INTRODUCTION: WHY CARE?

Introduction
The fascinating thing about care, as an ethics and a public morality, is its capacity to appeal, cajole and irritate. It is a concept that is impossible to deny yet very difficult to give form to: we all need care at some stage or other, some people have a disproportionate amount of caring to do, yet others do their best to avoid doing it or reflecting upon it. No one seems to be able to agree about what it is precisely or what it entails, yet it is a word that is bandied about on political platforms, used in proposals for social reform and is milked mercilessly in advertising. It is a concept that moves us – it reminds us of something primordially human, seems at the same time to promise something utopian and ideal and yet is often the terrain of bitter disappointment.

Just how care moves us is the subject of this dissertation. I want to know how care moves us – or in philosophical terms, how it motivates us, in particular how it does so in the form of an ethics. My concern is first and foremost normative: why should we care? But I am also concerned to know if there is an ethical theory that can sustain such a normative message – and whether we would want to have such a theory. How could we persuade someone to care for someone else if they are not inclined to?

The latter question, about how to persuade those who do not engage in the activity of caring to commence doing so, is a stringent manner of putting care ethics to the test. The following case study provides an example of someone who is apparently not susceptible to the normative message of the importance of caring. He notes it but does not feel it. He knows what is expected of him but cannot do it. He can think about his desire to care, his belief that he should, understand his role as a carer but none of this means that he can. He does want to care but somehow cannot. Can care ethics help this man? Does the ethics of care have the means at its disposal to persuade him, motivate him to be caring?

Case study
After two years of marriage, Pim and his wife moved from Amsterdam to Abcoude and a year-and-a-half later their son Sam was born.
“I am ashamed to admit it, but I found parenthood terribly difficult. I am so pleased with my son and I have not experienced one minute’s worth of regret concerning my choice to have a child, but I never expected it to be so exhausting. My wife breast-fed for the first nine months and I could sleep reasonably well at night and in the morning. But after that we planned to share the care for Sam equally. And that wasn’t easy, despite the fact that Sam spent three days in the week at the day-care and I only had to look after him for one whole day.

“As the months passed I felt more and more tired. I began to dread the days I had to look after Sam. Not because of him but because of everything that had to happen around him. Getting up early, changing his nappy, dressing him, preparing a bottle, making sandwiches, taking him to bed, conducting a careful phone call while listening for him all the while, vacuuming, checking my mail and yes, he was awake once more. Dressing him, another bottle, another sandwich, going to the shops, playing, afternoon nap. By half-past five I was tired-out and happy that my wife came home to take over from me. But yes, then he still had to eat supper, yoghurt, in bath and bed. And that time and time again.

“It drove me crazy that I could never do what I wanted to, without being disturbed. That all my activities were planned in advance and that I barely had any time to do things for myself. I must admit that I find that very difficult. Recently I have not been feeling very well and suffer regularly from rashes. I am also more frequently sick than I used to be. I am amazed at how my wife manages it all. She has a busy job in advertising, finds time to sport three times a week and nevertheless whistles while she folds the clean clothes in the evening. It seems as if she can manage everything.”

This case study is cited in an article in the Volkskrant (Magazine 19 February 2005: 22 - 26) called “The Young Father is a Little Tired”, and concerns a “new” phenomenon: the masculine variety of postnatal depression. This phenomenon is linked to the recent and increasing trend in the Netherlands of men who have children rather late in life - in their forties – and who have difficulty in adjusting to their new role. The article attributes the problems men have with caring tasks to a discrepancy between cognition and emotion: rationally they think that they should be able to participate equally in caring for the children and in the housework, but their behaviour shows something altogether different. It might have something to do with a clash of their convictions, as the article argues. One conviction could be that the man thinks of himself as a modern father who self-evidently should participate in caring, but at the same time he might have the conviction that women are
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actually better at caring for children than men are or that caring for children would be bad for his career. All of these convictions influence his behaviour.

It might also be a generational problem. Pim’s parents, in rebellion against their parents with their nineteen-fifty’s notions of family structures, were probably affected by the anti-establishment resistance to rules and structure mores of the sixties and seventies. Pim might very well have been brought up with a lack of rules and limitations: he did not have to do any housework when he was a child and could spend all his attention and energy playing. The result of this kind of upbringing is a type of man who has lots of space for his own needs but none for social obligations. This pattern is reinforced after leaving home: he studied, lived a luxurious life with (relatively) lots of money, went on holiday six times a year and then suddenly, the romantic idea of a descendant, the product of his greatest love, turns out to be the disrupter of this pleasant existence. All at once he is expected to delimit his private space and that hurts, concludes the article, even to the extent of his sinking into a postnatal depression.

While most of the care ethics literature begins with examples of loving and tender caring moments,¹ I have expressly chosen a case study that illustrates what I regard as the most urgent problem that care ethics faces: how to motivate people to care for others, particularly when they seem insufficiently moved to do so. What is problematic for care ethics is that there are those who do care and those who do not, and the danger is that the twain shall never meet. Furthermore, those who do not can do so by virtue of those who do; and those who do are obliged to continue doing so because of those who do not. Can care ethics effectively address those who do not do caring?² An ethics cannot force anyone to act morally (and supposing it could do so, there are good reasons for not wanting any system of thought that tries to). As force is out of the question, we are left to consider various persuasive or prescriptive theories and choose the ones with the most compelling arguments to motivate. Is caring best (most persuasively) described as a virtue? Or as essential to our nature as human beings? Is it a part of a broader

¹ See, for example, Selma Sevenhuijsen’s *Citizenship and the Ethics of Care* (1996) or Peta Bowden’s *Caring* (1997) and especially Nel Noddings’ *Caring* (1984).

² A note on terminology: 'to care' means 'to like' as well as 'to be concerned for the welfare of...'. I want to distinguish between 'to care for' in the sense of liking from 'being caring' or 'doing care' which is meant in the sense of actively caring for, ensuring the well-being of, someone. The latter meaning is that which is central to the feminist tradition of care ethics which stems from Carol Gilligan's psychoanalytical research in the nineteen eighties.
humanitarian approach that also values our weaknesses? Is caring a practice and not a (universalisable) theory because it is otherwise too individual and particular to be encompassed in a theory?

This latter aspect, that of expressing and encompassing (some aspects of) complex relationships, is a noteworthy aspect of care ethics. This ethical tradition emphasises dependence, vulnerability, fallibility and asymmetrical relations, argues that these qualities are typical of individuals rather than any abstract (Enlightenment) virtues - like freedom, autonomy, and rationality which are not attainable for all - and that we need the ethical skills of compassion and sympathy in order to have responsive relationships. This is an important and significant contribution by care ethics to the ethical literature. Care ethics is however less explicit in justifying its particular approach to motivation. It lays claim to a compelling type of motivation – caring should be done and it is good if it is done - but does not explicate why this is so. Rather, the value of caring is assumed to be self-explicit and to bear its own motivational logic. I want to know if we should be caring and how caring motivates us to action? In which ways does it affect us? Should it affect us more? How can it move us most? But first we need to know more about what care ethics is, starting with its history.

Background

In the nineteen-eighties, Carol Gilligan’s psychoanalytic research into women’s responses to moral dilemmas was responsible for a new trend in feminist research into what Gilligan called a distinctive moral orientation, a “different voice”, which she refers to as the care perspective. The care perspective in ethics involves seeing oneself as connected to others within a web of various relationships. And the ‘voice’ is one of care and responsibility, of concern and connection with other people. Gilligan claims that it stems from a self that is intrinsically related to other people. In the words of Gilligan:

> From within the care perspective, the relationship becomes the figure, defining self and other. Within the context of the relationship, the self as a moral agent perceives and responds to the perception of need. The shift in moral perspective is

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manifested by a shift in the moral question, from ‘What is just?’ to “How do I respond?’.

From this brief quotation we can distinguish three characteristics that are – in general - vital to care ethics. Primarily, it is a perception of the self within pre-existing social and relational forms and these forms define the self and others to whom the self has relationships. The self, significantly, is defined by relationships rather than by other factors like rationality or freedom, for example. Gilligan also describes relationships as being the context in which the “need” of the other becomes manifest: the perception of and response to need occurs within a pre-existing bond. Need is not something that exists as a problem prior to relationships; or rather, need can only be seen and dealt with from within a bond between people. Secondly, the person required to care must be able to perceive the appeal or request or demand for care – and respond to it. Indeed, perception of need is that which prompts the caring response not only the capacity of the person caring to care. Like need, caring also only exists within bonds between people and is a response to a perceived situation rather than a permanent state of affairs. Caring is the product of social relations: it is not prior in any transcendent sense. And lastly, Gilligan indicates that there is a shift from the question as ‘what is just?’ to the question ‘how do I respond?’ First of all, she clearly indicates that the caring response to need - or ‘care’ for short - is in opposition to justice and a tradition of ethics that sustains justice as a primary good. Second, there is a clear methodological shift away from the abstract query as to what something is (always and unchangingly), toward a first-person, contextual, concrete question: how do I respond?

To summarise, Gilligan names three characteristics of the care perspective: it is defined by relationships, it is the response to an awareness of need and it comprises a contextualised first-person approach. Most, if not all, of the chief characteristics of care as found in the tradition of care ethics that followed Gilligan are variations of or elaborations on these three aspects and all three characteristics will receive detailed attention in the course of this dissertation. But for the moment I want to concentrate on Gilligan’s question: ‘how do I respond?’

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5 A small point of terminology: I would prefer not to use the term ‘need’ because it is a complex term that could mean many things (‘vulnerability’, ‘want’, ‘necessity’, ‘desire’, etc) but I shall follow Gilligan in this matter for the moment.
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Because Gilligan (and all other care ethicists) reject a ubiquitous notion of caring, the individual instance and first-person perception is the most (and sometimes the only) relevant point of view. This approach contains within it two problems: according to which standards and measurements can we decide what good, or appropriate, care is? And what do we do in instances in which someone is unwilling or less willing to care? I suggest that the answer to the second question is contained within the first – if we know what the normative boundaries of care are - what is good or right about care - then we are more capable of persuading someone of its merits. In other words, specifying the normativity of care provides an explanation of how care motivates. Let me illustrate this by returning to the case study that I cited at the beginning of this chapter.

What can we say about Pim’s response? Well, first of all, in all fairness to Pim, he is aware that his response – his dread of having to take on the responsibility for a day’s caring and his (unconscious?) seeking escape in illness – is inadequate. He compares himself to his wife and sees his contribution to the caring tasks by no means matching her energy and consistency; in short, she takes on the greater responsibility for caring for Sam, contrary to their agreement. What is so patently missing from his perception though is what he could do to alter it, supposing that he does want to do so. What he sees is that his wife has some kind of caring ‘drive’ that he supposedly lacks.

The analysis that the article in the Volkskrant Magazine offers is that Pim’s response has to do with other convictions he might hold due to or as well as his background as an over-indulged child of ‘baby boomer’ generation parents. This would suggest, supposing that this is the case, that his response has been moulded by very specific economic-cultural conditions and, quite frankly, the ‘solution’ to his dilemma about why he can’t seem to want to care is unlikely then to come from those quarters. The point is that Pim’s response is suffused with his own inclinations to be free and spontaneous (“I could never do what I wanted to” because everything was planned or because he was always being interrupted), and to enjoy solipsistic pleasures (“do things for myself”). Pim sees his pleasures being disturbed by his responsibilities; he is, if you like, a wanton⁶ who places the burden of blame for the failure of his desired life-style outside of himself and would rather

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⁶ This term is borrowed from Harry Frankfurt’s article “Freedom of the Will” (in The Importance of What We Care About 1988) in which he describes “wantons” as agents whose only desire is to satisfy their immediate desires.
whysustains his solipsistic pleasures than sacrifice them. In this sense, Pim weighs up his alternatives according to psychological hedonism, according to which he must always choose what he believes to be the greater pleasure or the lesser pain – and he must therefore take whichever course of action it is that he believes will result, overall, in the most pleasant or least painful outcome, all things considered. But psychological hedonism is not going to help Pim to win any prizes in the ethics of care.

Can Gilligan’s question ‘how do I respond?’ be of any constructive help to Pim? He knows that Sam is dependent on him, he knows that he has agreed to meet Sam’s dependencies on occasion and he knows that his response is inadequate. But, I argue, Pim’s pondering solely on his own concrete situation will not render a further motivation to care because his specific economic-cultural background reinforces rather than alleviates his lack of motivation. Rather, what Pim needs to do is to be able to think critically and reflexively about those influences that have shaped his desires, to be able to consider alternatives to them and to have access to a set of normative guidelines to which he can refer when he senses a clash between his desires and his responsibilities. And these normative guidelines should not be narrow in the sense that they shouldn’t be institutional (for example, the policy on family structures advocated by Dutch Christian Democrats), nor should they be gendered (for example, the argument that women are better at caring because they supposedly have a pre-natal bond with their children). On the contrary, they should have a relevance that goes far beyond politics and should be general, in the sense of pertaining to both men and women.

Where should these guidelines come from? (Of course, it must be acknowledged that this recent interest in the ethics of care is itself the result of certain social trends - every conceptual discussion is unavoidably the result of very specific historical constellations.) In the case of caring, we can draw attention to Sam’s status as a young and vulnerable person, in need of care and nurturing. We can draw attention to the mutual benefits, Sam and Pim’s and Sam’s mother, in terms of emotional development that can be achieved by attentive and loving care. And we can draw attention to the

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7 Part of (the fifth premise of) David Davidson’s account of ‘weakness of will’. Davidson concludes that there are no incontinent actions – no actions on the basis of a lack of self-restraint. Cited in the Routledge Encyclopaedia of Philosophy 1998 "Akrasia”.

8 See, for example, Albert Hirschman’s delightful book in the tradition of the history of ideas, The Passions and the Interests, 1977.
beneficial results of contributing to human flourishing in an however small and individual fashion. In short, the reasons for caring are to protect and nurture those who are incapable of doing so for themselves, to encourage emotional development especially in those close to you (though not exceptionally) and to contribute to a society in which human flourishing is a general ideal. Where precisely these guidelines come from, whether they are Judeo-Christian virtues, or liberal democratic ideals, or late twentieth-century Dutch social norms, is not relevant here. What is significant is that they express a particular constellation of individual and social ideals that find their expression now: ideals of modern fatherhood, childhood, family structures and their relation to society as a whole. They are, to varying degrees, tried and tested ideals, though it is important to preserve a historical perspective: the idea of fatherhood as a nurturing role is novel; the notion of the family in which both parents work and have careers is less new though; and what we might consider to be unalterable truths about childhood are only a century or so old.⁹

Pim’s reply to “how do I respond?” will, therefore, have much to do with his current socio-cultural and historical context. But his reply – on a conceptual and ethical level – will also (whether in opposition to or confirmation of) relate to tradition and more universal values. Values like ‘humanity’, ‘rights’ and ‘rationality’, for example. Care ethics has also had to deal with this conceptual heritage: it is very firmly rooted in a tradition of Enlightenment critique and is therefore part of more than two centuries of critical feminism, starting with Mary Wollstonecraft’s *A Vindication of the Rights of Women* (1792). The care perspective in ethics has been contrasted, by successive care ethicists after Gilligan, with what they refer to as a ‘rights-based’ tradition in philosophy. Adherents of this liberal-democratic tradition are regarded as including the moral philosophy of the eighteenth-century philosopher Immanuel Kant, the moral and political philosophy of the nineteenth-century philosopher John Stuart Mill and the moral and political philosophy of the twentieth-century neo-Kantian philosopher John Rawls. The central features of this liberal-democratic tradition (and focus of contestation) for care ethicists are the notions of individual autonomy and possession of rights. In this tradition each individual is seen as having certain basic rights, such as the right to life, liberty and property. The self is seen as an autonomous

⁹ Philippe Aries, in his book *Centuries of Childhood* 1962, argues that our contemporary ideas of a childhood that lasts eighteen or so years dates back to the end of the nineteenth, beginning of the twentieth century. Childhood (as we know it here
individual, free to make those choices that do not infringe upon the basic rights of others. Justice, and the tradition that sustains it, these care ethicists argue, is a perspective that weighs up conflicting claims against a standard of equality or equal respect. This perception of equal individuals, possessing liberty, rights, and freedom is supposedly the dominant Western idiom and is the foil against which the care perspective has been developed: with its self defined by relationships, perceptive to need and responding to concrete situations.

Care ethicists argue that care ethics provides a much-needed alternative to current ethics which is either based on the sovereign individual or on the universal principle. Gilligan, for example, argues that the dynamics of family relations and friendships require another type of morality than rights-based morality. Intimate relations are fluid rather than formal and often both presuppose and require trusting and imaginative engagement for which there are no hard and fast rules, she says. Yet there are (morally) good and bad ways to act within intimate relations. In addition, as the moral philosopher Annette Baier argues, how we treat strangers in the political realm would seem to depend at least partially on whether we have learned from intimates what it means to truly respect, trust and appreciate another human being. And Gilligan says:

All human relationships, public and private, can be characterised both in terms of equality and in terms of attachment, and…both inequality and detachment constitute grounds for moral concern. Since everyone is vulnerable both to oppression and to abandonment, two moral visions – one of justice and one of care – recur in human experience. The moral injunctions, not to act unfairly toward others, and not to turn away from someone in need, capture these different concerns. (Gilligan 1987, 20)

Caring relations, because of the broader import or significance of their effect, are neither exclusively public nor private. Indeed, care ethics often proceeds from a first-person perspective that alternates between the private and public realm. The assumption is that caring is relevant to both spheres. No one sphere is prioritised.

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and now) in the Middle Ages lasted, according to Aries, only seven years!
Gilligan’s book (*In a Different Voice*) evinced a huge number of reactions, including a large body of feminist ethics on the issue of justice versus care, or justice and care. Yet despite their critique of this justice perspective, some feminists have had doubts about substituting an ethic of justice with an ethic of care, since justice and fairness are so obviously necessary in the public as well as the private sphere. As the feminist Susan Moller Okin argues, justice is needed to frame caring relationships and care for others is “so crucial for the achievement and the maintenance of justice”\(^\text{11}\). And Alison Jaggar, a prominent care ethicist, argues that care and justice as values or ideals are compatible - but when they are construed as alternative modes of moral thinking or reasoning they are not\(^\text{12}\). Some current approaches to the potential rivalry of care and justice, however, would suggest that they could not be synthesised. Care is an independent style or practice of moral thinking argues the care ethicist and ‘maternal thinker’ Sara Ruddick: they each have distinctive ontological, epistemological and practical commitments. Care and justice are “two non-assimilable moral orientations which foster distinctive cognitive capacities, appeal to distinctive ideals of rationality, elicit distinctive moral emotions, presume distinctive conceptions of identity and relationships, recognise distinctive virtues and make distinctive requirements on institutions.” Justice and care each offer:

> a point of view from which alone a certain sort of understanding of human life is possible. That is to say, each orientation is genuinely moral: neither can be replaced by or subsumed under the other, each covers the whole of the moral domain and therefore can check and inform the other; there is no third, ‘mature’, single integrative moral perspective within which each orientation has its place. (Sara Ruddick “Injustice in Families” 1995 in Held, V (ed.) *Justice and Care.*)

Yet other approaches have explored ethical concepts that overlap aspects of justice and care, for example, the concepts of trust, responsibility, empathy, dignity, respect, solidarity and relational autonomy\(^\text{13}\).

The justice versus care debate is indeed a large and comprehensive debate and has been exceedingly well documented\(^\text{14}\). But this is *not* the focus of this

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\(^\text{11}\) Susan Moller Okin “Reason and Feeling in Thinking about Justice”, 1989, 249.
\(^\text{12}\) Alison M. Jaggar “Caring as a Feminist Practice”, 1995, 185.
\(^\text{13}\) Authors include Annette Baier, Claudia Card, Daryl Koehn, Selma Sevenhuijsen, Marian Verkerk, and Margaret Walker.
\(^\text{14}\) For an excellent collection of essays see Virginia Held (ed.) *Justice and Care.*
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Rather, what this dissertation sets out to do is to locate the best type of motivating argument within care ethics that will persuade someone like Pim that he should care. The search for this type of argument will take me through a range of alternatives in the care ethics literature: care as ontologically basic, care as a practice, care as reliable knowledge, and care as a virtue. Each alternative has its own account of motivation and I shall review these one for one and work my way to a type of motivation that I regard as most persuasive. But before I leap into the discussion of motivation, we need to know more about care ethics in general. What is it? How does it differ to other ethical approaches? What makes it special?

What characterises care ethics?

There are several alternative opinions of what care ethics is in the literature – there is no one care ethics. Nevertheless, care ethics in general can be described as being typified by two distinct starting-points: first, care ethics argues that human existence is fundamentally relational and second, care ethical argumentation contains within it a moral sensibility, namely commitment and attentiveness. One could very well call the first starting-point ‘ontological’ because it is concerned with the definition of what human beings are and how they live in a world in which they have to survive together with others. The second starting-point has to do with (careful) moral reasoning and is related to a dedication to caring and to the role that caring plays in something teleological (the best example is the quite ordinary desire or goal to lead a good life). Neither of these starting-points however yet sharply distinguishes care ethics from other types of ethical traditions (care ethics in this regard resembles virtue ethics, for example).

Add to these two starting-points specifically what is meant by ‘care’ and we will begin to form the idea of a distinct type of ethics. Herta Nagel-Docekal in her article “Feminist Ethics: How It Could Benefit from Kant’s Moral Philosophy”, ¹⁵ argues that care ethics generally has three characteristics by which care is usually defined: it is sensitive to context, it is guided by relationships and it is governed by feelings. Care ethics’ sensitivity to context is derived from the “situated knowledge” tradition in critical feminist philosophy of science.¹⁶ In this tradition, shared by feminists like Donna

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¹⁶ See, for example, the feminist philosopher of science Sandra Harding: *The Science Question in Feminism* (1986) and *Whose Science? Whose Knowledge?* (1991).
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Haraway, Sandra Harding, Seyla Benhabib, Lorraine Code and Claudia Card, knowledge is regarded as being generated and understood in specific contexts. This view emphatically rejects the notion that there is a neutral ‘view from nowhere’ which would produce universal or non-contextualised knowledge. Thus the question is not what is known but who knows. From within care ethics, Gilligan’s question, ‘how do I respond?’, for example, falls within this situated approach.

The second characteristic of care, its relationality, is a very basic precept for care ethics. All of care ethics is about relations with others. But there are significant inclusions and exclusions in this category. Some care ethicists focus on the aspect of humanity and define humanity in terms of being vulnerable and fallible (care ethicists like Marian Verkerk and Henk Manschot and other Dutch care ethicists). The American care ethicist, Daryl Koehn also emphasises the concern of care ethics with vulnerability. She argues that: “Female ethics… argue for something like an obligation to care for and to empathise with (the) vulnerable members of our community”. Some care ethicists focus rather on perception and ‘how it is with the other’. This can include need and vulnerability - as well as happiness. The carer recognises and takes pleasure in the other’s happiness and identifies with and is concerned about her needs, and is also aware and responsive to the fragility and mortality of human existence. Ruddick argues that participants in caring relationships also strive to delight and empower each other. Those relations included in care ethics are thus ones of vulnerability and of happiness.

Those relations excluded from care ethics are relations expressed in terms of power. The issue of asymmetrical relations is addressed – some care ethicists argue that caring is selfless to the degree of not requiring a response, while others (like Marian Verkerk, following Ricoeur) argue that every reception of caring comprises of a response even if it is exceedingly weak:

17 The historical ontologist Michel Foucault with his concept of “care of the self” is an exception to this rule - but he does conclude that you cannot care for others unless you also care for yourself, and his caring for himself is a kind of objectifying of his own self. I will not be dealing with Foucault’s caring concept in any length in this dissertation. Foucault The History of Sexuality, Volume III, 1984.
18 See their essays in Marian Verkerk (ed.) Denken Over Zorg 1997.
20 Derived from the French philosopher Paul Ricoeur, cited in Verkerk 1994, 64.
This is perhaps the greatest test of care: when an unequal capacity finds compensation in an authentic reciprocity, which, in the hour of fear, can be found in whispering together or in weakly holding each other’s hand. (Paul Ricoeur *Oneself as Another* 1992:191, cited in Verkerk “Zorg of contract” 1994, 64).

But the potential that caring might have for the actualisation of ‘disvalues’ - exploitation, submission, subversion, manipulation, or domination – has not been a primary focus in care ethics. 22 This is largely because care ethics describes an ideal and beneficial addition to human existence and, as such, often has a tone of buoyant optimism (which can also be encountered in the Aristophanean ethics23 of Harry Frankfurt and in substantivist ethical theories like virtue ethics). However, given the critical feminist tradition upon which much of care ethics is based, and given that tradition’s assertive fluency on the subject of the negative consequences of many developments in modern Western liberal democracies for women, this is a controversial point. Some critics of care ethics have accused it of merely reinforcing gender roles found in society, whereas some care ethicists have made a point of promoting care ethics precisely as a means of breaking these stereotyped roles down.24

A third characteristic of care, as defined by Nagel-Docekal, in addition to its contextuality and relationality, is its ‘being governed by feelings’. (This emphasis on feelings is however not what the more politically-orientated care ethicists like Tronto and Jagger and Verkerk are concerned with. These political care ethicists are concerned rather with the notion of a competent practice and instrumental design.)25 Nagel-Docekal is correct that feelings do play a rather unique role in “personalist” or affective care ethics, two roles to be precise. The first role is that feelings26 are the instruments by means of

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23 Aristophanean ethics is based on the bawdy and comic humour of the ancient Greek playwright, Aristophanes. ‘Aristophanean’ as epithet can therefore be understood as meaning ‘blithe’ or ‘sanguine’.


25 I am grateful to Margaret Walker for this point.

26 I prefer the term ‘inclinations’ to ‘feelings’. ‘Feelings’ is a term with broad application refers to both emotional and moral sensitivity. I wish to draw a distinction between the two and, in my discussion, use ‘inclinations’ meaning emotions, desires, impulses, tendencies.
which caring is expressed and information about the cared-one is gathered.
All the beneficent inclinations (like compassion, concern, sympathy, empathy, and trust) are involved in gathering information and expressing the felt care. What precisely these caring inclinations comprise of has not been critically examined by care ethicists\(^{27}\) - so we are left a little in the dark about how they should work. Caring inclinations are assumed to exist but not specified, or contextualised, or elaborated on.

The historical roots of care ethics might reveal something more about what care comprises. Care ethics harks back to the moral sentiments theories of the Scottish Enlightenment thinkers Adam Smith, David Hume and Adam Ferguson.\(^{28}\) ‘Benevolence’, the cornerstone of this eighteenth-century ethical tradition, is the precursor of ‘care’ and was regarded by these moral philosophers as a universal sentiment. Both benevolence and care include commitment and attentiveness and both regard this sentiment as universally present.

The second role of inclinations in care is encountered in the writings of Nel Noddings, one of the creators of care ethics, in her book *Caring. A Feminist Approach to Ethics and Moral Education* (1984). This second role is one of absence or abeyance: Noddings’ caring theory proceeds from a selfless (and thus ‘inclination-less’) point of view. The idea is “to perceive the reality of the other” and to suspend an awareness of the self in order to do so. Noddings wants to ‘receive’ the other in herself. This is in contrast with the idea behind empathy, which is to project myself into the other by identifying with and understanding another’s situation, feelings and motives.\(^{29}\) Empathy is too indirect an experience of what the other is experiencing as far as Noddings is concerned. Noddings does not wish that the self be present in the ‘perceiving of the other’. This approach is also mirrored in the work of a more contemporary care ethicist, Vrinda Dalmiya, who concurs with Noddings that the only way in which the requirements of the other can be perceived is by a self that is not self-preoccupied or encumbered at that moment with its own inclinations.

\(^{27}\) Koehn’s discussion of care ethics as a “broad ethic of empathy” (see Koehn 1998) and Baier’s discussion of trust are notable exceptions. However, neither of these discussions come even close to Martha Nussbaum’s detailed (and literary) approach in *Love’s Knowledge* (1990) and *Upheavals of Thought* (2001), for example.

\(^{28}\) Care ethicists like Joan Tronto (*Moral Boundaries* 1993) and Marian Verkerk (1994) have elaborated on this history.

\(^{29}\) I am grateful for this point made by Anne-Ruth Mackor.
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This is an important but contentious point in care ethics. Perceiving the other as fully as possible is a noble goal in any ethics. How can it be achieved? There is a sense in which Noddings’ (and others’) suspension of the self coincides with older and more established notions of “disinterested interest”. This is a Stoic concept used to allow the person striving towards goodness to be able to do so - detached from inclinations. Good deeds are performed not for the benefits they bring to the one performing them, but because they are right. Kant, too, refers to this disinterested interest in his *Doctrine of Virtue* (“practical love” or “beneficence”). Care ethicists, in contrast, do not aim at a detachment from inclination because they do not argue, as Kant does, that inclinations cannot be moral. Care ethicists wish to suspend the self because it intrudes between the one caring and the one cared for. While I can imagine that a one’s self-interests could get in the way of perceiving the other fully, I am sceptical about the likelihood of selflessness being at all possible – or, for that matter, desirable. (I shall spend time discussing this aspect of care ethics in later chapters.)

Thus the three characteristics of care, contextuality, relationality and the significance of inclinations, are not uncomplicated. Especially the latter two characteristics need further specification: care is relational with respect to certain inclusions and certain exclusions. Care includes relations of vulnerability and happiness but has hitherto excluded detailed discussions of disvalue. Care prioritises certain beneficent inclinations and insists on the absence of self-interest - it propagates an absence of inclinations on behalf of the person caring.

It is quite possible that these inclusions and exclusions, and presences and absences have to do with the following feature of care ethics, namely, ‘particularity’. Why? Because ‘particularity’ is a thoroughly contextualised and descriptive conception of where someone is, here and now therefore requiring a far reaching inquiry into the position of the other. ‘Particularism’ is a viewpoint of the individual as she is at that particular moment, with her own needs, desires and possibilities, her own history and own perspective on life. It requires that each instance be, if necessary, judged on its own merit which demands a singular degree of ‘openness’ of mind on the part of the one caring. Not only openness as such, but a well-meaning or beneficent preparedness to perceive and a capacity to make judgements that are not

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31 For the sake of clarity: this is my conclusion, not Nagel-Docekal’s.
determined by one’s own preferences. After all, what is good for one person’s well-being might not be good for another.

Because of this particularism, care ethics makes its own - and unique - demands on moral reasoning. Empathy and attentiveness for the other, in respect to the uniqueness or difference of the other, demands ‘careful’ moral reasoning, directed at a particular and situated practice. This is why care ethics claims to be wary of rule-based or universal-type ethical theories (though, as I have indicated above, I believe that care ethics has its own universalising tendencies). Rather, care ethics finds natural allies in virtue ethics - especially someone like the virtue ethicist Michael Slote - and narrative ethics - like the moral philosopher Margaret Walker, for example - but finds that it does not easily fit in with other traditional ethical trends like deontology or utilitarianism.

How does care ethics relate to its allies? Firstly, virtue ethics: some reviewers of the care ethics tradition argue that care ethics is a form of virtue ethics.32 They argue this because, generally speaking, caring is treated as a skill, an accomplishment developed together with practical wisdom and is, as such, firstly, a feature or characteristic of a person and, secondly, something that is applied variously and according to the circumstances. Caring is a practice rather than a rule. These two aspects apparently overlap with an Aristotelian-type of conception of what a virtue is: a characteristic and part of what it is to have practical wisdom. The virtue ethicist Michael Slote says that he thinks that the morality of caring is best regarded as a form of “agent-based” virtue ethics. (Slote defines “agent-basing” as a form of morality in which the normativity is decided solely at the discretion of the person committing the deed. For example, Noddings wants to relate everything in morality to the motive or attitude of caring – rather than bringing in independent principles or considerations of justice, truth-telling, or whatever – and this is characteristic of agent-basing, says Slote.) As such, he says, the claim that this ethics makes - that caring is morally good or virtuous - is “a fundamental, intuitive judgement from which other moral judgements derive.”33 He argues that the ethic of caring is a distinctive morality that can stand on its own, and as such caring can be regarded as “an overarching and ideal moral virtue whose status as such is intuitively plausible in its own

33 Slote 1988, 174.
right."34 Whether or not and to what degree care ethics is a virtue ethics will be discussed at length in Chapter Four of this dissertation. Suffice it to say for the moment that virtue ethics is certainly an ally of care ethics because some versions of care ethics and virtue ethics share important assumptions and values.

Secondly, how does care ethics relate to narrative ethics? A narrative is a life story and, as the feminist ethicist Margaret Walker points out, it is the story of any life in any form. It is not necessarily a master story with a telos (as Alasdair MacIntyre would have it), or a “quest” (MacIntyre and Charles Taylor), or a “human life lived according to a plan” (John Rawls) or a “life roulette” (Bernard Williams).35 Lives (and therefore the stories thereof) “make sense of different actions (that) might be many, local, fragmentary, or discontinuous.”36 A life narrative can proceed in fits and starts and contain developments and interruptions; it is not an orderly or necessarily progressive account from problem to solution, or from chaos to order, and can sometimes even lack a clear linear or teleological structure. It is a story that can also include fallibility and aimlessness.

It is the narrative of an individual and, as such, has a strong particularistic character. In relation to narrativism, particularism means that people in different contexts tell moral stories in which meaning and significance, value and judgements are awarded. But particularity goes further than context: it contains within it a moral enhancement (rather than a reduction) of the individuality of the person. Moral particularity has been described as being non-universalisable because those practising it assign a discretionary weight, rank, or value to moral particulars, in the process of defining their own moral personae, the kind of persons they are.37 Indeed, responding to the needs of others in their concrete specificity as care ethics wishes to do, is understood as responding to them as unique, irreplaceable individuals rather than as “generalised others regarded simply as representatives of a common humanity”, according to the feminist Seyla Benhabib.

Perhaps the most distinctive and controversial feature attributed to care thinking is its particularity, which means not only that it addresses the needs of others in their concrete

34 Slote 1988, 174
35 See Walker 1998, pp. 120 - 2, 128 - 9, and 144 - 7 for an analysis of these moral narratives.
36 Op cit, 120.
37 Walker 2003, 9.
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specificity but that it is unmediated by general principles. (Benhabib “The Generalized and the Concrete Other”, 1986, 164)

Universal versus particular is a consistent theme in care ethics. The moral philosopher Lawrence Blum argues that care cannot be reconstructed in terms of rules that are in principle universalisable: “Care is a moral perception whose task it is to individuate the situations in which moral judgement operates, not to apply moral principles.”38 Care reasoning therefore focuses on the specificities of each situation, emphasising the ways in which it is unique and responding to those involved as particular in the sense of non-substitutable or irreplaceable.

To summarise, what are the specific features of care ethics? Care ethic’s starting point is that of human relations and its moral sentiment is characterised by attentiveness and commitment. Add to these characteristics of care the features of contextuality, the relations of vulnerability and happiness, and the importance of inclinations - as beneficent presence or as absence of self-orientation. These features do indeed go part of the way to distinguish care ethics from other ethics. But the most important distinguishing feature of care ethics is particularity. It distinguishes care as a practice rather than a rule and it creates the preconditions for certain philosophical allies - virtue ethics and narrativism - and certain opponents. It is also the approach which supposedly characterises the ‘openness’ of the one caring to the cared for: the ability to see what the other in that time and place requires.

Care ethics is thus an outspoken protagonist of particularism and ‘agent-based’ normativity. This means that moral dilemma or questions must be solved at the level of the individual, as care giver and care receiver, perhaps even at the level of uniqueness. Of course care ethics cannot succeed in maintaining this status of being one of a kind at every stage of its moral reasoning and nor should it endeavour to do so. Rather, the *sui generis* status of care ethical reasoning should be seen as the basis of a kind of practical wisdom or practice which means that care ethics strives to perceive the individual as individual without being blinded by theory or imposed moral precepts. As such, care ethics represents a critical deconstruction of monolithic tendencies in ethics, especially systems of ethics that sustain generalising, or what care ethicists call, ‘universalist’ moral theories.

However, as some critics have pointed out, the particularistic approach in care ethics suffers from a dearth of moral justification: approaching each caring act as a unique action undercuts being able to have reasons for those acts.

I fail to see why care ethics might benefit from this lack of justificatory explanation. On the contrary, I shall argue that not only can we find sound arguments to justify caring but that we should do so. Furthermore, I believe that care ethics, precisely because of its ‘agent-based’ normativity and its preference for particularism, lends itself to a very interesting type of phenomenological motivation. What moves me to care? How am I moved? When does it feel right (here I am using ‘feeling’ in the sense of moral sensibility)? Why should Pim care, especially when there seem to be several psychological and cultural factors hindering or impeding him from doing so? Is there a theory of motivation that can also facilitate the particularity of care ethics?

**Motivation in care ethics**

This dissertation focuses on the motivation for caring given in personalist (in other words, apolitical) types of care ethics: why it is we care. Furthermore, I shall seek a normative basis to this question: why should we care? This does not mean that the results of such a morality of caring are not important. On the contrary, anyone who cares about others cares about the consequences of his actions for those others. But, if we subscribe to a morality of caring, this doesn’t mean that we have to judge actions in terms of their good or bad results. On the contrary, an individual’s motivation is of first concern in any judgement of caring. As Slote persuasively argues:

> (i) if a caring individual makes her best efforts on behalf of a friend but fails to be helpful, we may still have a high moral opinion of her efforts; and such a judgement, to a first approximation, will be based on the caring individual’s motivation, rather than on any consideration of the consequences that result from her action. (Slote “The Justice of Caring”, 172)

Of course caring motivation is directed towards certain consequences, but ‘caring’ involves having a certain inclination or motivation and expressing it

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in the form of a moral sentiment of attentiveness and commitment. ‘Caring’, in this perception, is primarily an attitudinal disposition. Or in the words of Slote, “the very expression “morality of caring” implies the primacy of motivation within any such view”.

For this reason, he believes that “the distinctive nature, and indeed force, of a morality of caring is best brought out by interpreting it in motivation-based terms rather than as some sort of (...) consequentialism”.

But focussing on motivation, as I wish to do, does mean limiting myself to the functioning of the inner life of caring individuals. On the one hand, caring is a response - directly prompted by situations and contexts outside of oneself. We can be compelled to care in response to someone’s suffering or vulnerability, or cuteness or lovability. On the other, it is something that we do despite ourselves, or because of ourselves, or for qualities intrinsic to the person we care for; it can be voluntary, or involuntary or even as a result of an obligation. In short, I argue that caring involves that most contradictory (but most everyday) experience of being ‘voluntarily constrained’ or ‘willingly compelled’. Caring does something with us: it moves us, it propels us into action, it agitates and tugs at us – and it often does not even require our conscious and intentional participation to do so. Caring, in this sense, is ‘necessary’ – it is a motivation that is very difficult to say “No” to (and even if we do say “no” we have to refuse or deny the motivation thereby acknowledging it as motivation).

At the same time caring is normative; there is adequate or appropriate caring and inadequate and inappropriate caring. Therefore this compelling activity also requires from us that we critically examine how and under what conditions we care and if what we do is the best thing to do or the most we can do under the circumstances. We are required to endorse or confirm doing this compelling thing: to use our practical knowledge and engage our experience and judgement in performing it. Therefore, to summarise, the motivation to care contains within it a series of potential contradictions or tensions between opposite tendencies and it is amongst these tensions that I argue that the dynamic and unique qualities of caring lie. What I shall be doing in this dissertation is to set out to explore these tensions and describe what I regard as the best way of expressing them.

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41 Op cit, 173.
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Terminology

A brief note on terminology used here:

I do not make a distinction between ‘ethical’ and ‘moral’. In some literature ethics is represented as being about the ‘good life’ (teleology) and morality as being about rules regarding the ‘right thing to do’ (deontology).\(^2\) As far as I am concerned, and I believe I share this approach with several philosophers, doing the ‘right’ thing is intimately concerned with leading a ‘good’ life and the two cannot be separated. I therefore use ‘ethics’ and ‘morality’ indiscriminately.

‘Ethics of care’ refers to the body of literature on caring, now an established tradition in ethics. Because ‘care’ etymologically also means ‘being concerned’ or ‘worried about’ – which I do not always mean when I talk about care ethics, I prefer the term ‘caring’ which refers more directly to the activity or motivation of being committed or attentive to someone.

As I indicated earlier, I shall avoid referring to the needs of others as the motivating force for caring actions. I will be concentrating on the person caring, i.e. the person doing the act of care, as the subject of my investigation of motivation in care ethics. This is not to deny the importance of the person cared-for and their requirements and appeals to be cared for. This is merely a designation of the area of my focus.

In the literature there are several terms used to indicate the person doing the caring. I shall use ‘the one caring’. And for the person being cared for I shall use: ‘the cared-for’. The person caring is the one who is performing actions that I regard as moral actions and I am concerned about the motivational and normative content of specifically these actions.

Structure of book

In Chapter One, entitled Engrossed Care, I examine what I call a phenomenological account of what it is to experience the urge to care. Nel Noddings is the oft-cited care ethicist who has developed this approach to care ethics. I compare Noddings’ account of caring with that of Harry Frankfurt. These two authors are very different, at first glance. Further investigation reveals however that they share a (fairly radical) subjectivist

\(^{2}\)Stanford Encyclopedia of Philosophy, Bernard Dauenhauer, 2002
http://plato.stanford.edu/entries/ricoeur/
approach to care that involves necessity and a minimum of normativity. I argue that their approaches have some strong advantages to examining the question why we care – but also some very strong disadvantages.

In **Chapter Two**, entitled **Post Modern Care Ethics**, I examine an account of an ethics that rejects what it calls ‘overarching’ or ‘supra-natural’ categories of value. Each perspective is a unique perspective, argues Selma Sevenhuijsen (whom I have chosen to represent this theme in care ethics). Sevenhuijsen attempts to temper her radical particularity with an emphasis on the importance of solidarity and responsibility. I am critical of this attempt and include a discussion of Margaret Walker’s much more social concept of responsibility in this chapter as an alternative to Sevenhuijsen.

In **Chapter Three**, entitled **Knowing Care**, I examine an epistemological account of care ethics in which it is argued that caring generates a particular and better kind of knowledge – knowledge about the cared-for. Like the first two accounts of caring, this is based on knowledge generated by situated and particularised epistemic positions. The basis for this discussion is Vrinda Dalmiya’s epistemological care ethics and Walker’s epistemological basis for an ethical approach.

In **Chapter Four**, entitled **Virtue-Orientated Care**, I examine a type of care ethics that breaks with the tradition of accentuating the selflessness of the one caring. Virtue-orientated care ethics, represented here by Raja Halwani, in contrast to post-modern and epistemological care ethics, has a central role for the moral agent. This role includes a discussion of character, inclinations and social skills. Halwani argues that caring is necessary because of its essential role in securing quality of life. I have reservations about this particular form of argument. I refer to John McDowell critique of naturalism and Hursthouse’s exposition of character in order to elaborate on notions of virtue ethics and offer alternatives to Halwani’s approach.

In **Chapter Five**, entitled **Refurbished Obligation**, I continue the discussion of the notion of what necessity means in the context of an ethics. I spend much time revising the concept of obligation – taken from a philosophical tradition hitherto reviled by care ethicists - so that it is capable of expressing a complex and sensitive moral standpoint and is simultaneously a means of demarcation for moral actions. I discuss its ability to command, give permission and to restrain and I do so in a manner inspired by Barbara Herman and Marcia Baron. This chapter forms a bridge to the point to which I have been working throughout this dissertation, namely a discussion of (the compellingness of) normativity – in caring.
In Chapter Six, entitled Normative Caring, I enquire what normativity does. In order to do this, I look at Christine Korsgaard’s concept of normativity and some of her critics. I formulate a reply to the question ‘Why care?’ and I conclude that Pim must care at peril of feeling worse than death.