The Ethics of Care as a Normative Ethical Theory

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Abstract

This chapter argues that the ethics of care is a distinctive normative ethical theory. The chapter begins with a brief outline of care ethics' moral epistemology and methodology. It then illuminates care ethics' relation to three prominent normative ethical traditions: contractualism, consequentialism, and virtue ethics. As will be shown, care ethics has similarities to, and differences from, each of these normative ethical theories. The chapter then clarifies the status of care ethics as an 'incomplete' normative ethical theory. Finally, the chapter explores the somewhat fraught relationship between care ethics and feminist philosophy, arguing the care ethics can assist in certain feminist goals.

Keywords

Care ethics, feminist philosophy, contractualism, consequentialism, virtues, principles, intimate relationships

Introduction

The ethics of care is usually given just a passing mention in contemporary discussions of normative ethics. This mention is sometimes folded into virtue ethics (as in early editions of James Rachels's widely-used textbook *The Elements of Moral Philosophy* (e.g. Rachels 2002)) and sometimes folded into feminist ethics (as in *The Stanford Encyclopedia of Philosophy*, in which care ethics has no standalone entry but receives a brief critical discussion in the 'Feminist Ethics' entry (Norlock 2019)). The result is that many analytic philosophers have a forgivably hazy idea of what care ethics is about.[1] Isn't it something about mothering, plus something about kindness, plus something about our nearest and dearest? I think the answer is 'not centrally.'

My goal in this chapter is to present care ethics as a normative ethical theory that is distinct from contractualism, consequentialism, and virtue ethics.[2] I will present a version of care ethics that has important similarities to, and differences from, each of these other traditions. I proceed by explicitly comparing care ethics with each of these other traditions, using the concepts and terminology commonly used by their proponents.

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[1] That said, the concept of 'care' has gained traction in analytic philosophy—for example, in Stephen Darwall's work on the metaethics of welfare (Darwall 2004) and Harry Frankfurt's work on responsibility (Frankfurt 1988). Neither of these address care ethics as a normative ethical theory.

[2] I focus on contractualism, rather than other versions of deontology like Kantianism or Rossian intuitionism, because I find care ethics' similarities to, and differences from, contractualism to be particularly illuminating of care ethics' structure. That said, in my rendering, care ethics is distinct from these other deontologies, too: unlike Kantianism, care ethics does not analyse what's right in a context in terms of what is universalizable; unlike Rossian intuitionism, care ethicists take relations to be fundamental to moral explanation. These aspects of care ethics will be explained later in the chapter.

Before doing that, it will help to characterise care ethics in its own terms. Care ethics starts from a particular vision of human life, on which humans are inevitably entangled in webs of dependency relations. In short, we all depend on others in numerous ways and have others who depend on us in numerous ways. Our dependence is most evident when we are infants, children, ill, disabled, or elderly. But all humans are dependent, all the time, since we all depend on others for adequate nutrition, shelter, social connection, and safety; as well as for more optional kinds of support and assistance. Care ethics' core normative claim is that the fact of human dependence gives rise to moral imperatives: those who are dependent require *care* from those on whom they depend. The result is that we are all owed care from particular others (those on whom we depend) and we all owe care to particular others (those who depend on us). This 'care' includes attitudes, actions, habits, practices, dispositions, and so on: almost all manifestations of our agency can be (or fail to be) caring. Moreover, care is 'political' as well as 'personal': care requires institutional structures and collective actions, not just intimate relations and dyadic transactions. In the broadest terms, care is a response to others that aims to fulfil their important interests, especially interests that are appropriately described as 'needs.' This includes others' needs for autonomy and empowerment, which is important for avoiding problematic paternalism. We also can—indeed, are morally required to—give care to ourselves, which is important for avoiding problems of over-demandingness. I will elaborate other features of care ethics in what follows.

Due to space constraints, I will largely limit myself to elucidating the above-outlined version of care ethics. I will not argue that this is the received, or typical, version of care

ethics—still less that it is the best version of care ethics.[3] And I will be concerned to frame care ethics as a normative *ethical* theory. I will therefore leave aside care ethics' increasingly prominent status as a normative *political* theory (on which, see, e.g., Ruddick 1989; Held 1993; Kittay 1999; Held 2006; Tronto 2013; Bhandary 2020).

I shall begin with a brief outline of care ethics' moral epistemology and methodology. I then say more to illuminate care ethics' relation to the three normative ethical traditions mentioned above. From there, I move on to clarify the status of care ethics as an 'incomplete' normative ethical theory. Finally, I explore the somewhat fraught relationship between care ethics and feminist philosophy.

1. The Epistemology and Methodology of Care Ethics

Care ethics has long proved difficult to characterise succinctly. In part, this is because of its epistemological and methodological components. Care ethicists often reject general abstract theorising as an approach to moral questions. In particular, most care ethicists are resistant to general moral *principles* (Miller 2005, 139; Sevenhuijsen 1998, 57; Engster 2004, 114; Tronto 2013, 53-55; Meyers 1987, 142; Noddings 1984, 85). This includes general moral principles that one might use to characterise care ethics, such as the principle I suggested above: 'dependence relations produce moral imperatives to provide care.'

That said, some care ethicists do accept that some general principles are true. For example, Nel Noddings proposes "always act so as to establish, maintain or enhance caring relations" (2002, 30) and Joan Tronto advocates "one should care" (1993, 153). But these

[3] Though see Collins (2015), in which I argue that the principle 'dependence relations generate responsibilities' can unify, specify, and justify the range of claims found within the care ethics literature.

authors ‘endorse’ these principles only on the way to making the point that such general principles are useless. Instead, care ethicists often insist that the question of what to do, feel, or judge in a given situation cannot be answered in abstraction from the particular persons—and particular relations—at issue (Ruddick 1992, 152; Kittay 1997, 236; Held 2006, 80; Robinson 2011, 4). This leads to some epistemological and methodological commitments that make care ethics difficult to pin down.

Epistemologically, care ethicists find evidence for moral conclusions not just in their considered cognitive judgments—whether those cognitive judgments concern specific cases or general principles—but (more often and more importantly) in their emotional reactions, embodied sensations, and the ongoing practices of loving relations (Held 1993). The latter kinds of evidence are obviously difficult to verify—or even sometimes discuss—intersubjectively. The result is a potentially solipsistic epistemology, in which evidence and conclusions vary greatly from context to context (see relatedly the chapter on ‘Particularism and Anti-theory,’ this volume). This epistemology makes care ethics something of a slippery character, in terms of its substantive normative claims, principles, or rules.

Methodologically, care ethicists are often more concerned with the contextually-embedded upshots of their theory (what might be called ‘applied ethics’), rather than with the project of neatly formulating care ethics as a theory in ‘normative ethics’ (see, e.g., Barnes 2012; Robinson 2011; Sevenhuijsen 1998; Tronto 2013). This methodological inclination arguably follows from care ethics’ moral epistemology: if the evidence for moral conclusions has a nature that varies incommensurably from context to context (or from person to person), and if the search for ‘general principles’ is therefore a fool’s errand, then ethical theory can hardly be expected to do other than engage in the nitty-gritty of specific lived moral problems.

All of this is to note that care ethics is often taken to be a different *kind* of theory than other normative ethical theories, such as contractualism, consequentialism, and virtue ethics: a somewhat less principled, and somewhat more applied, theory. Thus, there are arguably sound care ethical reasons to be sceptical of the task I have given myself: to present care ethics as a normative ethical theory. Nonetheless, I think the task is worth pursuing, since I believe it can be completed successfully. Indeed, other philosophers have also been concerned to present care ethics as a normative theory—by subsuming it into, for example, Kantianism (e.g., Bramer 2010; Miller 2012), consequentialism (e.g. Driver 2005) or virtue ethics (Halwani 2003; Slote 2007). My goal is to present care ethics not just as *a* normative ethical theory, but as a *distinctive* normative ethical theory: one that cannot be subsumed into other theories. I turn to that goal next.

2. The Distinctiveness of Care Ethics

Care ethics has affinities with each of contractualism, consequentialism, and virtue ethics. Yet, I will argue, it cannot be subsumed under any of these. In this section, I will explain what (in my view) is distinctive about care ethics, in contrast to these three theories.

2.1 Care Ethics and Contractualism

Care ethics can fruitfully be viewed as having closer affinities with contractualism than with consequentialism or virtue ethics. For this reason, I will begin by comparing care ethics with contractualism. Both care ethics and contractualism are *relational* theories: the fundamental basis of moral requirements is found in relations between people. For contractualism, these are relations of agreement or claim-making among (possibly hypothetical) rational and reasonable persons. For care ethics, these are relations of dependence (including relations of symmetrical

dependence, that is, relations of interdependence). Dependence, in this context, is not a matter of reliance or trust. We can be dependent on each other without knowing it and without being disposed to act in any way on that basis. Instead, dependence is a matter of vulnerability: it's a matter of our most important interests being such that they can be fulfilled only (or most effectively, efficiently, or usefully) with certain behaviours or attitudes from the other. These behaviours and attitudes are morally required *caregiving*. .

Care ethics shares with contractualism a concern for the individuality, or distinctness, of the persons who are situated within the relational web—even though the web's thread differs under the two theories (for care ethics, the thread is dependence; for contractualism, the thread is agreement or claim-making). On the care ethical approach, persons are not mere 'value receptacles' (as consequentialism is sometimes accused of viewing people) and the important interests of the few should generally not be sacrificed for the less important (but much more numerous) interests of the many. In this way, care ethics has affinity with contractualism's concern for the separateness of persons. For care ethics, however, the separateness of persons arrives not via a concern with persons' rights or claims upon one another, but rather via a concern with the particularity of persons' needs, which often should not be aggregated.

Another affinity between care ethics and contractualism concerns the possibility of dilemmas. For care ethics, these arise out of the incommensurability of competing responsibilities. For example, one's spouse and one's sibling might each depend on one. Perhaps, on a given occasion, your spouse needs your emotional support while your sibling needs your practical support. Supposing you must choose between them, there may be no straightforward answer to the question of what to do. Even tossing a coin will leave a moral remainder: a requirement for regret or apology to the loved one who losses out. This situation of being torn between two loved ones is, I assume, a familiar one. In such situations, the care ethical approach focuses "on the limitations of any particular resolution and describe[s] the

conflicts that remain.' (Gilligan 1982, 22) It does not insist on practical action-guidance. The particularity of persons' needs, and of one's relationship to them, produces an incommensurability between different responsibilities. For care ethics, the incommensurability arises partly from one's distinctive *relationships* with the two persons, rather than from the persons' *self-standing* statuses as sources of side constraints or moral claims. This is one difference between care ethics and contractualism.

Another difference concerns who is included in the web. Given that care ethics focuses on relations of dependence, it has the resources to respond to a crucial objection to contractualist approaches. The objection is that many persons are (in Eva Feder Kittay's term) "utterly dependent." Kittay describes utter dependents thus:

> …dependency has a number of features that are separable in its lesser forms but inexorably linked in utter dependency … First, the dependent requires care and caring persons to meet the fundamental needs for survival and basic thriving. Second, while in the condition of dependency, the dependent is unable to reciprocate the benefits. And, third, the intervention of another is crucial to ensure the needs of the dependent are met and that the interests of the dependent are recognized in a social context. Dependency so understood underscores not only the limitations of an individual's capability but also the necessary labor of a dependency worker. (1997, 220)

The third of Kittay's features produces the objection to contractualism: utter dependents are unable to ensure that their own interests are recognized; they are unable to represent their own claims in a social context (including a hypothetical context in which agents are agreeing on moral principles). This inability is clearest in the case of infants, children, and adults with severe cognitive impairments. Because of this inability, utter dependents are unable to engage in the process of (hypothetical) rational or reasonable agreement or claim-making, or mutual

justifiability of moral principles. That process is often taken to be central to the contractualist project (e.g., Scanlon 1998; Darwall 2006).

Contractualists, of course, acknowledge this potential objection to their theory. Scanlon writes: "Because of these limitations [i.e., the limited capacities of utterly dependent persons], the idea of justifiability to them must be understood counterfactually, in terms of what they could reasonably reject if they were able to understand such a question. This makes the idea of trusteeship appropriate in their case…" (1998, 185-6; similarly Darwall 2006, 29) Thus, Scanlon suggests, utterly dependent persons can be incorporated into the moral community, where this is understood as the community of persons whose agreement grounds moral principles and the community of persons that bear rights and duties under such principles. Utterly dependent persons can be incorporated into the moral community via trustees.[4]

There are a few problems with this trustee-based contractualist approach to utter dependents, which the care ethics approach avoids. First, not all utter dependents have a trustee. Second, trusteeship gives the wrong kind of reason to be concerned with utter dependents: others owe actions and attitudes to the dependent, not to the trustee; yet trustee-based

[4] A different contractualist approach asks what moral principles people would agree to, given that one of the social positions they might end up occupying is a position of utter dependency. This is closer to Rawls's (1971) view than Scanlon's (1998) view, though Rawls himself did not include utter dependents within the social contract. (For discussion of Rawls and utter dependency, see Kittay 1997; Hartley 2009; Bhandary 2010.) I thank Connie Rosati for raising this. I suspect many care ethicists would worry that any approach requiring rational and reasonable agreement will import ableist assumptions about the realities of utter dependency, given that those making the agreement (or assessing the principles) are not themselves utterly dependent: if the parties to the agreement were utterly dependent, then the assumption that the parties are rational and reasonable couldn't hold. The problem is contractualism's grounding in rationality and reasonableness.

contractualism has a hard time explaining how this could be so, if it's the trustee's agreement that matters for the validity of the principle. Third, trustees will presumably represent dependents' *interests* to others in the moral community (Scanlon 1998, 186)—but contractualism is usually thought to be fundamentally about persons' *claims*, where persons' claims may not neatly align with their interests. In these ways, contractualism's relational ontology (where the relevant relations are agreement or claim-making) does not wholly comfortably encompass utter dependents.

By contrast, care ethics' relational ontology of dependence is centrally concerned with incorporating utter dependents. To the extent that trustee-based contractualism cannot respond to this concern, care ethics is preferable. Of course, I have only briefly examined one prominent version of contractualism, namely, T.M. Scanlon's. Other versions are possible. For example, Christie Hartley (2009) and Asha Bhandary (2010) each make proposals for incorporating utter dependents within contractualist political theory. It's a further question whether these proposals can extend to contractualism as a normative ethical theory.

It's clear how utter dependents can fit into the 'care recipient' side of a dependence relation: as Kittay characterises utter dependents, their important interests are vulnerable to the actions and attitudes of others. Yet it may be less clear whether and how utter dependents fit into the 'care giver' side of a dependence relation. Kittay's work is central here. She argues that those who care for dependents often see their well-being enhanced in the process (e.g., 2005, 468-9). Infants, children, and severely cognitively disabled adults have the capacity to fulfil crucial emotional needs of those that care for them.

Thus, care ethicists claim that their dependence-based relational ontology preserves the separateness of persons and the possibility of genuine dilemmas, while placing utterly dependent persons in a position of equal moral standing to all other participants in the moral

community. An important move here is that care ethicists eschew rationality and reasonableness as the basis of morality, in favour of dependence relations. Does this make care ethics a *better theory* overall than contractualism? That is a question for another day. My aim here is to demonstrate the ways in which it is a *distinct* theory.

2.2 Care Ethics and Consequentialism

Care ethicists, like consequentialists, are concerned with the needs of vulnerable persons. And the imperative to care (which, on the care ethical view, derives from dependence relations) looks like an imperative to produce outcomes: outcomes of need-fulfilment. In fact, one of care ethics' most prominent and earliest proponents, Nel Noddings, has suggested that "care theory is consequentialist (but not utilitarian). It asks after the effects on recipients of our care. It demands to know whether relations of care have in fact been established, maintained, or enhanced, and by extension it counsels us to consider effects on the whole web or network of care." (2002, 30)

I believe this framing does care ethics a disservice. To render consequentialism a distinctive view, I will take consequentialism to be the view that consequences are the *only* thing that (fundamentally) matter. Other normative theories can agree that consequences are *part* of what matter. Care ethics is no different to other non-consequentialist theories on this score: we should ask "after the effects on recipients of our care," as Noddings says. But care ethicists are concerned with values that are independent of consequences, as I'll explain in this sub-section. Thus, care ethicists should not say that consequences are the *only* thing that matters: care theory is not consequentialist, contra Noddings.

Crucial here is exactly how we characterise a 'relation of dependence.' One could argue that consequentialists are concerned with 'relations of dependence': perhaps relations of

dependence can be understood as relations in which some persons are dependent on a deliberating agent for the production of a state of affairs in which the persons' interests are fulfilled, such that the deliberating agent should produce the state of affairs in which the most (or enough) importance-weighted interests are fulfilled. On this type of picture, consequentialists are concerned with dependence relations, just like care ethicists.

But care ethics understands dependence relations differently from this, in two important ways. First, the interests of different dependents should not always be aggregated to determine what the deliberating agent should do, as explained in Section 2.1. Second, care ethics will say that some dependence relations produce reasons of care that cannot be fully explained in terms of the *consequences* that would be produced if those reasons were acted on. A central example to demonstrate this is *intimate* dependence relations. In examining care ethics' views on these relations, we will see the source of the common idea that care ethics is centrally about our 'nearest and dearest.' It is worth pausing on these relations, because intimate dependence relations usefully illustrate care ethics' differences from consequentialism (even though they are just one type of dependence relation amongst many and, therefore, should not be taken as the core of care ethics).

Consequentialism famously has a hard time explaining strong obligations to intimates, just as contractualism famously has a hard time explaining obligations to utter dependents. Care ethics takes strong obligations to intimates as datum, since such obligations are central to the everyday experience of morality. As explained above, care ethicists centre everyday experience in their moral epistemology. However, just as contractualists have used devices (like 'trustees') to produce obligations to utter dependents, so, too, consequentialists have used devices to produce strong obligations to intimates. By 'strong' obligations, I mean obligations to favour intimates: obligations to fulfil the interests of intimates rather than the equally important (or more important) interests of non-intimates. Arguably the most promising

consequentialist device for intimates is ‘sophisticated’ or ‘indirect’ consequentialism (Railton 1984; Jackson 1991). The idea of the sophisticated consequentialist is that, by-and-large, the best consequences are produced if one generally has a practice of favouring intimates; so, one should favour intimates, without thinking too hard about whether that’s what will produce the best consequences on any given occasion. There are some good consequences that can usually be best known, and best promoted, in intimate relationships.

Care ethicists argue that the consequentialist provides the wrong kind of motivation and justification for favouring intimates (Tronto 1993, 105; Held 2006, 80; outside care ethics, the point was made by Stocker 1976, 462; Blum 1980, 142–3). Care ethics says something different: that the nature of intimate dependence relations produces a stronger moral imperative than non-intimate dependence relations in which similarly-valued interests are at stake. In general, the strength of reasons produced by any particular dependence relation is not a straightforward function of the importance of the interests that are at stake in that relation. Instead, the reasons’ strength is also partly a function of the *type* of dependence relation that it is, which is determined by the history, mutual commitment, emotional entanglement, and uniqueness of that specific relation. The weight of reasons produced by different types of dependence relations derives from a source that is not easily incorporated into a consequentialist theory.

The weight of these reasons derives irreducibly from the type of relationship that *already exists* between people—and the fact that these relationships have intrinsic value—rather than from the *consequences* that would be produced if the relationship were treated as a source of weighty reasons. In this, care ethics is more akin to common sense morality than to consequentialism. According to common sense morality intimate relationships are an irreducible source of weighty reasons. Given care ethics’ epistemology (as outlined in Section

1), care ethicists would view this affinity with common sense morality as a virtue of the theory and an argument for the care ethical view of relationships' value.

Concerning *intimate* dependence relations specifically, I have previously argued that care ethics can be understood as making three claims about the obligations these relations produce (Collins 2015, ch. 3). First, intimate dependence relations should be taken as paradigms for morality generally. That is, we should aim to take the same *kind* of attitude—sympathetic, compassionate, concerned—to non-intimate dependents that we take to intimate dependents, even if not to the same extent. Second, some of the most morally important actions and attitudes aim to value, preserve, or promote intimate dependence relations. And third, some of the responsibilities that we have to all persons are weightier when they are had to intimates. Again, these claims accord with common sense morality.

The first of these three claims can arguably be produced via indirect or sophisticated consequentialist reasoning. Perhaps humans are the kinds of creatures who fare best if they take a sympathetic and compassionate attitude to all who depend on them. We naturally take this attitude to intimates. Therefore, we should aim to emulate our attitudes to our intimates in our relations with others. Noddings suggests something like this reasoning when she distinguishes 'natural caring' from 'ethical caring' (2002, 29ff.). For Noddings, natural caring is the caring we perform spontaneously for our nearest-and-dearest, while ethical caring is a more cognitive and detached mode of caring for those we have never met. Noddings suggests that the ideal caring agent works to expand their circle of natural caring. Using this framework, perhaps the attitudes we take to intimates are not special *because* we take those attitudes to intimates. Instead, perhaps those attitudes are special because we would all be better off if we eventually could learn to have those attitudes towards all persons.

I don't believe the preceding paragraph provides a distinctively care ethical justification for the first of the three claims about intimate dependence relations. Instead, the preceding paragraph's justification is most naturally viewed as consequentialist. By contrast, the care ethical justification takes the relevant attitudes to be valuable precisely *because* they are the attitudes that humans naturally take towards intimates. Again, this follows from care ethics' moral epistemology, which pays attention to emotional reactions, embodied sensations, and the ongoing practices of loving relations. Under care ethics, intimate dependence relations produce their own distinctive moral value. This same idea—that intimate dependence relations contain a distinctive kind of value—is also the care ethical approach to the second and third claims above: the claims that some of the most morally important actions and attitudes aim to value, preserve, or promote intimate dependence relations, and that some of the responsibilities that we have to all persons are weightier when they are had to intimates.

Of course, the consequentialist can respond that common sense morality is not the bar at which to judge a normative ethical theory. They can also question care ethics' moral epistemology: isn't impartial cognitive reflection on principles more reliable than embodied reactions to loving relations? Furthermore, consequentialists who support metaethical naturalism might contend that any alleged 'distinctive' value of intimate relationships is mysterious. Addressing these points would take us somewhat beyond the realm normative ethics. Without claiming to refute the committed consequentialist, I believe care ethicists would respond as follows. First, consequentialists' principles are themselves arguably best justified via common sense judgments like 'each should count for one and none more than one.' Second, supposedly 'impartial' and 'cognitive' reflection might encode problematically patriarchal values (see Section 4 on feminist philosophy). Third, the distinctive value of intimate relationships needn't be non-natural (that is, irreducible to non-moral facts). It only need be irreducible to *consequences*, in order to render care ethics distinct from consequentialism.

A final difference between care ethics and consequentialism is that certain motives are often viewed by care ethicists as an essential part of the proper response to dependence relations: when I am dependent on you for the fulfilment of my important interests, you should respond not just with behaviours of interest-fulfilment. You should also react with the motive of compassion, empathy, and concern for me as a particularized creature (e.g., Ruddick 1980; Noddings 1984; Held 1990). An intrinsic concern with motives—particularly emotional motives—is not a natural fit for a consequentialist theory. The consequentialist can be concerned with motives only *instrumentally*, that is, only insofar as certain motives are instrumental to producing good consequences. An *intrinsic* concern for motives is a more natural fit for virtue ethics, which is the final theory to which I will compare care ethics.

2.3 Care Ethics and Virtue Ethics

Virtue ethics is the normative ethical theory most often associated with care ethics (e.g., Slote 1998; McLaren 2001; Halwani 2003). Care ethics does share certain features with virtue ethics. One of these is the resistance to (the usefulness of) abstract principles, mentioned in Section 1. And, like virtue ethics, care ethics places an intrinsic moral premium on having certain emotional responses, in addition to certain deliberative methods or outward behaviours.

Perhaps most importantly, if care ethics is the view that persons live in a network of dependence relations, and that these relations produce moral imperatives to care, then the core demand of care ethics is the demand to *give care*.[5] And, in care ethicists' treatment, care does

[5] One might wonder if there can be a moral imperative to have emotions or attitudes, given that 'ought' implies 'can.' I believe there can (Collins 2015, 60-64). These might be imperatives to act in certain ways, attend to certain facts, recall certain memories, etc—much as a moral

have the appearance of a virtue. For example, in her early influential book on care ethics, Noddings (1984) described care as a matter of "engrossment," in which the caregiver perceives and responds to the care-recipient on their own terms (rather than projecting the caregiver's own interests onto the recipient) and in which the caregiver displaces any selfish motivations in order to act for the care-recipient. This looks like the exercise of a virtue.

Furthermore, the inculcation of caring dispositions looks very much like the inculcation of a virtue. In Noddings' treatment, the caring agent begins with the "natural caring" described above, and then gradually and reflectively uses "ethical caring," in order to gradually expand their domain of natural caring. The ideal (and perhaps never achievable) result of this process is a situation in which the caring agent has spontaneous caring for all those who are vulnerable to them for the fulfilment of an important interest. This is similar to accounts of virtue ethics in which virtue is reflectively cultivated, with the ideal (perhaps never achievable) being a situation in which one spontaneously embodies the virtues without the need for critical reflection.

Even if it's true that the caring agent cultivates their dispositions somewhat analogously to the virtuous agent, it still seems that caregiving is better viewed as an *interpersonal process*, rather than as the manifestation of a *personal virtue*. By viewing caregiving as an interpersonal process, the care-recipient becomes a much more active player in the completion of successful caregiving. On this view of caregiving, care arises out of interactions between the caregiver and care-recipient. This can be contrasted with a view on which care is entirely a matter of certain attitudes and actions on the part of caregiver, wherein the care-recipient is relegated to the role of passive bystander.

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imperative to rescue a drowning child might be an imperative to run to the water, wade in, reach out one's arms, etc.

A version of the 'interpersonal process' view is Joan Tronto's four-stage view of caring. Tronto's formulation makes the care-recipient active in the final stage of successful caregiving—which turns care into more of an interpersonal process than a personal virtue. Tronto's four stages are: (1) attentiveness, a proclivity or disposition to become aware of need; (2) responsibility, a willingness to respond and take care of need; (3) competence, the skill of providing good care to those in need whom one can help; and (4) responsiveness, consideration of the position of others as they see it and recognition of the potential for abuse in care (1993, 126-136).

Tronto's fourth phase can be enriched by including in it what Kittay (2014) calls "the completion of care," which is a stage in which the care-recipient "takes up" and responds to the actions of the caregiver. For an infant, this might mean ceasing to cry. For someone with advanced dementia, this might mean acting at ease. Kittay goes so far as to say that the care recipient has an obligation to receive care graciously, if they are able to bear obligations at all. Somewhat similarly, Virginia Held says that care is "more the characterization of a social relation than the description of an individual disposition, and social relations are not reducible to individual states." (2006, 42) The suggestion from all these thinkers is that successful caregiving actively involves both the caregiver and care recipient. This makes it look less like a personal virtue that's possessed by the caregiver. (For competing definitions of the 'care' at issue in care ethics, see Bubeck 1995, 127; Hamington 2004, 3; Engster 2007, 28.)

Care ethics further differs from virtue ethics—at least in virtue ethics' Aristotelean guise—when it comes to the source of the imperative to care. Again, very broadly, care ethics' imperative to care is arguably less caregiver-focused than its (neo-Aristotelean) virtue ethical counterpart. The imperative to care derives wholly from the relation of dependence that holds between the would-be caregiver and the would-be care recipient. There is no need for the notion of a caregiver's eudaimonia. The success of caregiving derives primarily from its *effects* on

care-receivers and caregivers—which gives it a more consequentialist, and less virtue ethical, flavour.

In sum, care ethics' relational ontology allows the theory to avoid collapsing into either consequentialism or virtue ethics. The guiding requirement of care ethics is not to maximise (or satisfice) the amount of care that there is in the world. Nor is the guiding requirement to be a caring person, where this is understood as justificatorily fundamental. By grounding the requirement to give care in relations of dependence, care ethicists accommodate non-aggregation and the separateness of persons (unlike, arguably, consequentialism) and they ground moral imperatives in relations rather than in facts about the person (unlike virtue ethics). We bear obligations to care in virtue of our standing in relations of dependence. Yet unlike prominent versions of contractualism, care ethics can view utterly dependent persons as full members of the moral community. Furthermore, the ties that bind the community are ties of dependence, rather than ties of hypothetical agreement, as under contractualism. Care ethics is therefore a distinctive normative ethical theory.

3. Are Dependence Relations All That Matter?

In its earliest incarnations, the ethic of care was often contrasted with the ethic of justice (Gilligan 1982; Noddings 1984; Clement 1996; Held 2004, 65, 68; Held 2006, 15–17; Robinson 1999, 23ff; Ruddick 1998; Tronto 1987, 167; though Pettersen 2008, ch. 6 analyses Gilligan's ambivalence towards the distinction). Care ethicists presented justice as emphasising the values of liberty and reciprocity, whereas care ethics emphasised the value of caregiving. Of course, this dichotomy is radically oversimplified. At the very least, the 'completion of care'

described above both respects the liberty of the care-recipient and implies reciprocity between caregiver and care-recipient. What's more, the liberty of caregivers is acknowledged when we see that they are also on the 'dependent' side of at least some dependence relations: care ethical requirements do not infringe the liberty of the caregiver, because the caregiver is also a creature whose important interests generate imperatives of care (including imperative to care for oneself). Conversely, more recent theories of justice focus on relationality (e.g., Anderson 1999).

Yet the dichotomy between care and justice raises the question: does care ethics claim to give us *complete* normative ethical guidance? For example, we might expect a contractualist to ask whether care ethics completely sidelines agreements as sources of obligation; we might expect a consequentialist to ask whether 'impersonal' values (values that do not accrue to any dependent person) can ever be considered by care ethics; and we might expect a virtue ethicist to ask if care ethics can accommodate non-care virtues. Here we are presented with a dilemma: either care ethics is implausible (if it says that dependence relations are all that matter) or care ethics is indistinct (if it says that the values endorsed by other theories also matter).

Virginia Held (2006) has provided one influential response to this dilemma. According to Held, 'justice' ideals may well matter, but they are not the purview of care ethics. Similarly to Held, I suggest that the dilemma is best navigated by presenting care ethics as a matter of emphasis. We needn't view dependence relations as the most important source of moral imperatives (here I depart from Held, who describes care as "the most basic moral value" (2005, 71)). Instead, we can view dependence relations—and the responsibilities-of-caregiving that they give rise to—as just one part of normative ethics, of equal standing to other parts (such as principles demanding that we honour agreements, promote impersonal value, or cultivate virtues such as justice). Care ethics does not give a verdict on how to resolve the conflict among these different aspects of morality. As mentioned in the discussion of

incommensurable trade-offs between different dependence relationships, care ethicists take the view that sometimes all we can do is acknowledge a conflict between competing moral demands.

Despite this potential concession to other theories, it remains true that the care ethical picture has received less airtime than other pictures of normative ethics. For this reason, a care ethicist might legitimately press that we should emphasise dependence relations (and the concomitant imperative to give care)—not because these relations are fundamentally more important than other moral concerns, but rather as a matter of correcting the prior imbalance in the emphasis of analytic normative ethical theory. Not all moral philosophers would want to make this emphasis, so we are not all care ethicists. Nonetheless, one can be a care ethicist while also endorsing a range of values or principles that are not about dependence relations.

On this view of what care ethics is, it is not a complete normative ethical theory. In this way, it differs from contractualism, consequentialism, and virtue ethics. The care ethical idea—'dependence relations generate imperatives of caregiving'—can sit alongside other ideas within one's broader moral picture. These other ideas might concern contribution (e.g., if one has contributed to harm, then one has a duty to provide remedy for that harm) (Pogge 2002); promises (e.g, if one has induced another to rely on one's performing some action, then one has a duty to perform that action) (Scanlon 1998, ch. 7); benefitting (e.g., if one has benefited from an injustice, then one has a duty to compensate the victims of that injustice) (Butt 2007); and so on. These other ideas are distinct from, though compatible with, care ethics.

4. Care Ethics and Feminism

The launch of modern-day care ethics is usually attributed to Carol Gilligan's treatise, *In a Different Voice*. The 'different voice' at issue was that of women. In contrast to earlier studies of how people think about morality (Kohlberg 1973), Gilligan conducted interviews in which she found that women resisted making categorical assertions about right and wrong. 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). At its contemporary inception, then, care ethics was presented as championing women's perspective. Hence, it became associated with feminism.

Care ethics' status as a feminine or feminist ethic was further entrenched by Nel Noddings (1984, 2002), who used the concept of a "maternal perspective" to guide her version of care ethics. The maternal perspective was not to be conflated with any generalisation about actual mothers, or with the claim that men could not occupy the maternal perspective. Still, Noddings' maternal approach had the effect of cementing care ethics' feminine status. The same was done by Sara Ruddick's influential *Maternal Thinking* (1989), which (amongst other things) distinguished three aims of maternal practices: preservation (keeping the child alive); growth (fostering the child's development); and acceptability (ensuring the child integrates into social groups) (Ruddick 1980, 348-9). Mothering principles such as these were, for Ruddick, a potential basis for moral and political action more generally.

For all these femin*ine* associations, care ethics' femin*ist* credentials have been a matter of heated dispute. Although care ethics is often presented as a feminist theory, care ethics' most

potent criticisms have come from feminism. An early criticism of care ethics was that it valorises ideals that lead to the oppression of women (Card 1990; Housten 1990; Hoagland 1991; Davion 1993). Women have been told, throughout history, that their job is to provide care for those that are dependent on them. Care ethics simply repeats this command. Yet the social entrenchment of this command has led to women's economic, social, and political disadvantage. So, the thought goes, we should be wary of championing care ethics, at the risk of further entrenching women's disadvantage.

A different, and distinctively epistemological, criticism of care ethics says that the theory not only risks *causing* women's disadvantage, but that the theory is *caused by* women's disadvantage (Puka 1990; Card 1990; Davion 1993). The idea here is that care ethics is a 'slave morality': a theory espoused by those who are disadvantaged, in order to make a virtue out of their less-than-ideal situation in life. On this view, women who espouse care ethics are engaged in a kind of false consciousness: they believe that they have an enlightened position on the values they endorse, but this seeming-consciousness is not true to reality, since the values they endorse derive from their (unperceived to them) inferior social position.

A third feminist critique of care ethics is that it both essentialises women and overplays the differences between women and men (Brabeck 1983; Collins 1990; more generally on anti-essentialism in feminism, see Spelman 1988). For example, as outlined above, Gilligan (1982), Noddings (1984), and Ruddick (1980; 1989) can all be read as claiming that care ethics represents the views of women. Yet, this third critique runs, care ethics does *not* represent the views of all, or even most, women. For example, Gilligan's studies drew on interviews with white women at elite colleges who were considering abortion. Gilligan's conclusions about 'women' therefore ignored black women, working-class women, and women who would never consider abortion, for example (Collins 1990, 6). And others have argued that the values of care are not distinctively feminine: care ethics has strong similarities to African ethics and

Confucian ethics, which have no particular associations with women (on African ethics, see Harding 1987; on Confucian ethics, see Li 1994 and Luo 2007; cf. Star 2002; Yuan 2002; Noddings 2010, ch. 5).

The first critique can be defanged by understanding who care ethics is a theory for. Care ethics is not exclusively—or even, I would suggest, primarily—an ethics for women. If it's true that women resonate more readily with the values of care than men, then it is in fact more important that care ethics is viewed as *for* men, rather than as for women. That is: boys and men are the ones who need to pay greater attention to the claims of care ethics. Care ethicists should be upfront about that and direct care ethics more to men than to women. If this is how care ethics is packaged, then far from entrenching women's disadvantage, care ethics can have a role in alleviating that disadvantage—for example, by highlighting the obligations men have to care for elderly relatives or young children.

What about the question of where care ethics comes from? This is the question at issue in the second and third feminist critiques. The question of whether care ethics is a 'slave morality'—and of whether it should therefore be rejected—takes us deep into the waters of genealogical debunking arguments in ethics. That's a topic well beyond this chapter's scope. But philosophers typically assume it is possible to assess the content of a theory, independently of assessing its origins or the psychologies of its proponents—even if the latter give us reason to be sceptical of the theory. I hope that this chapter has provided an analysis of the content of care ethics that can be assessed on its own terms, just as we might do for any other theory. Similar remarks apply to the facts that not all women support care ethics and that men have historically endorsed similar views. Regardless of the sociology here, an interesting and important job for philosophers is to engage with care ethics' ideas to see if those ideas are plausible. The greater the diversity of perspectives that are brought to this conversation, the better.

5. Conclusion

This chapter has sought to situate care ethics alongside the more mainstream normative ethical theories of contractualism, consequentialism, and virtue ethics. While it might be tempting to subsume care ethics into one of these approaches, I have outlined a version of care ethics that has similarities to, and differences from, all three. While care ethics is (in my view) a theory of just one part of morality, I hope to have shown that it provides a plausible account of that part of morality. I do not claim to have addressed all possible criticisms, still less to have refuted any of the 'big three' theories I have discussed.

Care ethics contends that we live in a vast web of dependence relations, in which each of us both is dependent on others for the fulfilment of our important interests and has others dependent on us for the fulfilment of their important interests. This web of dependence relations generates non-aggregated and sometimes incommensurable responsibilities to engage in the long-term interpersonal process of caregiving. The weight of these responsibilities varies with the type of dependence at issue, such as the different dependencies that occur between intimates, between economic transactors, and between those more distant. The mention of those 'more distant' naturally raises the question of care ethics' political implications, particularly the question of how care can be practiced and mediated by political institutions. These political upshots have been closely examined by care ethicists in recent years. In this chapter, I have kept my focus more squarely on normative ethical theorising, to which I believe care ethics has much to offer.

References

Barnes, Marian. 2012. *Care in Everyday Life: An Ethic of Care in Practice*. Bristol: Policy Press.

Bhandary, Asha. 2010. 'Dependency in Justice: Can Rawlsian Liberalism Accommodate Kittay's Dependency Critique?' *Hypatia* 25(1), 140–156.

Bhandary, Asha. 2020. *Freedom to Care: Liberalism, Dependency Care, and Culture*. Routledge 2020.

Blum, Lawrence. 1980. *Friendship, Altruism, and Morality*. London: Routledge and Kegan Paul.

Brabeck, Mary. 1983. 'Moral Judgment: Theory and Research on Differences between males and Females.' *Developmental Review* 3, 274-91.

Bramer, Marilea. 2010. 'The Importance of Personal Relationships in Kantian Moral Theory: A Reply to Care Ethics.' *Hypatia* 25(1), 121–139.

Bubeck, Diemut. 1995. *Care, Gender and Justice*. Oxford: Clarendon Press.

Card, Claudia. 1990, 'Review: Caring and Evil.' *Hypatia*, 5 (1): 101–108.

Clement, Grace. 1996. *Care, Autonomy, and Justice: Feminism and the Ethic of Care*. Boulder: Westview Press.

Collins, Patricia Hill. 1990. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment.* Routledge.

Collins, Stephanie. 2015. *The Core of Care Ethics*. Palgrave Macmillan.

Darwall, Stephen. 2006. *The Second-Person Standpoint*. Harvard University Press.

Darwall, Stephen. 2004. *Welfare and Rational Care*. Princeton University Press.

Davion, Victoria. 1993. 'Autonomy, Integrity, and Care.' *Social Theory and Practice* 19(2), 161–182.

Driver, Julia. 2005. 'Consequentialism and Feminist Ethics.' *Hypatia* 20(4), 183–199.

Engster, Daniel. 2004. 'Care Ethics and Natural Law Theory: Toward an Institutional Political Theory of Caring.' *The Journal of Politics* 66(1), 113–135.

Engster, Daniel. 2007. *The Heart of Justice: A Political Theory of Caring.* New York: Oxford University Press.

Gilligan, Carol. 1982. *In A Different Voice*. Cambridge, MA: Harvard University Press.

Halwani, Raja. 2003. 'Care Ethics and Virtue Ethics.' *Hypatia* 18(3), 161–192.

Hamington, Maurice. 2004. *Embodied Care: Jane Addams, Maurice Merleau-Ponty, and Feminist Ethics*. University of Illinois Press.

Harding, Sandra. 1987. 'The Curious Coincidence of Feminine and African Moralities.' Pp. 296–317 in E.F. Kittay and D. Meyers (eds), *Women and Moral Theory*. Totowa: Rowman & Littlefield.

Hartley, Christie. 2009. 'Justice for the Disabled: A Contractualist Approach.' *Journal of Social Philosophy* 40(1), 17-36.

Held, Virginia. 1990. 'Feminist Transformations of Moral Theory.' *Philosophy and Phenomenological Research* 50, 321–344.

Held, Virginia. 1993. *Feminist Morality*. Chicago: University of Chicago Press.

Held, Virginia. 2004. ‘Taking Care: Care as Practice and Value.’ Pp. 59–71 in Cheshire Calhoun (ed.), *Setting the Moral Compass: Essays by Women Philosophers*. Oxford: Oxford University Press.

Held, Virginia. 2006. *The Ethics of Care: Personal, Political, and Global.* Oxford: Oxford University Press.

Hoagland, Sarah Lucia. 1991. ‘Some Thoughts about ‘Caring.’’ In Claudia Card (ed.), *Feminist Ethics*. Lawrence: University Press of Kansas.

Houston, Barbara. 1990, ‘Review: Caring and Exploitation.’ *Hypatia* 5(1), 115–119.

Jackson, Frank. 1991. ‘Decision-Theoretic Consequentialism and the Nearest and Dearest Objection.’ *Ethics* 101(3), 461–482.

Kittay, Eva Feder. 1997. ‘Human Dependency and Rawlsian Equality.’ Pp. 219–266 in D.T. Meyers (ed.), *Feminist Rethink the Self*. Colorado: Westview Press.

Kittay, Eva Feder. 1999. *Love’s Labor: Essays on Women, Equality and Dependence*. New York: Routledge.

Kittay, Eva Feder. 2005. ‘Dependency, Difference and the Global Ethic of Longterm Care.’ *Journal of Political Philosophy* 13(4), 443–469.

Kittay, Eva Feder. 2014. ‘The Completion of Care -- With Implications of a Duty to Receive Care Graciously.’ In Ana Marta Gonalez and Craig Iffland (eds), *Care Professions and Globalization*. Palgrave Macmillan.

Kohlberg, Lawrence. 1973. ‘The Claim to Moral Adequacy of a Highest Stage of Moral Judgment.’ *Journal of Philosophy* 70(18).

Li, Chenyang. 1994. 'The Confucian Concept of *Jen* and Feminist Ethics of Care: A Comparative Study.' *Hypatia* 9(1), 70–89.

Luo, Shirong. 2007. 'Relation, Virtue, and Relational Virtue: Three Concepts of Caring.' *Hypatia* 22(3), 92–110

McLaren, Margaret A. 2001. 'Feminist Ethics: Care as a Virtue.' Pp. 101-118 in Peggy DesAutels and JoAnne Waugh (eds), *Feminists Doing Ethics*. Rowman and Littlefield.

Meyers, Diana T. 1987. 'The Socialized Individual and Individual Autonomy: An Intersection between Philosophy and Psychology.' Pp. 139–153 in E. F. Kittay and D. Meyers (eds), *Women and Moral Theory*. Totowa: Rowman & Littlefield.

Miller, Sarah Clark. 2005. 'Need, Care and Obligation.' *Royal Institute of Philosophy* 80, supp. 57 (supplement on 'The Philosophy of Need'), 137–160.

Miller, Sarah Clark. 2012. *The Ethics of Need: Agency, Dignity, and Obligation*. New York: Routledge.

Noddings, Nel. 1984. *Caring: A Feminine Approach to Ethics and Moral Education*. Berkeley: University of California Press.

Noddings, Nel. 2002. *Starting at Home: Caring and Social Policy*. Los Angeles: University of California Press.

Noddings, Nel. 2010. *The Maternal Factor: Two Paths to Morality*. Los Angeles: University of California Press.

Norlock, Kathryn. 2019. 'Feminist Ethics.' *The Stanford Encyclopedia of Philosophy*. Summer 2019 Edition. https://plato.stanford.edu/archives/sum2019/entries/feminism-ethics/.

Pettersen, Tove. 2008. *Comprehending Care: Problems and Possibilities in the Ethics of Care*. Lexington Books.

Puka, Bill. 1990. 'The Liberation of Caring: A Different Voice for Gilligan's 'Different Voice'.' *Hypatia* 55(1), 58-82.

Rachels, James. 2002. *The Elements of Moral Philosophy*. Fourth Edition. McGraw-Hill.

Railton, Peter. 1984. 'Alienation, Consequentialism, and the Demands of Morality.' *Philosophy & Public Affairs* 13(2), 134–171.

Rawls, John. 1971. *A Theory of Justice*. Belknap Press.

Robinson, Fiona. 1999. *Globalizing Care: Ethics, Feminist Theory, and International Relations*. Boulder: Westview Press.

Robinson, Fiona. 2011. *The Ethics of Care: A Feminist Approach to Human Security*. Philadelphia: Temple University Press.

Ruddick, Sara. 1980. 'Maternal Thinking.' *Feminist Studies* 6(2), 342–367.

Ruddick, Sara. 1989. *Maternal Thinking: Toward a Politics of Peace*. Boston: Beacon Press.

Ruddick, Sara. 1992. 'From Maternal Thinking to Peace Politics.' Pp. 141–155 in E. Browning-Cole and S. Coultrap-McQuin (eds), *Explorations in Feminist Ethics*. Bloomington: Indiana University Press.

Ruddick, Sara. 1998. 'Care as Labor and Relationship.' Pp. 3-25 in J.C. Haber and M.S. Halfon (eds), *Norms and Values: Essays on the Work of Virginia Held*. Lamham: Rowman and Littlefield.

Scanlon, T.M. 1998. *What We Owe to Each Other*. Cambridge, MA: Harvard University Press.

Sevenhuijsen, Selma. 1998. *Citizenship and the Ethics of Care: Feminist Considerations on Justice, Morality, and Politics*. New York: Routledge.

Slote, Michael. 1998. 'The Justice of Caring.' *Social Philosophy and Policy* 15(1), 171–195.

Slote, Michael. 2007. *The Ethics of Care and Empathy*. London: Routledge.

Spelman, Elizabeth. 1988. *Inessential Women: Problems of Exclusion in Feminist Thought*. Beacon Press.

Star, Daniel. 2002. 'Do Confucians Really Care? A Defense of the Distinctiveness of Care Ethics.' *Hypatia* 17(1), 77–106.

Stocker, Michael. 1976. 'The Schizophrenia of Modern Ethical Theories.' *The Journal of Philosophy* 73(14), 453–466.

Tronto, Joan C. 1987. 'Beyond Gender Difference to a Theory of Care.' *Signs* 12(4), 644–663.

Tronto, Joan C. 1993. *Moral Boundaries: A Political Argument for an Ethic of Care*. London: Routledge.

Tronto, Joan. 2013. *Caring Democracy: Markets, Equality, and Justice*. NYU Press.

Yuan, Lijun. 2002. 'Ethics of Care and Concept of Jen.' *Hypatia* 17(1), 107–29.