivsky, 2014, p. 252). Intersectionality is in fact used within care ethics, for instance by Nicky Ward (2015) and by Fiona Williams (2018), who has applied it to the sociological conceptuality of micro-meso-macro levels (cfr. Raghuram, 2019, p. 3).

There are also good theoretical grounds for intersectionality, because color and class always lose out against gender in care ethics; according to Hankivsky (2014), care ethics ultimately always prioritizes gender (p. 252). Hankivsky (2006) was initially optimistic about care ethics and its ability to integrate differences, but she has become much more critical. Care ethics should – according to Hankivsky (2014) – learn from the theory of intersectionality not to use any category of difference a priori (p. 256) and not to think in terms of an addition whenever another difference is included in the equation, “additively” (gender + color, for instance), or “multiplicatively” (gender x class). Intersection means looking at the actual interactions that occur: “focus on the meaning and consequences of interactive and interlocking sites” (p. 262). According to her, analytic prioritization as well as essentialist tendencies weaken care ethics (p. 262).

Intersectionality challenged

The intersectionality approach itself has also been challenged in several rather important ways. The French sociologist Didier Eribon (2016) has engaged in something similar to care ethics in the sense that he is interested in the how and the why of the silencing of voices; “voices that are made inaudible” (p. 132). Like Annie Ernaux (2008) and Édouard Louis (2015), Eribon links autobiography to analysis, and all three scholars refer to Bourdieu and wish to speak with a voice from within. From the perspective of a working-class, white, homosexual man who has acceded to the intellectual class, Eribon recounts how the “different cut-outs of the social world” (p. 151) *continue to chafe*. In his book *Retour à Reims* (2009), he recounts that and how the various dimensions of his life are always

indissolubly linked with each other and intersect each other, and cannot therefore be represented as various layers existing on top of each other. Intersecting also means that guilt and shame are never far off. In a reference to Bourdieu, Eribon (2016) speaks of a “honto-biographie,” a biography driven by shame (p. 144). Being a laborer’s son, white, gay, and an intellectual (but this can be equally true for a woman, a person of color, or a member of the middle classes), means also participating in the lives of working-class people, of white people, etc. No one is only subject to or part of one particular cut-out. There is no way of renouncing this form of participation. Hankivsky (2014) has contended that “care ethics and intersectionality are both social constructivist approaches,” and this is a reason why interplay is possible (p. 252). Eribon (2016), however, does not subscribe to any constructivist epistemology: the social world is all representation, and the principles on the basis of which cut-outs (class, gender, etc.) take place are epistemically and morally charged. What exists is “only” a struggle between representations. His key term for this struggle is inferiorization. At the same time, however, there is a distance between the representations and what they refer to and what they “grasp.” The social agents themselves have knowledge on the basis of their life’s practices, and it is dangerous to attempt to reach “below or above their knowledge” (pp. 153-154). They themselves in turn are historically and socially determined. The task is to study and respect the categories of self-perception, not to seize them, as Eribon (2009) has argued in the Epilogue of *Retour à Reims*.

What is at stake here are the researchers and the objects of research, but also those things that do not depend on constructions of meaning. This last aspect ensures that we are still in the political realm (rather than in the “existential” or “metaphysical” realm). When it comes to voicing, there is silencing and self-restraint in speaking (because not speaking can be protective, avoiding the risk of being seized by third parties), but there is also radical inexpressibility. This, it seems to me, is of great epistemological importance for care ethics, and it is one of several arguments to ask whether the ethics of care should in fact be regarded as a constructivist theory at all.

Eribon regards his initial shame at his background and his enduring shame at transitioning to another class, as the most powerful source of reflection.⁷ The emotion of shame is ultimately the intelligence of the political: it is not easy or comfortable, but it is necessary for a “political project” (Rehberg 2017, p. 25). His shame, according to Eribon, is a historically and socially grown mindset that is the very key to reflection and to keeping the critique on track. In other words, it is not a simple feeling of being victimized, but is a state of mind that he wants to account for and use as a key for research. Shame must not therefore be interpreted psychologically, nor should it become ground for therapy. Instead, it is about reflecting on breaking and on rupture, in Eribon’s life his distancing from a homophobic working-class culture, but equally from the bourgeois disciplining that is part of life as an intellectual. Eribon’s voice is not a voice that speaks about others, divided into groups, groups “aggregate . . . in bounded categories” as Hankivsky (2014) has critically observed in relation to care ethics (p. 256). More than the theory of intersectionality Eribon’s approach reflects on being uprooted, on struggle and rupture, and on actual practices. In view of this interpretation of politics, Glassmann (2018) has, I believe rightly, characterized Eribon’s book *Retour à Reims* as a “political book” (as he did with regard to Annie Ernaux’s *Les Années* (2008) [*The Years*, 2017] and Édouard Louis’ *En finir avec Eddy Bel-geule* (2015) [*The End of Eddy*, 2017]). Eribon is skeptical vis-à-vis the theory of intersectionality, even though he explicitly expresses his solidarity with the feminist movement and with Crenshaw and the burning issue she placed on the agenda, of violence against women of color (Eribon in an interview: Rehberg, 2017, p. 23). Intersectionality makes it possible to see the intertwining of class, gender, and sexual orientation. But intersectionality cannot be used as a solution, as a liberation strategy, as a strategy to simply split the cards and show that one layer is full of guilt and others are not (Eribon, 2016, pp. 49-53). For Eribon, the intersection is never given once and for all; it is constantly constructed and invented, and it should be stressed that it is constructed against pre-existing political representations which will not, however, disappear (p. 52).

Hankivsky's (2004, 2006) poignant programmatic proposal addressed to the ethics of care, which has still not been widely adopted so many years later, as well as Eribon's criticism of intersectionality – which focuses in part on the same issues that care ethics addresses – should be subjects of conversation in care ethics. Other strategies of complexity should also be discussed, like SKAD (the sociology of knowledge approach, which focuses on the clash between different descriptions of the same event (Keller, 2019)).⁸ Another more radical research strategy should also be considered: materialistic feminism (Galerand, 2015). It is still not a fixed part of the programme of care ethics to systematically and critically face up to the complexity of issues in which participants in a practice of care find themselves. It appears that care ethics remains undertheorized precisely in a field in which it should be profoundly interested.

An aporia: the problematic ontological "we"

Berenice Fisher's and Joan Tronto's description of what care is has been quoted and embraced by many in the ethics of care. "Caring can be viewed as a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible" (Tronto, 2013, p. 19, a description that dates originally from 1990). María Puig de la Bellacasa (2017) has tried to "rephrase" the "we" in a "nonhumanist" way: "We need to disrupt the subjective-collective behind the 'we': care is everything that is done . . . so that all (rather than 'we') can live . . . as well as possible" (p. 161). She has thus decentered the actorship of care. In addition to this "we" at the core of what care is, "we" is often used in care ethics to indicate the subject of speech and to create inclusion with the readers. Let me give a number of examples. "We can acknowledge the way much caring work expresses how persons care about, and are not indifferent to, others" (Held 2006b, p. 109). In this case, "we" refers to the philosophical "we". The philosophical "we" presumes the existence of mutual connection and understanding between writers and readers for each other's thought processes. Possibly this can be expanded to mean "we, people engaging in argument." The danger of

using the philosophical “we” is that the capacity to investigate an entirely different position is diminished or even destroyed. It is tempting to say “we, human beings.” In addition to the philosophical we, there is the rhetorical “we.” The danger of using the rhetorical “we” is that it can include groups on false grounds, as feminism, the queer movement, and the movement of racialized people has made abundantly clear. At the very least, circumspection is required to avoid that care ethics should itself engage in false inclusion and, for that matter, exclusion (Engster, 2018, p. 10).

Let me return to Fisher’s and Tronto’s description of care. Does this presuppose an already existing community of people: “humans,” “humankind,” “the human species”? Tronto (2017) later devised an ontological basis upon which her description can be fixed. The “we” is founded first of all on interdependency of all with all, and secondly on the fact that all people are vulnerable (p. 32). “Humans are essentially, in the plural, *homines curans*” (p. 28, referring to an expression by Albertus Magnus).¹⁰ In this way she has deployed an “ontology” to combat neoliberalism and its views on what it is to be human, and on care. It is an ontology that Puig de la Bellacasa (2017) in turn has attempted to replace by a different, wider ontology. Both believe it is possible to understand and prioritize a political issue through ontology. This “ontological turn” (Joronen & Häkli, 2017, p. 561, p. 564) had been in evidence in thinking about care much earlier. It was visible for instance in a book by Leonardo Boff, inspired by Heidegger, and tellingly entitled *Essential care. An Ethics of Human Nature*: “We do not *have* care, we *are* care. This means that care possesses an ontological dimension that is part of the human constitution” (Boff 2008, p. 56, italics by Boff).

This essentialized “we” is far removed from the critical insight that *reflection on care should depart from actual practices of care*. The objection is that the ontological turn in care ethics disregards the fact that it can, epistemologically, only be historically, socially, and culturally determined discourse about who and what people are. A patient look at the history of anthropological discourse will show that generalization is a recurring feature (today’s generalization being that people

are caring animals; see Tronto 2017). Time and again, characterizations arise that have the pretension of being valid across cultures and eras, only to be replaced very quickly by new characterizations (Marmion, 2018): the rational human being (Aristoteles' *animal rationale et sociale*), the speaking human being (Dante Alighieri), the laughing human being (François Rabelais), the playing human being (Johan Huizinga), or the human being as a being characterized by cruelty (Nietzsche). In a debate with care ethics on giving a greater role to narrativity, Chen has argued: "We are homo significans or meaning-makers" (Chen, 2015, p. 780).

"Human beings," "people"... all these terms are rhetorical of nature. Adorno pointed out that deciphering human actions (which is not the same thing as trying to determine the essence of human beings) in order to construct the denominator of "human being" is to circumvent the political (Hammer, 2006, p. 108). For a political theory that places practices of care center stage, it is a perplexing strategy to attempt to settle the debate with "neoliberal anthropology" through ontology. This is akin to circumventing the political: it is no use trumping one theoretical generality (described by Wacquant, 2012, pp. 69-70) with another one, even if it is a more sympathetic one. It is a recursive move, an inscribing of a moral solution in being, in human nature as such, an ontography – what cannot be gained politically is supposedly gained at a more fundamental layer, that of anthropology – that is not helpful.

Struggling against the image of self-sufficient entrepreneurial human beings by pointing at vulnerability is a different matter, at least if vulnerabilities are shown *as they actually exist* and as they appear in actions, omissions, and things endured. I would argue that the source of reflection for care ethics must be radically situated within practices. Relying on a generalized "existential," metaphysical or ontological (putatively more fundamental) vulnerability or ontology of "the caring creature," in my view, is to dodge the laborious analysis of the actual phenomena of vulnerability, of the paradoxical compulsory autonomous resilience, and of the killing of community. The epistemology of care ethics makes it possible to point at

phenomena that cannot be grasped. I cannot see, however, why it should facilitate the abandonment of ethics and a descent into ontology: this is incapable of providing the foundation that is sought. The ontologically constituted “we” has created an aporia in the ethics of care. An unnecessary one, but it is nonetheless real.

The actual “we”

My misgivings vis-à-vis the ontologized “we” of the *homines curantes* described above are clear; instead I believe we should look for the actual “we.” This is a way of breaking through the aporia. What I mean is the “we” that can be actually created through encounter, friction, self-confrontation, and by actually sharing concerns:

- the “we” of *grandparents* – otherwise inclined to be apolitical and conservative – who become engaged in the climate movement for the sake of their grandchildren who are involved in protests and create a new “we”;
- the “we” of *homosexuals* who reject the word “gay” and call themselves “faggots,” thus together appropriating the slur as a badge of honor;
- the “we” of *people of color* who begin to refer to themselves as “niggers” and form a “we”;
- the “we” of *patients in the oncologist’s waiting room* who see each other’s fears and engage in conversation with each other;
- the “we” of *women in Munich* who have been committed for years to activism for women in Congo who were raped as a strategy of war: they do not know these women in person and simply continue to build political pressure.

The use of the word “we” without actuality, without awareness of friction, and without the knowledge that a “we” can also be lost, is dangerous. Perhaps this is the most serious message of the postcolonial critique of Western feminism, of which care ethics forms part and on which it draws: the critique of the “proofs” of universality and transcultural validity (Montanaro, 2018, p. 45). It is precisely *the*

actual “we” that refers to complex community formation and to possible friction between different positions.

Lacune: inflecting community

My explicit reluctance with regard to using a “we” that is not sufficiently defined is linked to my amazement that there is a lot of theory in the ethics of care on relationality and connection, but very little on community and community of destiny, and also on, *and by actual* groups of women who are characterized by care labor, “dirty care” (cf. Dorlin, 2017, p. 177; see, however, Biroli in this volume).

Care ethics has pointed to lacunas in other types of ethics and political theory (Hamington 2018), but it is not free of lacunas itself. Engster and Hamington (2015) have averred “significant disagreements and gaps” (p. 7). I think there is such a gap in respect of the place of community.

There is little or nothing on establishing community and on the desire for community, in all its ambiguity and also in its deep cultural diversity. In relation to the ambiguity and the problematic nature of longing for community, the feminist historian Jill Casid (2012) has spoken of “the barbed wire of connectivity”: it is problematic to want to be connected, and yet it is a deep desire (p. 131). Pulcini (2009) has thoroughly explored the problem of community, but has not made any connections with the ethics of care (see also Laugier, 2014, pp. 179-207).

I call this a lacuna for two reasons. First, because community, the form of life that goes beyond I-you relationships, follows on from political care ethics. A second reason is that since the rise of care ethics, political developments have increasingly come to light that cut across the giving and receiving of care. I say “have increasingly come to light,” because they already existed before. I am referring to the desire to belong, the longing for community, for belonging, that is evident in so-called populism: the expectation that there are institutions that care for you, the political experience of not being seen despite a clear voice, and of thus not belonging to the body politic (Eatwell & Goodwin, 2018). The lack of care, the failure to recognize

voices that are being heard, is, I assume, an important concern of the ethics of care. This political experience of groups of people and this sentiment are deemed to be “populism.”

Populism is making its presence felt in care ethics (Shaw, 2018; White, 2017), but care ethics does not have its own conceptual apparatus to process it: there is no fully fledged institutional theory. Feminist care ethical theories “fall short of enumerating an institutional theory . . . when measured against existing institutional theories, their recommendations appear partial or incomplete” (Engster, 2004, p. 121). Nor are there any concepts for a loss of trust that is translated into politics. This political development contains another element that is important to care ethics: the protest – a very present voice – also contains anger that self-care is being frustrated: the decline of work, and therefore of the possibility to support oneself. “Work had been a passport out of fear, poverty, and humiliation” (Hochschild, 2016/2018, p. 157). The attention that care ethics is giving to precarity is a positive and very necessary recent development. But the connection with longing for community (including all the ambiguity and political danger which that entails, as well as the hidden appeal to the second Enlightenment – High Romanticism – that sometimes accompanies it) and with the concern for one’s own capacity to sustain oneself, has not, as far as I am aware, been further developed. Without becoming communitarianism, the ethics of care should inflect the giving and receiving of care in the mode of the community: making community, founding community, seeking community, losing community, destroying community. Despite its affinity with a core critical insight of care ethics – “relating” (a verb that does not exist yet, but does make sense) – this inflection is not yet taking place.

Conclusion: Care Ethics, a Movement and an Inquiry?

When I use the word “approach,” I refer to a movement of groups and people who approach care as a *politicum* which is connected with interdisciplinary scholarship, in the sense of inquiry. Care ethics is both a political movement and a scholarly discipline. Tronto begins

the preface to the French translation of her groundbreaking book *Moral Boundaries (Un monde vulnérable)* as follows: “*Moral Boundaries* is the fruit of my experience in women’s movements since the 1970s” (Tronto, 2009b, p. 11). However, what is at stake is not only the background of care ethics, but also the connection with social and political movements, a connection that sets the agenda for scholarship. Tronto also places pressure on the connection between movements on the one hand and the task of the discipline of care ethics to reflect on the other by contending that in the political battle, it is not only about groups whose voices are already beginning to be heard, but also about neglected, forgotten, and suppressed groups that must be brought to the fore: “How to include as political actors women and others who have been traditionally excluded?” (p. 175). She has hopefully concluded: “Care provides us with a strategy for such change” (p. 175).

The question can be asked whether the academic discipline of care ethics can be clearly identified as part of the movements, and what movements these in fact are, forty years after the emergence of care ethics. Does the discipline itself operate in a care ethical way within the academy, i.e. with “active attention,” “presence or being there for the other, seeing or discernment, active, careful listening, thoughtful speaking, honoring our intuition, reliability, and the recognition of plurality” (Bozalek & Winberg, 2018, p. 3)? And does it accompany the movements with research, is it deriving its issues, problems, and questions from them? Or is this not the way it perceives itself, and has it become, perhaps even only partially, disengaged from the movements, imposing its own agenda upon them? In that case, the discipline has become absorbed by a different practice than that of care: the practice of the academy. In a time in which Trump supporters have been called a “basket of deplorables” (by Hillary Clinton) and pro-Brexit voters “simpletons” (by Richard Dawkins) and “fruitcakes” (by David Cameron), the question what it means to associate with excluded political actors has only become more urgent. The American care ethicist Daniel Engster has pointed out that political and politically explosive movements could arise from deep fear for

the future, “care-based anxieties” and an equally deep “political yearning” for a policy that cares about them Engster (2016), cfr. Engster (2018)). The issue of voicing the unheard, and of binding care ethics to movements and burning issues has thus been firmly placed on the agenda. For the moment, it is important to retain awareness that the ethics of care is both a movement and a discipline.

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Notes

¹ At this place Cooper (2007, p. 254) is criticizing Tronto.

² Reasons of space prevent me from pursuing this issue further here. For the relation between care and justice in care ethics, see Daniel Engster’s chapter in this volume.

³ Tronto (1993/2009a, pp. 118-119) is drawing on Ruddick (1989).

⁴ Pulcini ultimately follows Levinas (Pulcini, 2013, p. 179).

⁵ This publication is referred to as a pivotal publication. It is published only in Japanese; I was therefore not able to consult it.

⁶ Casalini, 2017, p. 511, my translation: “While for Federici, the reinstatement of care is part and parcel of the search for new spontaneous ways of common living outside of the privatization and marketization of care, for Fraser, on the other hand – and I agree with her – this may just be a ‘romantic escape’ (a similar position seems to be taken by McRobbie (2016) in her discussion of Isabell Lorey’s (2015) book, *State of Insecurity*).”

⁷ See also one of Annie Ernaux’s novels on the metamorphosis into the bourgeoisie: *La Honte* (1997), translated (1998) as *Shame*, New York: Seven Stories Press.

⁸ Karan Barad’s entanglement idea, and, on another level of aggregation, Tronto’s idea of nested practices (Tronto, 2013, p. 21: “to understand . . . complex interrelationships”) should also be discussed here.

⁹ I will not discuss other kinds of “we” here, like the *imperativus majestatis*.

¹⁰ Incidentally, it seems to me that it is mistaken to read “*homines curans*” as “people who care”: Albertus Magnus is commenting on Christ who cures people, clarifying how the pericope in the Gospel (John 9,6), where Christ heals a blind person with mud mingled with His spittle, can be understood. (In: Albertus Magnus (1651), *Opera Omnia*, XI, *Commentarium in Ioannem*. Lyon (Lugdunum), p. 178.) The “*curans*” (*nominativus*, *participium praesentis activi* of the verb *curare*) *homines* (*accusativus*), the one who cures (not: cares for), is Christ. In the meantime the expression “*homines curans*” has been taken up by other authors (Shaw, 2018).