

# **Care Ethics: The Four Key Claims**

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This paper condenses chapters 2 to 5 of:  
Stephanie Collins, *The Core of Care Ethics* (Basingstoke: Palgrave Macmillan, 2015).

This chapter investigates a somewhat neglected moral theory: ‘care ethics.’ This theory can be traced back to the 1980s work of Carol Gilligan, a psychologist who studied how women approach real-life moral dilemmas. In contrast to findings about men in earlier studies (Kohlberg 1973), Gilligan found women did not appeal to general principles or make categorical assertions about right and wrong. Instead, they focused ‘on the limitations of any particular resolution and describe[d] the conflicts that remain.’ (Gilligan 1982, 22) This seeming indecisiveness resulted from their perception of many conflicting responsibilities: to their family members, to their friends, to themselves, and to those more distant. Paradigmatically, Gilligan described ‘Amy,’ a subject who saw the world as ‘a narrative of relationships that extends over time’ in ‘a world that coheres through human connection rather than through systems of rules.’ (1982, 28–9) This contextually-embedded and relationship-oriented approach has driven care ethicists ever since.

But care ethicists are not just concerned with ‘what women think.’ Instead, they believe their theory can -- indeed, should -- guide all of us in moral decision-making, regardless of our gender and the particular dilemmas we face. Through reflection on the lived reality of ethical decision-making, care ethicists are led to the following ideas: that responsibilities derive from relationships between particular people, rather than from abstract rules and principles; that decision-making should be sympathy-based rather than duty- or principle-based; that personal relationships have a value that is often overlooked by other theories; that at least some responsibilities aim at fulfilling the needs of vulnerable persons (including their need for empowerment), rather than the universal rights of rational agents;

and that morality demands not just one-off acts, but also ongoing patterns of actions and attitudes. Most importantly, care ethicists believe morality demands ongoing actions and attitudes of *care*, in addition to (or even in priority to) those of respect, non-interference, and tit-for-tat reciprocity -- which care ethicists see as over-emphasised in other ethical theories. Importantly, though, care ethicists do not claim that other theories get nothing right: care ethics is not a theory of the *whole* of ethics or morality, but of important parts of it that have been inadequately appreciated by other theories. (Engster 2007, 61–2; Held 2004, 65, 68; Tronto 1993, 126).

This essay aims to crystallise the care ethical cluster of ideas, by describing, refining, and defending four key claims that constitute the central pillars of the theory.

## 1. Scepticism about Principles

### 1.1 Deliberation and Justification

Care ethicists view principles as insufficient at best -- and distortive at worst -- for proper ethical deliberation. We can think of principles as conditionals (“if, then” statements) with an imperative (“do this”) in the “then” slot. Principles include: “if you’ve made a promise, then keep it”; “if you can save someone’s life at low cost, then save their life”; “under all circumstances, don’t murder.” Care ethicists object that these generalise too much. The reasons you should keep a promise, or save someone’s life, or even refrain from murder, are always unique to particular circumstances. We can’t capture all those unique details in a general “if” or “under these circumstances” clause.

Care ethicists’ ideas here can be divided into two camps: those regarding *deliberation*, and those regarding *justification*. Deliberation refers to the *procedures* we use when making ethical decisions. Justification refers to the outside-the-mind *reasons* why someone should do

this-or-that. For example, suppose I can easily save a toddler from drowning in a shallow pond. When it comes to deliberation, I might just think: “The toddler’s drowning! Act!” This is a sensible method of deliberation in the circumstances. But the method of providing a justification for my action will be quite different: my justification might refer to the value of human life, the fact that I would want someone to save me if they easily could, and so on. These abstract justificatory notions don’t feature in the deliberation, and rightly so.

When care ethicists deride principles, sometimes they’re arguing that we shouldn’t use principles in deliberation. For example, in Selma Sevenhuijsen’s version of care ethics, ‘[m]oral deliberation is ... looking ... at an issue from different perspectives and taking conflicting moral reactions and moral idioms as sources of morally relevant knowledge.’ (Sevenhuijsen 1998, 57; similarly Miller 2005, 139) At other times, care ethicists want to reject principles as justifications. Virginia Held gives the example of honouring one’s parents, suggesting that the (justificatory) reason why a child should honour their father is because their particular father is worth honouring, for reasons that can only be spelled out by describing the details of that relationship over the years, and that cannot be captured in a general “if” clause. (Held, 2006, 79-80; similarly Noddings 1984, 85; Ruddick 1980, 348-9; Tronto 1993, 27) In the next two sub-sections, I will assess care ethicists’ views on deliberation and justification in turn.

## **1.2 Deliberation**

Care ethicists are surely correct that wholly principle-based deliberation is not always best. As Ornaithe O’Dowd puts it: if a child is drowning in a river, then ‘sitting down by the riverbank to stroke one’s chin and ruminate on a particularly thought-provoking passage from [Immanuel Kant’s] the *Metaphysics of Morals* is hardly justifiable...’ (2012, 419) Not only

that: if we went through life with principles always explicitly in mind, we would miss out on a lot of what's valuable -- human connection, sympathy, and spontaneity, for example.

This would be irrelevant if there were no alternative to principle-based deliberation. But care ethics offers an alternative: sympathy. This involves appreciating someone else's situation from their perspective, and being moved to help them because of what one sees from that perspective. This requires giving full attention to the person, while attempting to see the world as *they* see it from their perspective -- not to see the world as *you* would see it, if you were in their situation.<sup>1</sup> (Kittay 1997, 236; Noddings 2010, ch. 2; Sevenhuijsen 1998, 62) This allows you to know better what they need or want, why they need or want that thing, and how you might help them get it. It forces you to remove your self-interested goggles in approaching life. It is worth quoting Virginia Held at length on this:

Kant famously argued that benevolent or sympathetic feelings lack moral worth; only the intention to act in accord with the moral law required by reason is morally rather than merely instrumentally of value. ... Such theories miss the moral importance of actual, caring relations. They miss the importance of the emotions for understanding what we ought to do, and for motivating our morally recommended actions. Without empathetic awareness, one may not be able to meet another's needs in the way morality requires. Without feelings of concern, one may not take responsibility for responding to those in need. To the ethics of care, morality is less a matter of rational recognition and more a matter of taking responsibility for particular other persons in need. (Held 2014, 109)

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<sup>1</sup> For present purposes, 'sympathy' and 'empathy' can be treated synonymously, though there are subtle distinctions that are relevant for other purposes.

Care ethicists often contrast this sympathetic mode of deliberation with a principle-based mode. For example, Nel Noddings says '[i]t is not just that highly mathematicized schemes are inevitably artificial ... but they tend to fix our attention on their own gamelike quality. We become absorbed in the intricacies of the game instead of the plight of real people' (Noddings 2002, 60). Something is clearly lost in the deliberation Noddings describes. But should we deliberate with absolutely *no regard* for principles? Can't we have *both* principles *and* sympathy in our deliberation? Indeed, there are at least three reasons why care ethicists can, should, and sometimes do preserve some role for principles in deliberation.

First, principles are *compatible with sympathy*. Moral philosophers of all stripes give a role to sympathy in deliberation -- alongside principles. Most obviously, virtue ethics give sympathy a central deliberative role, though the theory also includes principles or 'virtue-rules' (Hursthouse 1999, Part II). Virtue ethics is the mainstream theory most similar to care ethics -- some even see care ethics as a species of virtues ethics (Slote 2007), though this is a minority position. So care ethics can draw on this. Likewise, sophisticated consequentialists claim that deliberators should go back-and-forth, as circumstances allow, between an 'indirect' sympathy-based deliberation and principle-based deliberation (Railton 1984; Driver 2005 on connecting this to care ethics). Care ethicists themselves have argued that Kantian ethics is consistent with a sympathetic approach to moral practice (Miller 2005; O'Dowd 2012). In sum, a combination of sympathy and principles is recommended by a range of mainstream ethical theories. Care ethicists can follow suit -- and some already have.

Second, principles are *informative*. Sometimes, the results of sympathy are unclear or indeterminate: sympathy pulls you towards this person, and towards that person, with seemingly equal strength. Which one should you help? In such situations, conscientious carers need general principles to determine whose interests come first. Often, these decisions are made by likening the current situation to previous ones. This likening can occur only by

referring to general features that the situations share. Recognizing these general features, and reacting to them consistently, brings order to our judgments: '[t]o argue that no two cases are ever alike is to invite moral chaos.' (Held 1987, 119)

Third, principles sometimes *rightly overrule sympathy*. Consider parents engaging in 'tough love,' policymakers who must prioritise after funding cuts, or nurses deciding how to divide their time amongst patients. Here, principles serve to constrain the effects of sympathy. Sympathy is intentionally put to one side, in order to do what is best overall. This is in part because engaging in sympathy -- considering another's situation from her point of view -- sometimes blinds us to other morally relevant features of the situation.

In sum, we should endorse sympathy in deliberation, but not at the complete exclusion of principles. That is the most that care ethicists can credibly claim -- but they are right to claim that much.

### **1.3 Justification**

If we grant a role for principles in deliberation, this might just be because they are useful 'rules of thumb.' If so, principles might have no role in *justifying* moral decisions. Along these lines, Noddings and Joan Tronto -- two prominent care ethicists -- both suggest that any principle general enough to be true will be too broad to be a full justification of particular actions. Noddings considers the principle 'always act so as to establish, maintain or enhance caring relations' (2002, 30). Tronto considers the principle that 'one should care' (1993, 153). They use these principles to demonstrate the *emptiness* of true, general, and universal principles for care ethical justifications of actions. Crucially, though, these unconditional principles are viewed by their authors as *true*. They are just not very rich justifications, since they don't say anything about why we should care.

This raises the question: are there rich principles of justification that ring true to care ethics? Yes. Here are three examples from the literature. First, Eva Feder Kittay's 'principle of social responsibility for care': '*[t]o each according to his or her need for care, from each according to his or her capacity for care, and such support from social institutions as to make available resources and opportunities to those providing care, so that all will be adequately attended in relations that are sustaining*' (1999, 113, emphasis in original). Second, Daniel Engster's 'principle of subsidiarity': 'we should shift the actual delivery of care whenever possible to the most local and personal levels. We should care for others whenever possible by enabling them to care for themselves.' (2007, 58) Third, my own 'dependency principle': when an important interest is unfulfilled, and you're capable of fulfilling that interest, and fulfilling the interest will be not too costly, then you have a responsibility to fulfil the interest. (Collins 2015, ch. 6) In short, some principles are empty and uninformative, while others are not. Informative principles might have a justificatory role within the best version of care ethics -- we should leave this as an open possibility.

#### **1.4 Conclusion: Claim 1**

A key care ethical insight is that sympathy and direct attention to concrete particulars are important in deliberation. I have suggested that principles should also have some role in deliberation, and that care ethicists *can* preserve a place for principles in justification (though I haven't here argued that they *should* do this). We thus arrive at:

*First Claim of Care Ethics.* Deliberation should include sympathy and direct attendance to concrete particulars.

## 2. Personal Relationships

### 2.1 Three Claims about Relationship Importance

Care ethicists greatly value personal relationships, that is (roughly), relationships that are not formally contracted, that depend on a shared history (and/or predicted future) between the participants, and that are valued non-instrumentally by the participants. In personal relationships, participants tend to take one another's interests as their own: it is good *for me* when something good happens to my relative. Examples of such relationships include parents and children, siblings, friends, and spouses.

Care ethicists make three claims about personal relationships. First, personal relationships are paradigms for the rest of morality. We should take the same kind of attitude -- sympathetic, compassionate -- to everyone that we naturally take to personal relatives (even if not the same extent). (Noddings 2002, 2, 29; 2010, ch. 3) Second, some of the most morally valuable actions and attitudes are those that value, preserve, or promote personal relationships. (Clement 1996, 15; Held 1987, 126; Noddings 1999, 3; Tronto 1993, 78) Third, some of the responsibilities that we have to all persons are weightier when had to personal relatives. (Kittay 1997, 234; Bubeck 1995, 229-236)

Common-sense accords with these claims. Imagine a person who does not visit his lonely mother in a rest home, despite living nearby. We think that (a) this might indicate a general moral ineptitude; (b) he has more reason to value, preserve, or promote his relationship with his mother than his relationship with other lonely rest home residents; and (c) his responsibilities to visit his mother are weightier than any such responsibility he might have to other lonely residents.

But care ethicists do not think that the three claims of relationship importance apply to *all* personal relationships. Many relationships are abusive or disrespectful to participants, despite having the general characteristics of personal relationships mentioned above -- simply

consider abusive spousal relationships. So we need to specify the relationships to which the three claims apply.

## 2.2 Which Relationships?

One option is to say that the claims of relationship importance apply to those personal relationships that are valued by their participants. However, participants are not always good judges of whether personal relationships are worthy of emulation, preservation, and special attention. Taking this option would mask the power dynamics that limit some people's abilities to properly assess their relationships' value -- most notably children, and in many societies women. Relationships so strongly inform our values, and do this in such a slow and creeping way, that it seems impossible to trust our own judgments of their value. Often, we're too enmeshed in them to judge. (Minow and Shanley 1996)

A second option suggests that the social community -- and its norms, expectations, and so on -- could mark out the valuable relationships. But this gives too much power to norms and tradition, and not enough to marginalised voices, such as those of women and subordinated cultural groups. And if marginalised voices are given input, then we may be left with disagreement within the social community about which relationships are valuable. We would be left in a stalemate.

We can begin to resolve this by noting an assumption here: the assumption that 'relationships are sources of moral importance.' This is suspect. More plausibly, relationships -- similarly to food, shelter, and security -- are valuable in virtue of how they affect *persons* (Pettit 1997, 155). The relationship is not the thing *for the sake of which* we should take the claims of relationship importance to be true. Rather, we should take them to be true for the sake of the *people* in relationships.

Following this, I suggest the claims of relationship importance apply to all and only those personal relationships that have ‘value to’ their participants. The idea of ‘value to’ a person includes a subjective aspect: part of what adds value to a relationship is that participants *take* the relationship to be valuable to them. One might object to this, since, it seems, an abusive relationship’s value is not enhanced by the fact that the abused participant *takes* the relationship to be valuable. But we can acknowledge the minimal value the subjective aspect adds in this case, while emphasising that the subjective aspect does not exhaust a relationship’s value to its participants. Another part of what adds value to a relationship is that the relationship is in fact life-enhancing for them, whether they take it to be or not. This is the objective aspect. In an abusive relationship, the objective *disvalue* greatly outweighs the subjective value, so that the relationship is disvaluable overall.

Why adopt this view of the relevant relationships? A powerful reason relates to the scope of care ethics. Contemporary care ethicists deny that their theory applies *only* to personal relationships. They instead emphasise that the responsibilities of care ethics are global: we have them to those at a great distance from us (Engster 2007; Held 2006; Kittay 2005; Miller 2010; Robinson 2011; Ruddick 1989). This has resulted in a tension within care ethics: on the one hand, personal relationships are still seen as important in the three ways outlined earlier. On the other hand, non-personal relationships are recognised as sources of imperatives to care. How can care ethicists account for the latter imperatives?

They can do it by saying that the importance of *any* relationship -- personal or non-personal -- is determined by that relationship’s value to the individuals in that relationship. When our relationships to distant others have high value to us and to them, these non-personal relationships are moral paradigms, are worthy of preservation, and give rise to weighty obligations. The first two claims of relationship importance -- that the relationship is

a paradigm and ought to be preserved -- are true to the extent that the relationship is of value to participants.

For the last kind of relationship importance -- that the relationship is a source of morally weighty duties -- the story is more complicated. Here we want to say that a relationship that has *negative* value to its participants -- such as an exploitative relationship -- might give rise to weighty duties. Care ethicists do not disagree with this. But these are not duties of *care ethics*. Recall that care ethics is not a theory of the whole of morality. Morality includes duties that arise out of harming others, out of receiving benefits, out of making promises and contracts, and so on. It also includes duties not to interfere with others. These are all important duties -- but they are not duties of care ethics. Neither are the duties that arise out of non-valuable relationships.

That said, the exaltation of 'relationships that are valuable to participants' gets us a wider range of duties than might first meet the eye. This is because the claims of relationship importance -- in particular, the second one about relationships being valued, protected, and promoted -- properly apply not just to relationships that *already* have value to participants, but also to relationships that *would* have value to participants, *if* the relationship were formed. If we *could* create a relationship that would have value to participants, then care ethics says we have moral reasons to form -- i.e., promote -- that kind of relationship. Obviously, these reasons need to be balanced against moral reasons of all other kinds, including reasons to care for oneself. And -- given what I said above about globalising the theory -- *personal* relationships aren't the only kind of relationships that are relevant here. If we could form a 'relationship' with an impoverished person that involved us contributing to institutional arrangements that benefited that person, and if that relationship would have value to them and/or us, then we have moral reason to form that relationship. This is part of promoting valuable relationships.

The suggestion, then, is that the importance of *any* relationship -- actual or potential -- is determined by that relationship's value to the participants. The special role of personal relationships within care ethics -- as embodied in the three claims of relationship importance - - is explained by personal relationships' high value to participants. But these are not the only relationships we should emulate, promote, and respond to. This interpretation allows us to exclude abusive personal relationships from being valuable, and, perhaps most importantly, to make sense of how we can globalise and institutionalise the demands of care ethics: we have moral reason to create all sorts of valuable relationships, even over long distances or mediated by institutions. In some cases, relationships can give rise to duties in other ways -- such as if the relationship is exploitative -- but this is not part of care ethics.

### **2.3 Conclusion: Claim 2**

Care ethicists generally agree that personal relationships are moral paradigms that ought to be preserved and that generate weighty responsibilities. I suggested that we identify the relevant relationships by asking whether they have value to their participants. So we get Claim 2 of care ethics:

*Second Claim of Care Ethics.* To the extent that they have value to individuals in the relationship, relationships ought to be (a) treated as moral paradigms, (b) valued, preserved, or promoted/formed, and (c) acknowledged as giving rise to weighty duties.

### **3. Caring Attitudes**

#### **3.1 What Are Caring Attitudes?**

Unsurprisingly, care ethics calls upon agents to care. Care is multi-faceted. We can care about something -- pay attention to it, emotionally invest in it, worry about it. We can care for something -- tend to it, nurture it, help it thrive. We can take care around something -- make sure it isn't disrupted, ensure it is left to go on without our interference. We care through directing our thoughts, through one-on-one interactions, through coordinated action with others, by supporting other carers, and by contributing to institutions that care. Care can last a minute or go on for decades. It occurs on a multitude of levels, from the individual to the global. I'll divide care into two basic kinds: caring attitudes and caring actions. Some care ethicists run these together (Tronto 1993, 108; Held 2004, 60; Ruddick 1980, 348), but I will demonstrate that they each have value of their own. The present section focuses on attitudes, while Section 4 focuses on actions.

What are caring attitudes? In brief, to 'care about' something is for it to matter to you -- and for your emotions, desires, decisions, and attention to be influenced by how you believe things are going with it. The possible objects of caring attitudes are numerous: we can care about someone, something, some place, or some time. We can care about types or tokens: we might care about a type of thing ('interests'), or a type of person ('individuals with interests'). We might care about a type of event ('volcanic eruptions'), a type of state of affairs ('poverty'), or a type of property ('being ill'). Or we might just care about a particular token -- a particular individual with interests, a particular volcanic eruption, a particular illness of a particular person, or similar. This type-token distinction matches onto a distinction made by Michael Slote and Virginia Held (respectively) between 'generalised' (type-focused) and 'specific' (token-focused) caring attitudes. (Slote 1999, 2-3; Held 1993). Caring can be positively valenced (a pro-attitude, e.g., 'I care about scientific discovery, so I

want it to continue') or negatively valenced (a con-attitude, e.g., 'I care about human rights abuses, so I want them to discontinue'). For you to genuinely not-care about something, you have to be entirely indifferent to it ('I don't care about what we have for dinner'). In short, caring attitudes are everywhere, and are easy to hold.

But presumably care ethics calls upon agents to have only those caring attitudes that are *morally valuable*. Which caring attitudes are these?

### 3.2 Morally Valuable Caring Attitudes

Plausibly, caring attitudes are like relationships: valuable in proportion to their value *to persons*. That value might lie in the attitude's being instrumental to a person's wellbeing, being partly constitutive of their wellbeing, or simply being a valuable attitude to them or for them, independently of their wellbeing. Thus caring attitudes have only *extrinsic* value -- they are valuable in virtue of their relation to something else -- but this doesn't mean that it only has *instrumental* value -- that it is valued only as a means to some further end. Rather, caring attitudes might be non-instrumentally (but extrinsically) valued as *manifestations* of love, kindness, forgiveness, or so on -- where these goods are intrinsically valuable to persons.

Care ethicists, though, are particularly concerned with caring attitudes that fulfil persons' needs (Bubeck 1995, 132; Engster 2007, 48; Held 2006, 10, 39; Kittay 1999, 133, 233; Miller 2010, 141, 150; Noddings 2010, ch. 7; Sevenhuijsen 1998, 60; Tronto 1993, 137–141). Needs are the most basic or vital constituents of, or means to, a minimally decent life. Should we *restrict* morally valuable instances of caring attitudes to those that fulfil needs? I suggest not. There may be a *stronger*, or *more urgent*, moral imperative to fulfil needs than other interests. But this does not exclude imperatives to fulfil less basic, urgent, or important interests. It is just that these imperatives will be of a weaker strength.

One plausible view of caring attitudes' moral value, then, is this. Morally valuable caring attitudes have as their object something that has, or that might affect something that has, interests, where the caring about is a pro-attitude to the fulfilment of those interests. This is consistent with us caring about things without interests, though such caring has no moral value. It is also consistent with us caring about things without interests (like medicine), where that caring has moral value, if the caring is nonetheless a pro-attitude to the fulfilment of interests (like the interests of people who need medicine). So, this is not to say that morally valuable caring attitudes are necessarily a positive response *to the object* of the caring. For example, to have a negative attitude to human rights abuses -- that is, to be invested in such abuses discontinuing -- is to respond positively to the interests of beings (humans) that are affected by that object. Caring about human rights abuses in a negatively valenced way is morally valuable.

But can mere attitudes really be morally valuable? To answer this, imagine an aged father, Frank, who needs to have his house maintained. In one scenario, Frank's child, Sean, does this out of a personal, deep, long-lasting attitude of care for his father. In another scenario, a social worker, Wanda, does this because she's getting paid. Wanda cares about Frank to some extent -- she wouldn't like to see Frank hurt. But Wanda's care doesn't affect her emotions, decisions, desires, attention, and so on nearly as much as, or in the way that, Sean's affects his. Wanda doesn't have the same kind of, or extent of, caring attitudes. Plausibly, Sean's assistance has value to Frank that Wanda's assistance does not.

How can we explain this? First, a caring attitude can be instrumentally valuable, by enabling attention to detail that generates knowledge of this particular person's interests and a motivation to fulfil those interests. Second, the caring attitude might have non-instrumental value, due to the attitude's relation to a fact whose truth they indicate -- in this case, the fact that Sean loves Frank. Sean's attitude could have this value despite the fact that Wanda is

equally disposed to recognise Frank's needs when they arise, equally recognising of the specificity of his needs, just as motivated to fulfil them (though motivated in a different way, i.e., money), and equally aware of the desirability of fostering caring attitudes within herself. This is not to say that Wanda's attitude is not caring: Wanda does take a pro-stance towards the fulfilment of Frank's interests. But our concern is the *moral value* of the two caring attitudes. Sean's attitude fares better in this regard.

We are now in a position to more carefully characterise the kinds of attitudes that are called for by care ethics. These are attitudes that (i) have as their object something that has interests, or something that might affect something that has interests; and that (ii) are a positive response (e.g. promoting, respecting, revering) to those interests; and that (iii) lead the agent's affects, desires, decisions, attention, or so on to be influenced by how the agent believes things are going with the interest-bearer. Clauses (i) and (ii) derive from the moral value of caring attitudes. Clause (iii) ensures that the attitude is one of caring, as characterised in the previous sub-section.

### **3.3 Responsibilities for Attitudes?**

An objection arises: attitudes -- and particularly the desires, emotions, and so on that might constitute, cause, or result from those attitudes, and generate their moral value -- seem not to be under our voluntary control. It seems we can only have responsibilities to do things that are under our voluntary control. So, care ethics cannot say that we 'should' have caring attitudes.

In reply: we can, in many circumstances, bring ourselves to have caring attitudes, including their motivational and emotional aspects. We do this by consciously attending to the reasons we have to care about something, downplaying the reasons against caring about the thing, or simply acting as if we care about the thing (with the aim that such actions will

produce the attitude). And even if this is impossible, we can exercise long-term cultivation of dispositions and capacities to experience care emotions -- so that the statement “you ought to care about suffering” (say) would translate into “you ought regularly to attend to others’ suffering, do your best to ignore other demands on your attention, place yourself in environments where suffering presents itself, remember or imagine yourself suffering...” and so on. This is perfectly intelligible.

### **3.4 Conclusion: Claim 3**

The attitude of care comes in many forms. Care ethics calls for those forms that have moral value, which, I have suggested, are those that are positively oriented towards interests. We now have:

*Third Claim of Care Ethics.* Agents should have caring attitudes, that is, attitudes that: (i) have as their object something that has interests, or something that might affect something that has interests; and that (ii) are a positive response (e.g. promoting, respecting, revering) to those interests; and that (iii) lead the agent’s affects, desires, decisions, attention, or so on to be influenced by how the agent believes things are going with the interest-bearer.

## 4. Caring Actions

### 4.1 What Are Caring Actions?

In addition to having attitudes, we care by performing, practicing, or giving care. I will use the phrases ‘caring for’ (as opposed to ‘about’), ‘giving care,’ and ‘taking care of’ synonymously, to refer to actions of care. This includes actions that intend to leave alone, or not disturb, the thing we care for.

Caring actions differ from caring attitudes in a number of ways. First, the range of possible objects is smaller. One does not *care for* a type of event (‘volcanic eruptions,’ ‘human rights abuses,’ ‘scientific discoveries’), or a type of state of affairs (‘poverty’), or a property (‘having AIDS’). We might care for (as well care about) those who are *affected* by volcanic eruptions (human rights abuses, scientific discoveries, having AIDS), but then we are not caring for these things themselves. Also, care as an action is not open to a ‘pro’ and ‘con’ reading: to care for something is always to respond positively, rather than negatively, to that thing. And minimally caring actions are more costly to realise than minimally caring attitudes. While we care about anything we are not indifferent to, caring for something requires intentional actions or omissions.

Specifically, caring actions are intended in the manner ‘trying to do what I believe is good for this thing.’ Why just ‘trying’ and ‘what I believe’? Consider a child who keeps a rock wrapped up in a blanket, carries the rock around with him, asks people to be quiet when he believes the rock is sleeping, and so on. He is asked whether he is caring for the rock, and he answers affirmatively. Does he actually care for the rock? He at least intends to. He intends to look after the rock, tend to it, enable it to live well, and so on. In short, he does what he believes is in the rock’s interests.

I suggest that the boy does, in fact, care for the rock. He just does not do it very well. It is often difficult to distinguish doing something badly from not doing it at all. If I get out

paints and use them to represent the bird outside my window, then I am painting the bird even if the painting is unrecognisable as a bird. In such cases, my intentions (along with, perhaps, social conventions) are key to determining whether I am painting the bird. For caring, I suggest, it is *all* in the intentions. To care for someone is to do what you believe is in the interests of that thing -- even if that thing, in fact, lacks interests, or even if you are incorrect about their interests. (Importantly, this is what it takes for an action to be *care* as opposed to *non-care*, not what it takes for an action to be *good care* as opposed to *bad care*.)

The intention is not a very strict condition. The carer need not consciously entertain their intention as 'doing what I believe is in the recipient's interests' and they need not have a full-blown concept of interests. They just need an implicit belief that the action is good for the recipient in some way. Children, for example, can perfectly well care for their parents, without a hint of reflection on the fact. Moreover, fulfilling the person's interests need not be the final intention of the carer -- the care can be intended to be instrumental to some other aim. Consider our social worker Wanda, who intends to fulfil Frank's interests only as a means to a paycheck. She cares *for* Frank, despite not caring much *about* Frank.

As a result, I will use the following definition of caring action (to be distinguished, in the next sub-section, from *morally valuable* caring action):

an action is caring if and only if it is performed under the (perhaps tacit) intention of fulfilling (or going some way to fulfilling) interest(s) that the agent perceives some perceived moral person (the recipient) to have.

## 4.2 Morally Valuable Caring Actions

The above definition is broad, and allows more specific definitions to be used for specific purposes. In particular, we should whittle this definition down so that it specifies only those caring actions that are called for by care ethics, that is, the morally valuable caring actions.

In defining caring action, I talked only about the *intentions* and *beliefs* of the caregiver. These things enhance moral value. But the *effects* matter greatly. Take the boy and his rock. The boy's actions do not fulfil any interests of the rock. The rock does not *have* any interests. The boy's actions are caring. But they have less moral value than if the rock had interests that were being fulfilled. Effects matter.

One might object as follows. Imagine you and I each stumble upon injured dogs. We each attempt to drive our dog to the nearest vet. While your dog reaches the vet in time and is healed, I get caught in traffic and arrive five minutes too late. It seems odd, one might think, to say that your action is more valuable than mine. Your action had better effects, but this seems irrelevant for the *moral* assessment of the action.

However, we should distinguish: (i) the sources of an action's moral value, (ii) the conditions under which an agent morally ought to perform the action, (iii) the conditions under which the agent should be praised or blamed for performing the action. You and I deserve equal praise for our dog-saving efforts. And assuming that I couldn't reasonably have known about the traffic, we each had an equally weighty reason to do what we could for our respective dogs. But it is nonetheless true that your action was more valuable -- was better care -- than my action, through no fault of my own. That is to say, when we are retrospectively assessing the value of an action (as opposed to prospectively assessing whether the action should be performed, or retrospectively assessing the praiseworthiness or blameworthiness of the agent), its actual effects matter, alongside intentions and beliefs.

Additionally, some effects matter more than others. This point is frequently made by care ethicists, who, as we have seen, focus on persons' *needs*. While care might be directed at fulfilling any interest -- however trivial -- care will have value if it fulfils a more vital, important, or compelling interest (a need). By allowing that care is more valuable if it fulfils interests -- and even more valuable if it fulfils the *most important* interests -- we are able to avoid the 'paternalism objection' to care ethics. This is the objection that care ethicists endorse actions that patronise, belittle, or otherwise undermine the autonomy of the care recipient -- by fulfilling interests that are trivial, or not the ones the care recipient wants fulfilled. For morally valuable caring actions, it is not enough that the action is *intended* to fulfil important interests: to be valuable, the care must *actually* fulfil important interests. In many cases, these will be the interests *the recipient themselves endorses*, including empowerment, autonomy, independence (insofar as this is ever possible), and so on.

I suggest the following, then, about morally valuable caring actions. The *moral value* of caring action is a function of (1) how well that action fulfils the recipients' interests (where needs are more important than other interests), and (2) the strength of the agent's intentions to fulfil the recipient's interests. (2) is separable from (1). An action can be caring despite having little moral value, just as long as it has the right intentions (i.e. fulfilling perceived interests). Above this threshold, a caring action can have more or less moral value, as a function of (1) and (2).

#### **4.3 Conclusion: Claim 4**

Caring actions are actions performed with intentions to fulfil interests. These actions are morally valuable in proportion to the strength of the intention and the goodness of the effects. That is:

*Fourth Claim of Care Ethics.* (i) Agents should perform actions that are performed under the (perhaps tacit) intention of fulfilling (or going some way to fulfilling) interest(s) that the agent perceives some moral person (the recipient) to have; (ii) the strength of this ‘should’ is determined by the moral value of action, which is a function of the strength of the intention, the likelihood that the action will fulfil the interest, and the extent to which the interest is appropriately described as a ‘need.’

## Conclusion

These four claims are merely the *normative* claims of care ethics. Many care ethicists make *descriptive* claims that support their overall outlooks. For example, many care ethicists endorse a relational view of autonomy, according to which autonomous plans, projects, and purposes are inseparable from, and hugely influenced by, those around us. Many care ethicists emphasise that the world of ethics is constituted by complex webs of relationships between fragile, embodied human beings. With the four key normative claims now on the table, it is easy to see how they might arise out of a deep appreciation of these descriptive claims. But the four key claims are what make care ethics a *normative* ethical theory.

Although moral theorists who do not call themselves care ethicists may endorse the four claims, the claims are unlikely to be the central or most important parts of non-care ethical theories. Non-care ethicists are unlikely to be interested in intricately analysing actions of *care* in particular, or in vindicating sympathetic modes of deliberation in particular, as a central part of their theoretical edifice. It is the combination of these claims, and their status as the most important normative aspects of the theory, which makes care ethics distinctive.

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