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Beyond demarcation: Care ethics as an interdisciplinary field of inquiry

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Abstract

Background: For many years the body of literature known as 'care ethics' or 'ethics of care' has been discussed as regards its status and nature. There is much confusion and little structured discussion. The paper of Klaver et al. (2014) was written as a discussion article to which we respond.

Objectives: We aim to contribute to the ongoing discussion about the status and nature of care ethics.

Research design: Responding to 'Demarcation of the ethics of care as a discipline' by Klaver et al. (2014) and 'Three versions of an ethics of care' by Edwards (2009), we identified shared concerns and formulated criticisms of both texts in order to develop an alternative view.

Participants and research context: This paper has been written from the academic context of a master in care ethics an policy.

Ethical considerations: We have tried to be fair and respectful to the authors discussed.

Findings: Both Klaver et al. (2014) and Edwards (2009) raise important concerns about the question if care ethics can be considered an academic discipline, and to what extend it can be seen as a moral theory. Despite shared concerns, their arguments fail to convince us in all respects.

Discussion and conclusion: We propose to conceive care ethics as an interdisciplinary field of inquiry, incorporating a dialectical relation between empirical research and theoretical reflection. Departing from the notion of caring as a practice of contributing to a life-sustaining web, we argue that care ethics can only profit from a loosely organized academic profile that allows for flexibility and critical attitude that brings us close to the good emerging in specific practices. This asks for ways of searching for a common focus and interest that is inherently democratic and dialogical and thus beyond demarcation.

Keywords

Care ethics, normative theory, empirical, interdisciplinary, theoretical

Introduction

In recent decades, care and care ethics have been conceptualized by a variety of scholars from various viewpoints and disciplines in different ways. Thinking about care has a long tradition among nursing theorists and ethicists in the nursing domain.[1–4] In the early 1980s, however, feminist interpretations of care gave rise to a new body of literature which became known as ethics of care or care ethics.[5–16] First-

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generation care studies of this kind were no longer written from a nursing perspective, but from a number of other perspectives, seeing care as part of the domain of women and social care.[5,13]

Second-generation care studies responded to this by critically analysing the limitations of first-generation writings and considered the relevance of care beyond the domains of gender and social and healthcare settings.[5,13] These authors aimed to disentangle care from first-generation care studies' association with kindness, dedication and generosity – care as a set of values or an attitude – and to strive towards an understanding of care and its ethics from a social political perspective. Politically oriented care ethicists have explored the meaning of a practice-oriented perspective, seeing care as 'a collective and political practice that builds up society'.[17] This implies that care is more than a virtue, bound to persons, and that care ethics is not a version of virtue ethics.

Again others see care ethics as a paradigm: a way of being that is accompanied by a shift in moral thinking representing something different from a normative theory of moral adjudication.[18] These scholars radically acknowledge the epistemological underpinnings of care as embodied and dialectically connected with our moral, relational selves.

Recently, Klaver et al.[19] contributed to the debate on the status of care ethics with a discussion paper in which they pleaded for the demarcation of care ethics as a discipline. In our contribution, we take up this invitation to discuss the nature and status of care ethics in three steps. We will first present a short outline of the argument of Klaver et al. – a paper that is best read on its own in order to fully understand our response – and argue why we propose an alternative viewpoint. Subsequently, we will discuss a paper that was not included in their analyses but that we think should be addressed as well in order to have a solid foundation of discussing the status of care ethics.[20] Finally, we will outline our own view of care ethics as an interdisciplinary field of inquiry.

The argument of Klaver et al. (2014)

Outline

In their discussion article, Klaver et al.[19] propose that 'a tentative demarcation of an ethics of care may serve as an opening for further discussion on the care ethical discipline'. They argue that being presented as a young discipline within philosophical and theological ethics, the ethics of care is said to evolve by adapting itself to new fields and coming into contact with other disciplines.[19] This, according to Klaver et al.,[19] involves the risk of messing things up and becoming contaminated as a discipline. The challenge is then – according to the authors – to expand as a strong discipline with a clear identity. The authors turn to Krishnan who lists six characteristics of an academic discipline and to Shneider who believes that scientific disciplines evolve through four stages.[19] They subsequently position the ethics of care as moving slowly between the third and the fourth stages of development as a discipline, between the stage at which a toolbox of methods and techniques is developed, and the stage at which the highest number of original research publications is generated. In this process, there is a risk of being 'polluted' when researchers from other disciplines enter the field.[19] Discerning between disciplinarity, multidisciplinarity, interdisciplinarity and intradisciplinarity, the authors encourage that the ethics of care slowly moves towards the last, which is defined as all relevant knowledge sources and methods being combined in a coherent discipline. Because this coherent discipline uses elements of other disciplines as their basis, criteria are needed in order to determine which elements are welcome and which are not. The authors present four features necessary to speak of an ethics of care: relation-based programming, recognition of situatedness and contextuality (entailing particularity of judgments), care ethics being a political–ethical discipline and being empirically grounded (or at least informed). The first three criteria are seen as in agreement with the international development trends of the ethics of care, and the fourth criterion is added by the authors. In the last part of their paper, the authors present two of their own research projects as meeting all four criteria.

Shared concerns

In their effort to clarify the status of care ethics, Klaver et al. aim to take away a number of misunderstandings and misconceptions with respect to care ethics. Care ethics, for example, has been misunderstood to be identical with a specific version of healthcare ethics, nursing ethics, professional ethics or applied ethics. The problem with these misconceptions is that they fail to recognize the generic nature of care, being a concept that semantically connects a great variety of human practices which are found not only in healthcare and nursing (hence the importance of these fields for the reflection on the topic) but also in many other contexts. The perspective of care ethics cannot be reduced to specific domains or realms of society. For this reason, we prefer to use the term 'care ethics' instead of 'ethics of care'. In our view, the term 'care ethics' helps expressing that care is the perspective from which ethical reflection departs (such as virtue ethics, theological ethics or feminist ethics), rather than a specific practice or realm that is the object of ethical reflection as is the case of ethics in relation to journalism, education or the healthcare sector. We acknowledge, however, that in the literature, 'care ethics' and 'ethics of care' are used as synonyms, causing confusion from time to time.

A second general misconception about care ethics is that it consists of a set of 'values' such as attentiveness and responsibility that lack theoretical foundation and can be applied to any practice in order to make moral judgments that in the end are as weak as the foundation of these values. In our view, care ethics works just the other way round. We conceive a caring practice as an inherently moral practice, or a moral ecology,[21] formed by normative expectations and negotiated and redirected responsibilities.[22] As Margaret Urban Walker puts it, 'morality itself consists of practices, not theories', and we should 'attempt[s] to find out what people are doing in bringing moral evaluation to bear [. . .] on what they and others do and care about, and whether some ways of doing what they are doing are better than others'.[10] Working from practice upwards, care ethics becomes an empirically grounded way of doing ethics.[23]

A third misconception about care ethics in general is its confusion with or reduction to virtue ethics.[24,25] The problem with this approach is that it fails to see that care ethics focuses on caring as a relational practice that is constituted by more than one agent and not about individuals aiming to perfect their individual moral capacities.[22] Moreover, it runs the danger of becoming politically naïve in forgetting the political and institutional structures that are constitutive to moral practices among other factors.[9,26]

What all these misinterpretations of care ethics share is that they fail to appreciate that this field of inquiry is the result of decennia long discussions – rooted in nursing and caring sciences, women's studies – and having resulted in a number of shared insights regarding bodiliness, practices, power and unjust division of responsibilities.[7]

Although we share the concern of Klaver et al. to take away the misconceptions about care ethics, we feel that the way these authors try to create clarity by tentatively demarcating care ethics is in contradiction with some of the central insights in care ethical literature that are guiding in the way care ethics works. Let us take a closer look at the argument they make.

Criticisms

In their paper, Klaver et al. suggest that care ethics needs to be pure and demarcated. They argue that once care ethics is purified from contaminating influences, some problems should be solved. The way in which the authors aim to reach this demarcation and purification raises questions. After having warned for messing up things, for example, a plea is made for an ethics of care that follows a transdisciplinary approach, comparing transdisciplinarity with fruit which is blended as a smoothie (interdisciplinarity) and used as basis for a new dessert. Thus, according to the authors, ethics of care should be both transdisciplinary and a specific discipline at the same time. From a logical perspective, this is challenging. In addition, when studying the four demarcation criteria, according to the third criterion, care ethics should be a political

ethics. If this is the case, however, it is difficult to see why the passage about transdisciplinarity is needed. We wonder whether the authors meant that care ethics includes attention to political dimensions of practices *as well* as non-political dimensions.

Another challenging argument concerns that, on one hand, the authors fear 'contamination' and 'pollution', while, on the other hand, a genuine care ethical approach is characterized by relationship-based programming. The question then is what criterion is offered to determine whether those with whom we engage in relationship-based programming are a possible source of contamination or pollution? As clearly none of the other three criteria listed can do this job, how would these criteria be able to help us at all in this respect?

This directly points towards what is underneath the argument of this paper. There seems to be an incongruence between the first criterion (relationality) and the epistemological underpinnings of the argument itself. Epistemologically, a split between subject and object and the knower and the known seems to be assumed. The focus of Klaver et al. on developing 'criteria' to (tentatively) demarcate the ethics of care points towards a positivistic approach to 'knowing' because their argument is presented from a non-relational stance. There seems to be a world 'out there' that can be assessed against criteria. If our analysis is right, then the argument of Klaver et al. proposes a positivistic, non-relational view on the ethics of care, and their first criterion should be reconsidered. If care ethics begins with a radical view on relationality (as the authors propose), this would also entail a relational epistemology in which the knower and the known are closely intertwined. Who then – we may ask – is capable and authorized to determine the right criteria? We think that this should be a collaborative undertaking, marked by interdependency and the particularity of situations at hand. The authors stress the importance of context-bound judgments and particularity. They argue for a local validation of meaning. But then, this raises the question who determines what matters and what should or should not be done in care ethics itself? How can care ethics validate its own meaning locally? This is one of the more fundamental challenges the paper raises.

In our view, the project of demarcation in combination with the development of care ethics is problematic. One vital paradigmatic element is missing in the authors' list, that is, thinking radically from the concept of care as a point of departure. We believe this is the bottom line of any approach that calls itself care ethical. We think that this point of departure would lead to a directedness towards 'maintaining, continuing, and repairing a life-sustaining web', instead of defending and excluding from conflicting outside influences.[9] The central question, then, rather seems to be how an ethics of care is capable of connecting and including elements of various disciplines in order to contribute to a more caring world. The authors do not seem to make this ontological shift.

Moreover, they choose a definition of academic discipline that is not critically examined against the background of how care ethics works differently in different professional practices. In this regard, they could have profited from a distinction of Ernest Boyer that has been taken up in theoretical nursing, distinguishing between scholarship of discovery, scholarship of teaching, scholarship of practice and scholarship of integration.[27] Before presenting our view on the status and nature of care ethics, however, we propose to present another criticism to the ethics of care that has been formulated but was not taken into account by Klaver et al. Having responded to this criticism as well, we will be in a better position to develop an account of care ethics that reckons with its position between other ethical traditions.

The argument of Edwards (2009)

In a critical paper in *Nursing Philosophy*, Steven Edwards argues that care ethics, although being subjected to serious criticisms, continues to have a great appeal to many scholars.[20] Part of the explanation seems to be that there is a close connection to nursing and care, added by the gendered aspect of the earlier works in an ethics of care. Edwards complains of its vagueness and the development of three versions of an ethics of care since the seminal works of Gilligan[6] and Noddings.[7] He subsequently discusses these three versions – connected to the

work of Gilligan,[6] Tronto,[9] and Gastmans[29] – concluding that either an ethics of care is interesting but implausible or it is insufficiently distinct from other more well-known approaches to moral problems in nursing.

Edwards' main point of criticism is that none of the three versions of an ethics of care – although building on each other – is able to give clear directives in the process of moral decision-making. For this reason, he states that an ethics of care cannot be seen as a distinctive moral theory. Care ethics merely provides the promotion of some general attitudes related to caring, leaving the really normative work to traditional normative theories, for example, principlism or consequentialism.

A fundamental problem concerning Edwards' contribution is his claim that the work of three authors (Gilligan, Tronto and Gastmans) subsumes or represents 30 years of care ethical discussion. Nowhere the author justifies his selection. The interesting question he raises, however, is whether an ethics of care is a distinctive ethical theory or rather a 'moral perspective or orientation'.[28] Again, the question is about demarcation, this time not so much of disciplines as of ethical theories. Both questions of demarcation, however, cannot be separated, since in our view, one of the reasons that care ethics is an interdisciplinary field of studies is the fact that the notoriously vague concept of care does not allow for any monodisciplinary of monotheoretical approach. In what follows, we will sketch our proposal of how we could see care ethics, taking up both questions of disciplinarity and normative theory simultaneously in their interrelatedness.

Care ethics as an interdisciplinary field of inquiry

Taking seriously the idea that all knowledge is – among other things – contextually and collaboratively mediated and determined, we acknowledge that our view of what care ethics is has also been developed within a specific context. This context has been defined by teaching and doing research in Tilburg at Tilburg University (2009–2012) and the University of Humanistic Studies (2012–present) in Utrecht, the Netherlands. We emphasize that we present our version of care ethics as one among many; we welcome any discussion that brings the field of care ethics further in a care ethical way. In what follows, we will develop our view in nine interrelated statements with short commentaries.

1. Care ethics is an interdisciplinary field of inquiry, which is driven by societal concerns. Since the beginning of the 1980s, in this field, various movements and disciplines have an interdisciplinary conversation, among which philosophy, ethics, social sciences, political and policy sciences and nursing sciences.

Looking historically at care ethics, it is clear that it derives much of its critical and renewing power from the fact that scholars from different disciplines found each other around the concept of care and its great potential for rethinking current practices. Some examples are as follows: Carol Gilligan was trained as a psychologist, Nell Noddings was trained in mathematics and education, Joan Tronto is a political scientist, Eva Feder Kittay is a philosopher and Chris Gastmans is a theologian and philosopher. Care ethics is the result of a meeting of these disciplines and appreciates the spaces where the power of renewal is originated. By 'societal concerns' we refer to the concern-driven feature of our view on care ethics.

2. The contribution to care ethics as developed in our research group is a specific form of ethics. The key question of our version of care ethics is what is morally good from the perspective of care, given this particular situation? In order to answer this question, we use a theoretical framework, which functions as a multifocal interpretative lens.

The fact that we understand care ethics as an interdisciplinary field of inquiry does not excuse us from clarifying from what discipline we ourselves contribute to this discussion. We think that an interdisciplinary field of studies can only develop soundly if those who engage in this field contribute from specific

disciplines. There are three arguments for this: being nourished by discussions in one's primary discipline, (a) one is kept well informed and nourished with new ideas and critically challenged by peers; (b) one is in a strong position to feed insights from care ethics back into the monodisciplinary discussions one partakes in; and (c) one helps to prevent that care ethics becomes an isolated movement.

3. The theoretical framework is built around the concept of care, which is broadly understood. Caring is primarily seen as a socially and politically mediated practice. This means that people continuously attune to others and themselves, in professional settings or otherwise, and are always embedded in an organized society. People 'attune' to themselves, others and their environment, in order to 'maintain, continue, and repair our "world" so that we can live in it as well as possible'. In practices, the morally good can emerge and be experienced by those involved. In this process, those who receive care play a crucial role.

Our position with respect to the question whether care is primarily an action, a virtue, a practice, a habit or anything else is that we primarily approach it as a social and political practice. This does not exclude that care might also be seen as a virtue or an attitude, but it is not our primary focus. Nor does it exclude our interest in the lived experiences of the people who are caring and cared for (cf. point 8). We call care a social practice because we consider care as being inherently relational and co-constituted by both caregivers and care receivers. We also see care as a political practice because it is a practice that is co-constitutive to the living together of people in an organized community. The sentence quoted above is a bow to the definition of care proposed by Tronto,[9] who has convincingly made clear how important it is to focus on the political dimension of caring. This political dimension of care ethics has important methodological consequences: it implies that the question of whose perspectives and knowledge should be included to determine what is 'good' care is important to address.[22]

4. The theoretical framework, built around the concept of care, is fed by two sources: on one hand, the interdisciplinary discussions known as care ethics, which run for more than 30 years now (cf. 1), and various forms of empirical research, on the other hand.

The importance of being theoretically nourished by the interdisciplinary care ethical discussions that run back to the work of Carol Gilligan and others[1–16] is important in order to profit from the many shared insights that have been developed over the past 35 years. The theoretical care ethical discussion can be considered as a growing body of knowledge, which is enriched by contributors from a variety of cultures, disciplines and generations. Next to this theoretical body of literature, empirical research is fundamental to care ethics. The importance of empirical research goes, again, back all the way to the work of Carol Gilligan, long before the empirical turn in ethics.[30] The main argument for this empirical part lies in the care ethical (and feminist) point of departure in moral epistemology believing that moral understandings are socially and culturally embedded, and one needs to learn the particularities of these contexts in order to be able to do a form of ethics that departs from the lives of ordinary people.[10]

5. These two sources, namely, conceptual and empirical research, are in a dialectical relation with each other. Conceptual and theoretical insights are being questioned and enriched by empirical research and vice versa. In other words, we have a normatively loaded care ethical theory that is simultaneously used as a theoretical framework and as a hypothesis that is tested and adapted on the basis of empirical research and theoretical reflection.

Because we think that concrete practices of caring – rather than specific caring activities – should be the point of departure of any care ethical reflection, empirical research is needed in order to learn what occurs in everyday practices, for example, nursing on an intensive care unit (ICU) or a hospice. In order to be attuned

to the diversity among and particularities of any specific caring practice, qualitative research methods seem best qualified for this. Qualitative research methods, however, depart from a great variety of theoretical and epistemological presuppositions. In our view, these presuppositions should be critically questioned by the theoretical sources on which care ethics is built. As mentioned, we depart from a dialogical, relational stance. New insights derived from empirical research, however, should be fed back into care ethical theory so that this theory can be renewed by insights collected from the study of caring practices.

6. In the theoretical framework (cf. points 3 and 4), a number of developed concepts (shared insights) are guiding, such as relationality, contextuality, affectivity, practices, vulnerability, bodiliness, attention to power and position and meaning.

Care ethical theory can only develop if it builds on the insights gained in long running discussions in which a number of concepts have been developed as shared insights. The fact that these critical insights are guiding does not mean that they play the role of a specific set of well-defined concepts that function as a canon. We think such an approach would be too dogmatic and lead to the kind of demarcation that we consider less fruitful and problematic in terms of democratic and scientific processes that we think are essential to care ethics. In our view, it is the authors themselves who decide to engage in the care ethical discussion by adopting and rethinking one or more of the shared insights that seem to hold together the theoretical body of knowledge that has been developed in the past 35 years.

7. The empirical research methods used in our version of care ethics focus on lived experiences, practices of care and the way society is organized (political–ethical). In our work, the methodological toolkit, which is used and developed further for this goal, contains the following methods: phenomenology, narrative analysis, discourse analysis, institutional and auto-ethnography, visual data analysis and responsive evaluation.

In order to be able to deliver a focused contribution to the care ethical discussion – and because we cannot master all empirical research methods in a rigorous way – we limit ourselves to studying lived experiences, practices of care and the way society is organized. Ideally, all three perspectives are present in our care ethical analyses, but sometimes, one or the other focus may preside. We do not proclaim that our way is the only way or the best way to proceed, but we consider that the combination of these three focuses the most fruitful for care ethics. The focus on lived experiences is important in order to feed back into the lives of concrete people who are the subject of care, and as such, the ultimate evaluators of what is morally wrong or right. This focus also enables to reflect on the dimension of meaning in caring practices. The focus on practices of care is given with our epistemological point of departure which conceptualizes care as a relational practice. Caring practices are embedded in larger structures that make up society as a whole, in which power relations are defined and contested and which have impact on the way we are able to deliver that care we would like to deliver. Studying these structures and analysing its impact on caring practices and the lived experiences of people prevent us from being politically naïve.

8. Summarizing the theoretical framework and drawing upon the above-mentioned ‘shared insights’ (cf. 6) direct the empirical research approaches towards (a) the lived experiences of those who are involved in caring practices, (b) on these practices as such and/or (c) their political context. In this way, insights are gained about the morally good that emerges here.

By summarizing our epistemological way of proceeding, we are now in the position to clarify how we can come to normative conclusions and respond to the criticisms of Edwards.[20] In our view, the answer to the question whether a practice is morally good emerges out of the procedure we have just described. In order to be morally good, something must be connected with (a) the experience of being meaningful for

those engaged in the practice, (b) it must be in accordance with the internal standards of that particular practice and (c) it must be in accordance with some form of justice.[31] The distinction between moral good and moral wrong is not a matter of black and white, but the more these three indicators are met, the more we can be confident in the moral goodness of what we have been studying.

9. Thus, the epistemological position of our version of care ethics can be described as expressive-collaborative and embodied. We only get access to the good when we acknowledge and relate different positions, perspectives and types of knowledge to each other, by being in dialogue and using participatory types of research accordingly.

By summarizing and reformulating our approach as expressive-collaborative, we express our indebtedness to the epistemological work of Margaret Urban Walker.[10] What goes for our access to the good, also goes for the project of care ethics as a whole. We see care ethics as an open interdisciplinary field of research that is constituted from the inside, by the engagement of those who are interested in this specific and simultaneously generic perspective on the world.

Conclusion

In this article, we have tried to work out the viewpoint that care ethics should be considered as an interdisciplinary field of inquiry. This view on care ethics begins with practice and the complex interweavings that constitute it: detailed, embodied, everyday life experiences, socially and politically embedded. Departing from the notion of caring as a practice of contributing to a life-sustaining web, we argued that care ethics can only profit from a loosely organized academic profile that allows for flexibility and critical attitude that brings us close to the good emerging in specific practices. Doing care ethics as an academic practice is subject to the same principles of expressive-collaborative work as the practices care ethics reflect on. This asks for ways of searching for a common focus and interest that is inherently democratic and dialogical and thus beyond demarcation.

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