7

An Ethics of Care

> When women who are not mere students of other persons' philosophy set out to write it, we cannot conceive that it will be the same in viewpoint or tenor as that composed from the standpoint of the different masculine experience of things.
>
> —John Dewey (1993, 40)

> The philosopher who begins with a supremely free consciousness—an aloneness and emptiness at the heart of existence—identifies anguish as the basic human affect. But our view, rooted as it is in relation, identifies joy as a basic human affect. . . . It is the recognition of and longing for relatedness that form the foundation of our ethic, and the joy that accompanies fulfillment of our caring enhances our commitment to the ethical ideal that sustains us as one-caring.
>
> —Nel Noddings (1984, 6)

7.1 Is Care an Important Concept for Philosophy?

All Western philosophy, said Alfred N. Whitehead, is a series of footnotes to Plato. This frequently cited declaration is meant to express the idea that in Plato's magnificent corpus, all the important ideas that philosophers have grappled with are laid out, and all the rest is commentary. Truly, it is rare that any genuinely new ideas enter into philosophy. Most philosophical treatments of ethics and political theory have their roots in Plato. Seemingly new and too often ignored philosophical issues, such as women's equality, love, and the education of children, were already present in his work.

Care too makes an appearance as *therapeia*, "care of the Gods," and as *melô*—the notion of improvement, in the sense of self-care or care of the soul.[1] Just as

[1] Thanks to my colleague Alan Kim, who writes: "First, it seems that in Plato, the notion of 'care' is importantly connected with the Good and the dialectic between 'improvement' (motion toward the Good) and 'corruption' (the opposite). Socrates appears as the improver and hence the carer, whereas Meletus, in name the Carer, is in fact the corrupter. In Aristotle's *Nicomachean Ethics* (chapter 1, section 2) too, we find the idea that the statesman's job boils down to tending

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the midwifery of Socrates, bringing forth the ideas created in the minds of men, is a metaphoric appropriation of women's role as midwives of flesh-and-blood children from the bodies of women, so these references extend the metaphoric appropriation of women's carework, beyond childbirth and onto the rearing of the child. As women care for children past infancy, men are engaged in the care of the Gods or care of the soul.

The source of the metaphor, care of dependents and the ethical concerns that emerge from this enterprise, do not take center stage anywhere in the grand opus.[2] Nor are these present in the many "footnotes" to Plato. In contrast, in our quotidian lives, the care that we offer to an ailing friend, that a parent gives or fails to provide for her child, that we devote to an older parent or a stranger in need, or even how we care for our nonhuman fellow creatures and our earth,[3] are all matters that figure in our moral evaluation of ourselves and others. These constitute the heart of our moral selves. We think of a caring person as having lived a morally good life, and a deeply caring person as having lived even a saintly life. The deep divide between the philosophical conceptions of a good person and ones that ordinary people accept are at least as striking as the difference between what philosophers insist is needed for a good life and what many good and thoughtful people value in a life.

Although care as a moral value is not new, what is new is the claim that care requires articulation as an ethical perspective, as an ethical theory. In her studies of how women deliberated about moral dilemmas, Carol Gilligan (1982) claimed she heard "a different voice," the voice of an ethic of care. Gilligan's studies brought something fresh into philosophy: a new conception of ethics, and the beginnings of a new ethical theory.

to the citizens of the state in much the way Socrates describes the shepherd in the *Republic*. He is supposed to create or maintain the conditions for maximal thriving of his wards. But we clearly also see in Socrates, Plato, and Aristotle the idea that Foucault calls 'the care of the self.' The person who knows how to care for others in the first place cares for him or herself, and this self-caring is, it seems to me, the prime expression of Greek virtue. It means getting your soul in order, and thus into a healthy condition, which is the equivalent of happiness or 'living well' (*euzên*)" (personal communication, October 27, 2014).

[2] It seems like philosophy here can take place only where women step aside and men play their role in education, statesmanship, and philosophical improvement.

[3] The increasing moral importance of care of the earth and its creatures is beautifully highlighted in both the substance and the title of Pope Francis's Encyclical Letter, "On the Care of Our Common Home" (2015).

7.1.1 An Ethics of Care Emerges on the Philosophical Horizon

Gilligan's empirical work led her to claim that the abortion debate, structured as a conflict of rights—those of the fetus versus those of the woman—fails to reflect the decision-making of women faced with an unexpected pregnancy. Rather than ask if the fetus was a rights-bearing person, the women in Gilligan's study asked questions such as: Is it responsible to give birth at this time of my life? Am I prepared to take care of a child? How will giving birth to a baby now affect my relationship to my lover, my spouse, my parents, my children? Will I be true to myself or cause harm by my decision? Rather than asking about rights, these women were asking about their responsibilities. Rather than framing the dilemma as a conflict between oneself and the unborn, they tended to think in terms of their relationships to a future child, current children, a spouse or lover, and other family. In particular, they were concerned how their decisions would affect those about and for whom they would be caring.[4] Other philosophical work by feminists soon took up the notion of care. Of particular importance were Nel Noddings's phenomenological treatment in *Caring* (1984) and Sarah Ruddick's *Maternal Thinking* (1989). These three works laid the groundwork for subsequent treatments of care.[5]

There is a plausible explanation for why there is little in the long history of moral thought that highlights care, whether as a virtue or as the basis for right action. Very few of those who have penned moral theories have been women or had access to the experiences of women when not in the company of men. Women, moreover, have been in a position neither to make decisions in the sphere that men have dominated, nor (as John Stuart Mill shrewdly observed) have they been sufficiently independent of a man's power to say what it is that they really think. The systematic moral scrutiny applied to promises, contracts, and conduct in battle and business was not applied to areas that men didn't occupy, like care for children and the ill.

[4] Gilligan's claim was that the dominant discourse in moral theory is what she called a justice perspective, while the ethical life of women traditionally has revolved about issues of care. Her theorizing and its subsequent development has set up an opposition between an ethic of justice and an ethic of care. The dichotomy has vexed theorists since, and I attack it in my own way (2015). Because I no longer hold the dichotomy to be valid, I refrain from opposing care to justice.

[5] If we grant that care has a role in Plato and the footnotes that follow, then perhaps we can say that rather than introducing the notion of a care ethics that is a break with the philosophical tradition, women have provided still another footnote to Plato, one that develops a different conception of care. Other predecessors who have come closer to the notion of care that contemporary feminist philosophers are developing include women philosophers such as Jane Addams, who are generally given short shrift or entirely excluded in the canon. I thank Richard Rubin for these insights.

Caring has been treated less as a moral virtue and more as the fulfillment of nature's plan. For example, a woman who failed to care for an ill spouse was doing something unnatural, something unfeminine—but not necessarily something to be accounted for within a conception of ethical behavior. And while a woman who leaves her child is viewed as monstrous, a man who abandons his child is viewed instead as doing something immoral. Women's position has changed, and we have discovered that men too are capable of caring for children and whomever is in need of care. Such a statement is not meant sarcastically. It hasn't been until the late twentieth century that feminists have even begun to demand that men share in childcare. Once care is no longer regarded as an instinctual and a natural disposition found mostly in women, we can de-naturalize and de-gender care and understand it as a mode of moral conduct. In this way feminism has, as Julia Driver (2005) puts it, added more data into the data bank that moral philosophers now need to consider.

Some aspects of care have entered the philosophical canonical literature. We have already alluded to Plato's work. *Love* is motivationally close to care, and it has had a small but important place in Western philosophy. Notions of *sympathy* (important to Sentimental philosophers), *benevolence* and *beneficence* (in utilitarianism and Kantianism), and *altruism* are important counters to *egoistic* theories of morality. These concepts share some of the attitudinal features of care. They all do some of the work of care: they all enlist other-directed motives, motives that arise out of a felt concern for or attachment to another. Often, however, the place of these attitudinal other-directed concerns lies not with right action but with supererogation. They cover those acts that are good (even saintly) but not required, and so are supererogatory. In contrast, the caring that is part of quotidian life includes not only a benevolent attitude and altruistic actions, but also actions that are *required* of a carer and so are not supererogatory, even when they demand significant sacrifice on the part of the carer. For instance, no one thinks to call the care a parent gives her child supererogatory.

Care has more recently become a concern in Western philosophy from a number of quarters. Within Continental philosophy "care" or *Sorge* entered into the philosophical lexicon via Heidegger.[6] But like Plato's conceptions of care, Heidegger's is far from the examination of care that has preoccupied more recent feminist thinkers. His is a feature of his metaphysical views of the nature of Being. The work of Levinas has been thought to have a close affiliation to a

[6] The Heideggerian notions of *Sorge, Fürsorge*, and *Besorgen* designate caring about, taking care of, and being concerned, and they are the ways in which *Dasein* is manifested in the world (Heidegger 1962). There is, however, a question as to whether the Heideggerian notion can be used for examining caring for another, since *Sorge* is a condition of *Dasein* rather than a relation to one in need of care (see Lavoie, De Koninck, and Blondeau 2006).

feminist ethic of care.[7] Harry Frankfurt (1988; 2004) and some of his followers have made a major contribution bringing care into the philosophical literature of Anglo-American philosophy. In their work, care is recognized as a central motivation in all human life. The most extensive contribution to the articulation of an ethic of care, however, has come from feminist moral philosophy.

Once we begin to think about it, it seems extraordinary that philosophers have taken this long to consider care as a central moral concept. A world without care would not only be a dismal world, it would be a world in which great harm would be done. A world in which nobody cared about anyone else would be a world in which needs of those who could not attend to their own needs (and that is all of us at some point in our lives) would be neglected. Although an implicit ethic of care has been indispensable to the survival and development of human society, its development into an articulated moral theory is still in its infancy. The idea, first put forward by a woman psychologist about the moral life of mostly women, has prompted a number of female philosophers (and some women-friendly male philosophers) to till new theoretical fields and come up with a set of notions that justify the claim that there is an ethics of care that governs the best practices of care and whose values spill out onto other moral domains. Furthermore, this ethic is different from the trio of ethical theories that have hitherto claimed the territory: a Kantian deontological ethics, utilitarianism, and virtue ethics.

7.1.2 An Ethic of Care: Descriptive or Normative?

A question that continues to haunt debates around an ethic of care is whether the concerns expressed in terms of care are fully normative ones. Calling something "an ethic" has always been ambiguous between an anthropology (that is, a descriptive account of the rules or codes that govern activity within a certain community—even a band of thieves can have an ethic in the descriptive sense), and a fully normative account (that is, whether the rules that are descriptively adequate are also rules that *ought* to be followed). Insofar as the idea of "an ethic of care" arose out of a set of psychological studies, it might be taken to be a description of what people think it is appropriate to do rather than an account of what in fact is the right thing to do.

[7] Levinas's conception of our responsibility to the other is close to the feminist concept, but it supposes an obligatory relation to the other that is not essential to a feminist conception of care. There is a literature that has developed regarding the applicability of Levinas's notions as they pertain to a feminist ethic of care. See Lavoie, De Koninck, and Blondeau (2006); Diedrich, Burggraeve, and Gastmans (2006); Bookman and Aboulafia (2000); Reynolds (2016); and Nortvedt (2003).

What makes the question especially confounding is that care is always embedded in a practice of care, for example: mothering, nursing, eldercare, or assistance for a disabled person. And practices are themselves a source of normativity. Practices provide the context by which we make claims of truth or falsity (Winch 1958) and within which we practice the virtues (MacIntyre 1981). A practice (that is, that set of activities with structures, rules, values, and virtues) has an aim (*telos*) by which we evaluate a behavior as good within that practice. Killing someone who is your enemy is generally commendable in the practice of war, but killing someone who is your enemy, even your mortal enemy, is generally not a good or right action.

Sarah Ruddick speaks of a gender-neutral *practice* of "mothering"—that is, a set of activities that have as their goals the preservation, nurturance, and socialization of children (whether done by women or men, and whether the parents be biological or adoptive). In respect to these aims of mothering, one can be either a good or a poor mother. We can speak similarly of nursing. The norms of nursing govern what counts as care from a nurse, allowing us to speak of good nurses who assist in comforting and healing their patients and poor nurses who are careless, neglectful, or incompetent. The *telos* is the regulative ideal by which we evaluate not only the behavior of individuals, but also the activities and structures, the rules and conventions that characterize the practice. When rules run counter to the *telos* of nursing, a good nurse should be willing to break those rules, weighing only if doing so will undermine her ability to continue to do good nursing.

Gilligan, however, in speaking of an ethic of care, was trying to get at something less descriptive and more fully normative. Women trying to decide whether to terminate their pregnancy were deliberating on what *the right thing* to do would be. They were assessing what a good person would do in her circumstance.[8] If care is a fully moral concept which tells us what is and is not right to do, what is good and what fails to be good, then the practice and its regulative ideals must themselves have moral validation. Thieving is a sort of practice. But honesty among thieves does not make a thief honest. The point of thievery is simply to enrich the thief. A moral practice is one which, when meeting its regulative ideal, is a morally good or morally right practice.

What gives a practice such moral validation? Consider mothering. It may seem that a good mother can be one that does everything for her child regardless

[8] More precisely, the women were trying to determine if their decision was *the right thing* to do (a moral judgment), and what would be right *for them* (a prudential judgment). Those committed to a religiously based belief that abortion was a moral wrong took a prudential decision to be merely selfish. For those not committed to an exterior moral authority, the deliberation was to come to a morally acceptable determination.

of the cost to others. But one of the aims of mothering is to socialize her child, to guide the child in becoming a member of her community. A mother who is ruthless in obtaining things for her own child may appear to be the good mother. But viewed from the perspective of the practice understood as a whole, she will actually be doing a poor job, for such a parent does not model behavior that is acceptable. Mothering does not set its own aims apart from the world in which the child must live, and we see our role as parents to equip the child with a grasp of what is morally acceptable in that world.[9] What caring practices share is an ideal that leaves no one's genuine needs and legitimate wants—needs and wants that can result in real harm—unattended. More positively, caring practices tend to people's CARES, to those things people care about, which figure in their flourishing, and which they cannot accomplish without the proper assistance. Avoiding harming another and allowing others to flourish are conceptions that are familiar to all moral theories.

A moral theory based on care gives special consideration to the avoidance of neglect, to the importance of attending to those who are inevitably dependent (and so cannot attend to what they require themselves), and to a motivational structure based on affective ties and empathetic capacities. If we are correct about the moral validation of practices of care, then we have a basis for thinking that there is a notion of care that is fully normative and not merely descriptive and can serve as the guiding virtue for a true ethics of care.

The way we normally speak of caring is the way we speak of mothering or nursing. You can do it well or poorly; you can be a good carer or an inadequate one. You can care "too much" ? (e.g., a parent constantly hovering over a child—the "helicopter parent"—or a nurse who, in her vigilance, causes more irritation than comfort to the sick patient) or "too little" (e.g., being callous, negligent, or even abusive in carrying out presumed acts of care). This is a perfectly serviceable way to speak of care most of the time.

But if we want to speak of a fully normative conception of care, then can we really speak of "caring too much"? Consider that we never speak of a person as being "too just." We may speak of a person being too rigid in the application of laws or principles, or we may say that a person serves up too stern a form of justice. What we do not say is that someone offers up bad or poor justice. If it is bad, it is not just. For the outcome to be just, it must be something worthy of approval, even if we have reservations about the outcome that comes from

[9] Studies indicate, however, that parents are most likely to act dishonestly to benefit their children. However, when parents are in the presence of their children they are more likely to behave honestly, although they were more prone to act dishonestly in front of their sons than their daughters (Houser et al. 2016).

a different set of values or another practice—for example, that a particular just judgment was not sufficiently merciful.

Moral virtues such as justice are already defined normatively, and, as Aristotle tells us, they are generally a mean between two vices.[10] So, we cannot be *too* courageous, for then we are tending toward recklessness. As the guiding virtue for an ETHICS OF CARE, CARE too is a mean between too extremes. On one extreme is over-solicitude, that is, the unwanted attention to another person and their needs. Alternatively, there is the paternalistic imposition of someone's idea of what good is for the cared-for, without consideration of what the cared-for regards as their own good. On the other extreme is a neglect borne either of indifference or a misplaced "respect for another's autonomy" that involves a failure (or unwillingness) to perceive another's need, an insufficient concern for the other's well-being, or a failure to seize the opportunity to act upon the perception of another's need. The point of caring is to benefit the cared for, but when the person who is presumably being cared for says that the carer cares too much, they are complaining that the benefit the carer assumes she is bestowing is not a benefit at all. In chapter 8, we will speak of the need of the cared-for to take up the actions of the carer as care. This last requirement is essential if we are to have a way of identifying whether what we do for another's benefit is indeed a benefit for that person.

7.2 Features of an ETHICS OF CARE

The concept of an ethics of care has now been around for approximately thirty years, and some of its core features have been identified. I incorporate these into the particular conception I am offering here. An ETHICS OF CARE needs to hold together a tripartite conception of CARE as labor, an attitude (or disposition), and a virtue. As a labor, caregiving requires attending to the needs of another, putting aside one's own needs for someone more vulnerable, and often becoming intimate with the body and the bodily functions of the cared-for.[11] The labor of care is, for the most part, carried out on the body of an individual. An ETHICS OF CARE is one in which the embodied existence of each, in both our unique individuality *and* in our material connectedness to one another, is never eclipsed. As such, it must be able to dignify each morally significant individual in his or her embodied existence.

[10] When we are courageous or virtuous in any regard, we act according to the mean between these extremes: we do the right thing "at the right times, with reference to the right objects, towards the right people, with the right motive, and in the right way" (Aristotle 1908, Book 2 Sec 6).

[11] See MacIntyre (1999); Gastmans, Dierckx de Casterlé, and Schotsmans (1998).

The custodial maintenance of the body is not yet CARE. The attitude of CARE, the open responsiveness to another—so essential to understanding what another person requires—is needed if the work is to constitute caring labor. Sarah Clark Miller captures the nature of caring labor when she defines care as "the process of responding to another's need by understanding their self-determined ends, adopting those ends as one's own, and advancing them in an effort to cultivate, maintain, or restore their agency" (2005).[12] For this to take place CARE requires a "shift . . . from the interest in our life situation to the situation of the other, the one in need of care" (Gastmans, Dierckx de Casterlé, and Schotsmans 1998) and what Nel Noddings (1984) calls "engrossment" in the other. That is, attitude must accompany the labor.

CARE, as we said, is also a virtue to be cultivated, a disposition to make the attitudinal shift as it is called for. Those in whom this virtue is present are able to respond to people in need of care even when the parties are not bound by intimacy. Carers not only care about and for those whom they encounter, they also care about CARE (Dalmiya 2002).

The skills and virtues of caregiving are many, and the degree to which the caregiver must become enmeshed (in Nodding's words) in another's needs in order to adequately meet those needs varies with both the urgency and extent of the other's dependency and with the degree to which one has cultivated the virtue of CARE. Because it involves a shift from one's own interests to those of the person in need of care, it often requires the caregiver to defer the fulfillment of his or her own needs. When caring for someone who is extremely (and inevitably) dependent, the deferral can take too long to ever be fully compensated, and it is effectively a loss for the caregiver. Another must come to the aid of the caregiver. The caregiver herself becomes dependent on someone who will look after *her* interests and attend her *own* (first-person) CARES, as well as allow her to care for the dependent. The self of the caregiver and her relation to the dependent have a moral value no less than the person for whom she cares, even if attention to the caregiver's concerns must be deferred given the urgency of the needs of the cared-for.

In addition, an ETHICS OF CARE can be characterized by concepts that one can find in other moral theories. One way to sketch out an ethics of care is to consider how it differs from other moral theories in treating the concepts of

[12] Because I want to speak not only of needs, I use a more inclusive term, CARES, to cover both needs and wants. Doing so also has the virtue of avoiding the difficulties of delineating what constitutes a need. However, since the term "needs" is so naturally employed when speaking of care, it is often too stilted to speak always of CARES, and I will slip into speaking of needs, unless the context requires a careful demarcation of terms.

moral selves, moral relations, moral deliberation, the scope of moral judgments, the aim of morality, and moral harm.

7.2.1 Moral Selves and Moral Agency

Most ethical theories begin with an explicit or implicit understanding of the self, or the moral agent. Modern theories of ethics generally begin with independent autonomous individuals as moral agents in rational pursuit of their own good, as they see it. An ETHICS OF CARE begins with embodied selves who are regarded as inextricably connected to other embodied selves. Such a self is vulnerable and embodied in a particular way: that is, this self, unlike the idealized self of many other theories, has a gender, a race or ethnicity, a social position, and a set of abilities and disabilities as these are, or should be, realizable within the context of their lives. Their relationships play a constitutive role in the formation of their desires and in their identity.[13] Moral deliberation must contend with the way in which differences among selves make a difference in the outcome of our practical actions.

While (in dominant ethical theories) the self is a self-determining adult who is an independent agent and party to an ethical determination, an ETHICS OF CARE does not presume that all parties in an ethical exchange are adults capable of self-determination and independence. Some are deeply dependent on others for care. The fact of our dependency does not take us out of moral consideration, but rather constitutes a ground of our moral world. We cannot extricate ourselves from our vulnerability to dependency and our interconnectedness.

The self who is engaged in a caring relationship is a *relational self* that is capable of being motivated by the CARES of the other. The CARING self needs to be able to make itself transparent to the needs of the other, that is, it needs to bracket its own CARES so that these do not cloud its ability to apprehend the CARES of another. Yet such *transparent selves* do not become mere ciphers—they must be capable of self-direction, self-rule, and self-reflection (Meyers 1989;

[13] That our relationships are a constitutive part of what it is to be a self does not mean that there is no self apart from the relationships we have with others. But from the first breath we take we are already in relationships: with the birth mother, with those who care for us so that a fully dependent being can survive, and with all who have helped in our birth. We also occupy certain relational roles. For example, we are a child of some human being. But it is not the case that anything can be a child of someone. All relations already specify something about the nature of the relata. Gravity is a relation. But it doesn't relate entities that lack mass. The relationship arises out of the properties of the relata, but the relationships also constitute the relata. For an account of the importance of these relations in the recovery of a shattered self, see Brison (1997; 2002). For a discussion of the relation of autonomy and relationality see the essays in Mackenzie and Stoljar (2000), and see Friedman (2003). For a discussion of the relational self and identity see Brison (2017).

1994). Self-reflection allows them to consider how their own desires might continue to obstruct their ability to be attentive and responsive to the other; self-rule and self-direction allow them to evaluate and determine the extent to which the other's CARES should direct their own actions. An ETHICS OF CARE ought to preserve the caregiver's ability not to stray from her own moral compass in her willingness to become "engrossed" in the other.[14] Similarly, a fully normative theory ought to encourage caregivers to be alert to the exploitation or abuse that caregivers can be subject to. They also need to be sufficiently self-reflective so they do not subject the cared-for to some abuse that they themselves might unwittingly or carelessly inflict.

7.2.2 Moral Relations

In contrast to the presumptions we find in many other ethical theories, the relationships in which such relational selves stand may not be self-chosen and are not always among equals—and so there is no presumption that reciprocity is possible, much less that it is obligatory. Care ethics then deals with our obligations and responsibilities in relationships of asymmetry in situation and power.[15] In such asymmetrical relationships, the carer needs to be attentive, mindful, and responsive to the genuine needs and legitimate wants of the other, and respond in a way that addresses the other's particularity. Although all moral relationships require a level of trust and trustworthiness, those qualities have a heightened importance in care relationships, given the special vulnerability of one party to the actions of the other. Nonetheless, as I will argue in the following chapter, there is a legitimate expectation that the ones cared for (when and to the extent that they are able) do their part by taking up care offered in good faith and with the requisite competence.

7.2.3 Moral Deliberation

Love, empathetic concern, commitment, loyalty, compassion, and other attachments and emotions are important motivations to act on behalf of another. Within an ETHICS OF CARE they play a part in moral deliberation both because they direct our motivations, and because they are a rich epistemic resource.[16]

[14] Noddings (1984) uses the apt term "engrossment," but it is a term that can be taken to mean that in this sort of involvement one loses oneself and one's own good judgment.

[15] While the caregiver may be more powerful along some dimensions, the cared-for may have more socioeconomic power. Each party who has an advantage over the other party has the obligation not to abuse that power, turning the advantage into dominating the other. I discuss issues of power and domination in Kittay (1999, chapter 2).

[16] See Gallegos (2016) for a fine discussion of this point.

However, as emotions and attachments have been thought to be unreliable moral guides that give rise to skewed and arbitrary decisions, most moral theories, especially Kantian and Utilitarian ones, prefer generalized principles that rely on reason alone and result in conclusions that are impartial. But care ethicists point out that caring for a sick child is motivated more by empathy and concern than by algorithms utilizing a calculus of maximizing pleasure and minimizing pain; kindness to an elderly person is more reliably evoked by a feeling of sympathy than by a sense of duty; and (as the moral sentimentalists have already told us) even keeping a promise is more readily motivated by moral sentiments such as honor, shame, or loyalty than an application of the categorical imperative. To counter the charge that emotions are unreliable, the care ethicist (in common with other virtue theorists) would reply by calling for the active cultivation of moral emotions and for the modeling of their appropriate use.

What a care perspective adds to virtue theory and sentimentalist ethics is the understanding that these motivational forces also make us more alert to what is required in this particular circumstance. The attentive responsiveness critical to successful caring is made possible—often, at least—by an empathetic connection to and understanding of the other. These enable us to "read" the mind of another, especially in cases where the other is either temporarily or permanently incapable of communicating through speech. As such, these affective connections are a needed moral epistemic resource. They have this epistemic reach because moral emotions draw us into the subjectivity of the other, allowing us to respond to this particular concrete other, not a generalized other (Benhabib 1987).

Our relationships to others come with additional (although not always privileged) epistemic access to the other—and with such knowledge come special responsibilities to respond to that individual's CARES. Giving priority to one's spouse or children in situations of crisis is not immoral. Rather, as Bernard Williams memorably pointed out, hesitating to do so is to have "one thought too many" (1976). Surely not all of our ethical life is circumscribed by such relations, but having them allows us to understand the importance care has as a moral conception. Further, if we care about care, we come to understand how we enlarge the circle of those whom we care about and why we must see to it that all can be cared for through meaningful relationships.

7.2.4 The Scope of Moral Judgments

Most dominant moral theories are supposed to give us judgments that are universal in scope. That is to say, if it is morally right to treat a person in such and such a manner, this is true of whosoever that person may be. For example, it

is no more permissible to lie to a stranger than it is to lie to someone near and dear. Such universality works well when the injunction is a negative one, such as "one must not lie" or "one must not trample on another's basic rights." But such universality is not always appropriate when we are thinking about CARE. An injunction as presumably universal as not lying gets complicated when we try to apply the best standard of care for a person with Alzheimer's disease. A fellow philosopher and caregiver of a spouse with Alzheimer's disease remarks:

> Lying becomes especially problematic with dementia. One woman in my support group used to say, "You have to learn *how* to lie." I don't regard it as lying per se, but simplifying communication to take care of the cognitively impaired person. Indeed, it's better to deflect than to lie. If a woman in a nursing home thinks you are her sister, you don't want to tell her that her sister is dead, but you also don't want to pretend to be her sister. It's better to get her to talk about her sister and to inquire indirectly why she is thinking of her.[17]

Another injunction that is generally seen to have universal scope is a principle of noninterference. Except when we act in ways that are harmful to others, we should not be interfered with in our pursuits.[18] But when we are dealing with those who require care, "noninterference" is often neglect and the source of great harm. More generally, however, the idea that noninterference is of upmost importance arises from an understanding of moral life as occurring amongst nonrelational, self-sufficient selves. If we begin with our interconnectedness, we want to look instead at the inevitable impact each of our actions has on others. We also recognize that the impact of our actions is often (though not always) proportionate to the closeness of our relations to others.

Within an ETHIC OF CARE, impartiality, along with noninterference, loses its moral supremacy. Helping another to flourish (according to the cared-for's conception of her own flourishing) takes precedence over a principle of noninterference. But as such intervention is demanding on the caregiver, it is quite unreasonable to expect everyone to be fully engaged in caring for everyone else—or even to be equally caring toward all. The limitations of our ability to

[17] Richard Rubin, personal communication, June 21, 2015.

[18] A classic statement is John Stuart Mill's harm principle: "The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others" (1860 [1978], 9). Similarly, John Rawls's conception of the basic liberties is to guarantee that each one has the freedom to pursue their own conception of the good, without interference, as long as doing so is compatible with others having the same freedom. The priority of the right over the good is another form of the idea that noninterference is more important than fostering another's good—at least in the realm of justice.

form significant emotional engagements beyond a rather narrow sphere, as well as the demanding nature of care, means that a CARE-based ethics is inevitably sensitive to proximity, whether it be the relational proximity of family or friends or the geographical contiguity of neighbors and fellow citizens. The scope of care is therefore partial and contextual, and not universal.[19]

An ETHICS OF CARE, which is anchored in our relationships with and connections to others that are at least partially constitutive of who we are, nonetheless requires a cultivation of care for those who are distant. If CARE itself is a fundamental value, as we averred in section 7.1.2, then it should be a value that is not confined to our relations to intimate others, but needs to characterize a certain moral stance we take in the world, one we can call caring about CARE (Dalmiya 2002). If we understand that we are all connected, we see that noninterference can too easily morph into neglect globally as well as locally. How to properly adjudicate and execute such obligations and responsibilities is something for which an ETHICS OF CARE needs to provide guidance, guidance that may be based on degrees of intimacy, proximity, urgency of need, or a general concern that adequate care be available when needed. Acknowledging our relationships is a first step toward understanding the many ways these connections risk becoming forms of domination or occasions for neglect, and thus an ETHICS OF CARE must guard against both an indifference to those who are distant and a temptation to dominate those to whom we are connected.[20]

7.2.5 The Aims of Moral Relations

Perhaps the most fundamental difference between moral theories resides in how they conceive of the point and purpose of moral interactions. Ethical theories within a liberal tradition stress the importance of people being able to live their lives according to their own lights, free of unnecessary interference from others. Utilitarian theories understand moral theory to provide the greatest good for the greatest number. Communitarian theories understand the point of moral relations to serve a communal good.

An ETHICS OF CARE stresses, first of all, the concern for the well-being (or flourishing) of a person *for their own sake* and the moral importance of enabling each one to flourish. Like other moral theories, an ETHICS OF CARE is primarily one that is concerned with the interactions among selves, each of whom have a subjective life. Such selves have a well-being to which a carer is responsive. I will

[19] Universality, however, makes an appearance in the notion that a care ethics is one in which care is a universal value. I may not have a duty or responsibility to care equally for all, but I do need to acknowledge the equal right all have to receive care.

[20] For a good discussion of domination see both Young (1990) and Pettit (1997).

not here engage in the disputes that surround the nature of well-being. The view to which I subscribe, and which I believe inheres in an ETHICS OF CARE, is that the well-being of an individual (who is also a subject) is a form of *flourishing*. In the context of an ETHICS OF CARE an understanding of flourishing requires the following:

1. A person flourishes when the person has (or has access to or can strive to attain, either on her own or assisted by another) the things an individual truly cares about (in the sense that these are the things that make it worthwhile for a person to get up every morning).
2. The things the individual truly cares about that are genuine needs are met (that is, needs which if they fail to be met will result in a genuine harm to the individual), and legitimate wants are satisfied (that is, wants that can be met without sacrificing the equally legitimate wants of another).

That is, when we CARE for another, we are concerned with that person's welfare as it contributes to that individual's flourishing. Furthermore, this caring is not for the sake of the larger community or some abstract conception of goodness, but for the sake of that individual. It is this concern with the other's well-being for his own sake that places *responsibilities* on us for the other's care. Because relationships of affiliation and affinity are themselves constitutive of how selves-in-relationship understand themselves, the other's care and the other's CARES are not external to our own well-being.

7.2.6 The Nature of Moral Harm

Ultimately, the point of moral theories is to help us prevent harm: harm to ourselves and harm to another. Within dominant moral theories, moral harm is identified as the violation of rights or the unwarranted intrusion in the form of paternalism, domination, or violence. In an ETHICS OF CARE, moral harm results when important genuine needs and legitimate wants (especially of vulnerable persons) go unmet; when our concerns elicit only indifference, when vulnerability arouses disdain and abuse rather than care, and most especially, when human connections are broken through exploitation, domination, hurt, neglect, detachment, or abandonment.

7.3 Temptations and Critiques of an Ethic of Care

A moral theory that stresses the importance of relationships and moral emotions comes with a host of "temptations" (Ruddick 1989, 30). Temptations are

vices that result when otherwise beneficial tendencies are overindulged. We encounter the lure of temptations when we consider critiques of care ethics that question whether women and people with disabilities should embrace an ETHICS OF CARE. As a feminist and an advocate in solidarity with people with disabilities, I have sympathy for both critiques, and some of these were addressed in chapter 6.

An ETHICS OF CARE should acknowledge the temptations pointed to by feminist theorists and people with disabilities and address them. Once we have an ETHICS OF CARE properly articulated, we will come to see that it is the moral theory that best serves the interests of both, and it may well be the ethical view best able to provide a vision for a fully realized human existence.

7.3.1 Indifference to Distant Others

Although our connections to those who are close have special moral importance, we also need to guard against indifference to those who are distant (whether through geographic proximity or social position) from us. Ignoring the plight of others is a temptation of an ethic for which partiality and the restricted scope of moral obligations are a feature. Nonetheless, we are inextricably connected to others through vast and often unfathomable networks, making others susceptible to our actions regardless of our distance and our intentions.

Within an ETHICS OF CARE, connections generate responsibilities, and while such responsibilities to distant others are weaker than to those close at hand, they are nonetheless morally significant. We do, of course, have laws and principles to govern our relationships to distant others, but these cannot do all the moral work required to ensure that we act well and responsibly toward distant others. As Alasdair MacIntyre writes:

> The networks of giving and receiving in which we participate can only be sustained by a shared recognition of each other's needs and a shared allegiance to a standard of care . . . [without which] laws will often be observed from fear of the consequences of doing otherwise, sometimes grudgingly and always in a way that has regard to the letter rather than to the spirit of the laws. (1997, 84–5)

7.3.2 Undesired Benevolence—Especially as Care is Directed at People with Disabilities

A feature of an ethic of care, which we cannot really term "a temptation," is that we should be attentive to people who may need care and anticipate the need

even before help is requested. We should not wait until a person has already struggled getting a suitcase up three flights of stairs before asking if that person needs help with the fourth flight. Yet many people with disabilities regard unsolicited help as intrusive, paternalistic, and sometimes outright insulting. Adam Cureton, a philosopher of disability, has zoomed in on this conundrum. He writes, "Simple acts of kindness that are performed sincerely and with evident good will can also, paradoxically, be received as deeply insulting by the people we succeed in benefiting" (2016, 74). Yet for people without speech or another form of expressive communication, such careful attention to their needs is necessary precisely because they cannot ask for help.

But is this anticipation of need always appropriate? Imagine that you see someone who is blind and using a cane, who is about to head for a store window rather than a street crossing. You take his arm and start walking with him to the crosswalk and escorting him to the other side. The man needed help but does not display much gratitude. Have you acted wrongly, or has he not been gracious in accepting needed help? Imagine that you are vision impaired and moving through an airport you have traversed many times before. Your journey is interrupted several times by some kindly airport attendant who suggests that you request wheelchair assistance. The first time you answer matter-of-factly that you are very familiar with this route and when you need help you will ask for it; by the third time you are stopped you repeat the same words brusquely, almost rudely. At the end of chapter 8 I will argue that we have an obligation to accept care graciously when offered with good faith and with competence, and when there is a need. Has the disabled person in these instances failed to meet this obligation, or is the fault in those who have intervened? Why do we encounter the hostility to our efforts to assist? How and when should we make offers of assistance?

Cureton alerts us to one difficulty that the instrusive benevolence generates. Generally we feel the need to reciprocate when another does us a kindness. Without the opportunity to reciprocate we feel indebted, and we can even feel inferior if we are unable to reciprocate. Therefore unsolicited acts of kindness, when directed at people who are frequently stigmatized and regarded as inferior in ability, need careful consideration. The temptation to assist may be just that: a temptation. Unless we have checked in with the person in question or accurately observed that the person desires our help, we may be gratifying our sense of our goodness rather than the need of another. Cureton's caveat suggests that attention needs to be directed not only at what we perceive as another's need, but also at whether or not the person we are tempted to assist desires this assistance. If they do not, then the caring thing to do is to leave them be.

7.3.3 The Cult of Self-Sacrifice and the Collapse of Relationality

Another temptation of an ethic of care arises directly from the need for the caregiver to set aside her own needs when the needs of the cared-for are pressing. This can lead to a cult of self-sacrifice that, as Carol Gilligan so astutely remarks, undermines the very connectedness that sits at the heart of care. A relationship involves more than a single self, but when one self sacrifices for another, there is no longer a relationship between two integral selves—one self is lost in the process. Gilligan writes that in an ethic of care, the transition from a conventional to a postconventional morality "begins with reconsideration of the relationship between self and other, as the woman starts to scrutinize the logic of self-sacrifice in the service of a morality of care. . . .The woman asks if it is possible to be responsible to herself as well as to others and thus to reconcile the disparity between hurt and care" (1982, 82).

A contrary but related temptation, one that people with disabilities who need care are especially wary of, is the potential for the carer to lose sight of the separateness of the person for whom she cares. The danger is that she will impose her own conception of the good (or alternatively an abstract notion of what is good) upon the cared-for without sufficient attention to the subjectivity of the one for whom she cares. Once again, to affirm the relationality of the self, it is also imperative to affirm the distinctness of each self in the relation. Another way to put this is to say that an ETHICS OF CARE needs to be sensitive to the rights and individuality of both caregiver and cared-for, even as it stresses the responsibilities that arise out of the relationship of care and the intermingling of desires and interests to which such a relationship gives rise. The self, in an ETHICS OF CARE, is at once deeply enmeshed with others and yet always also a distinct self.

7.3.4 Care Ethics as a "Slave Morality"

A frequent criticism lodged at an ethics of care comes from feminists who have argued that care is, as Nietzsche would have it, a "slave morality." Feminist critics of an ethics of care claim that if it is empirically true that women exhibit an ethic of care, it is an ethic borne of their subjection, arising as it does from women's traditional labor, labor that women have been compelled to perform by custom and law. They argue that if women are to emerge from this subjugated condition, they need to adopt an ethic more suited to liberation from traditional roles. These criticisms have a bearing for disabled people as well: If disabled people are to demand their place in the world as equal citizens, then why subscribe to a "slave morality," a morality of the powerless?

In response to such criticisms, proponents of an ETHICS OF CARE can argue that an ethics arising from a subjugated position reveals that the subordinated in fact do have a voice. This different voice can inject new values into an oppressive society. To aspire to dominant values is often to collude with the very values that serve to oppress. The discussion in the previous chapter concerning the relationship between disabled people's embrace of "independence" and the invisibility of the personal attendant exemplifies this conundrum. I don't believe that people with disabilities want to perpetuate what Annette Baier called the "moral proletariat," the position of domestics and care workers within a theory focused on rights and independence (1995, 55).

7.3.5 Unequal Relationships

One still may want to ask whether people with disabilities should embrace an ethics based on the inequality of parties in a moral relationship, rather than one that presumes and works toward equality. An ethic of care has often used the care of an infant as a paradigm of care, which can then lead to the same error we identified in chapter 6: assuming that all dependency is infantile. Treating an infant as an incapacitated adult or an incapacitated adult as an infant will not be providing good care for either, but neither will the pretense of equality serve either in the relationship well.

Addressing the limitations of a rights approach to morality, Annette Baier speaks of the sham in the " 'promotion' of the weaker so that an appearance of virtual equality is achieved . . . children are treated as adults-to-be, the ill and dying are treated as continuers of their earlier more potent selves." She continues:

> This pretense of an equality that is in fact absent may often lead to a desirable protection of the weaker or more dependent. But it somewhat masks the question of what our moral relationships *are* to those who are our superiors or our inferiors in power. (1995, 55)

She goes on to suggest that a morality that invokes a mock equality and independence, if not supplemented, may well "unfit people to be anything other than what its justifying theories suppose them to be, ones who have no interest in each others' interests" (1995). That is, it may leave us without adequate moral resources to deal with the genuine inequalities of power and situation that we face daily, and which not infrequently are conditions that certain impairments (apart from social arrangements) impose on us.

Instead we need an ethic that can guide relationships between different sorts of care providers (nonpaid family members, hands-on paid care assistants,

professional medical personnel) and people with different sorts of care needs. The urgencies of need, whether they arise from medical emergencies, a breakdown in critical medical equipment, or disabling conditions not addressable by accommodation, are ones that render disabled persons (and often those who care for them) vulnerable. Many able people are also subject to such circumstances, and when they are, they do not want to be "abandoned to their autonomy" (Pellegrino and Thomasma 1987, 31).[21] An ETHICS OF CARE walks the line between the Scylla of paternalism or domination and the Charybdis of neglect.[22]

[21] See also O'Neill (1984).

[22] The inequalities extend beyond the relation of carer and cared-for. Where a child needs professional care from a physician, for instance, the parent and the child are both vulnerable and dependent on the physician. The same is true for a disabled adult and her carer when the disabled adult is in need of specialized care. For an excellent discussion of this sort of vulnerability see Feder (2002).