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ARTICLE

Caring Actions

Steven Steyl

Department of Philosophy, The University of Notre Dame, Sydney, New South Wales, Australia
Corresponding author. stevensteyl@hotmail.com

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Abstract

Though the literature on care ethics has mushroomed in recent years, much remains to be said about several important topics therein. One of these is action. In this article, I draw on Anscombean philosophy of action to develop a kind of meta- or proto-ethical theory of caring actions. I begin by showing how the fragmentary philosophy of action offered by care ethicists meshes with Elizabeth Anscombe's broader philosophy of action, and argue that Anscombe's philosophy of action offers a useful scaffold for a theory of caring actions. Following this, I defend an account of caring actions as those that aim to meet needs. I argue that care aims at satisfying eudaimonistic needs, those things without which one cannot flourish. I then consider the place of caring actions in care ethics. I suggest that if caring actions are to be a starting point for an ethical theory, we ought to reject the notion that a caring action must bring about its intended consequences, and I show how the concept of practice better equips us to evaluate caring actions.

Care ethics has always regarded itself as an ethic at the coal face. Care ethics, it is said, is a *practical* ethic, rooted in the lived experiences of caregivers and care-recipients. For this reason, care ethicists have often taken some type of action, activity, work, labor, or practice to be a, if not *the*, central moral concept (see, for example, Kittay 2001; Held 2006; Collins 2015). A great deal of work has been done to flesh out particular elements of these concepts and their role in care ethics. Petr Urban, for instance, argues that care ethicists ought to borrow from "enactivism" an "alternative to the conceptions of mind and agency in mainstream cognitive science in the early 1990s" (Urban 2015a, 217), which "asks and attempts to answer questions such as: what is an agent, what is autonomy, why does anything matter to someone" (Urban 2015b, 121). Here I propose some answers to a different set of foundational, ontological questions that have also attracted relatively little attention from care ethicists, namely: what *are* actions and practices? How are we to disentangle these concepts? How does care fit into these concepts? In what ways are they *moral* concepts?

These questions are consequential for a number of reasons. One of these is that major misunderstandings about care ethics persist in moral philosophy. Care ethicists have often lamented the frequency with which they are mislabeled as virtue ethicists (see, for example, Groenhout 1998), insisting that the two normative frameworks are different for a plethora of reasons, including virtue ethics' individualism (Noddings

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2002b; Hamington 2004; Held 2006; Noddings 2010; 2015), virtue ethics' conservatism (Held 2006; Pettersen 2011; Groenhout 2014), and the nonidentity of the two ethics' primary moral currency (Held 2006). As I point out elsewhere (Steyl 2019), greater clarity on what exactly care consists in will help combat these misunderstandings. Care is widely regarded as a virtue, but it is also slotted into a variety of other conceptual categories, and deeper incursions into those other categories enable care ethicists to differentiate care from virtue ethicists' central moral concepts: virtues and dispositions.[1] Another benefit in developing a more comprehensive account of the particular ontological categories into which care fits is that it affords care ethicists greater clarity about the philosophical resources they have at hand and the trajectory their discussions ought to take. Further discussion of actions, emotions, virtues, practices, professions, and other categories in this neighborhood will enable care ethicists to draw further on insights from preexisting discourses on these topics. Finally, a significant amount of work remains to be done on the topic of *right* or *good* action in care ethics. Some view care ethics as an alternative to other normative ethics whose aim is to compete with them successfully (see, for example, Engster 2004; Slote 2007), and if that is the case, then one of its central tasks will be to develop a theory of right action, which itself involves theorizing about what actions and caring actions are. Even for care ethicists who do not proffer an ethic of care with the aim of ousting other normative ethics (see, for example, Tronto 1993; Baier 1995; Held 1995; Noddings 2002b, part III), the care-ethical practice of giving concrete advice about problems facing caregivers in various contexts requires an account of *why* that advice ought to be followed, and a fuller theory of what caring actions are will help care ethicists map that terrain.

This article contributes to care ethical efforts to answer these questions by offering a meta-ethical scaffold for caring actions. It begins by laying out an Anscombean theory of action and a care ethical theory of practices and considering the relation between them. I argue, in short, that the two theories are consistent with each other and indeed mesh well. In section II, I lay out a theory of caring actions. I suggest that care ethicists ought to conceive of caring actions as those that intend to meet needs. I argue, however, that we ought to interpret or reconceive needs as those things without which we cannot flourish because a eudaimonistic theory of needs better encapsulates the concept of caring action. In section III, I begin the transition into ethics by discussing the evaluation of caring actions. I suggest that caring actions are not always successful, as some care ethicists have maintained, and I show how other concepts in this neighborhood might be evaluatively useful.

I. ACTIONS AND PRACTICES

In this section I develop accounts of care as a kind of practice and a kind of action, beginning with a study of actions, practices, and the distinction between the two. These are not, of course, the only concepts at play in care ethical philosophy of action. Care ethicists habitually speak of care as work or labor (see, for example, Clement 1996, 54–56; Kittay 2001, 259). Nor are these meanings of care mutually exclusive. One may choose to treat labor and work as ontologically distinct from practices, but maintain that there is no inconsistency in regarding them all as sorts of care. One may also choose to treat care as an action or practice, and then go on to define labor or work as certain sorts thereof. Here I shall focus on care as an activity and a practice because (a) these concepts lie at the heart of many of the most influential accounts of care (Tronto 1993; Ruddick 1995; Held 2006); (b) those accounts typically see actions and practices

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as intimately connected concepts; (c) work and labor have professional connotations that complicate the picture in ways that cannot be dealt with in sufficient detail here (see, for example, Ruddick 1983, 4); and (d) it is at least possible, and indeed very likely, that the concepts of action and practice are more basic or fundamental than those of work or labor (Held 2006; Lanoix 2013). So I shall limit myself here to these two kinds of care.

Anscombe's Philosophy of Action

What then do we mean by "action" and "practice"? Care ethicists have not fully fleshed out an account of what actions in general *are* or how care fits into such an account. But there are numerous theories of action on which they might lean. The one I shall defend is Anscombean. One of the most pressing ethical issues in Elizabeth Anscombe's eyes, which she addresses in both "Modern Moral Philosophy" and *Intention*, is what is sometimes known as the "problem of relevant descriptions" (Anscombe 1958; 1963). It is foundational to Anscombe's view, Onora O'Neill tells us, that: "*action is propositional*. Acts fall under many descriptions; act-descriptions may have many instances. Although individual acts—act tokens—are events in the world, we both think about action and act *under certain descriptions*. We consent to action as described in certain ways, but not others" (O'Neill 2004, 305, original emphasis). But this gives rise to problems in ethics. Anscombe argues that Kant's "rule about universalizable maxims is useless without stipulations as to what shall count as a relevant description of an action with a view to constructing a maxim about it" (Anscombe 1958, 2), and like Kant, Mill "fails to realize the necessity for stipulation of relevant descriptions, if his theory is to have content" (3). Both Kant's and Mill's accounts therefore succumb to what Anscombe regards as a fatal flaw: "Any act-token will fall under many true descriptions, hence also under many possible principles of action. Absent a proper philosophy of psychology, how can we tell which act description is relevant for moral assessment?" (O'Neill 2004, 306).

Anscombe goes on to develop a means by which act-types can be individuated. As Candace Vogler summarizes it, on Anscombe's account, "an act-type is just any isolable, determinately describable aspect of an exterior act done on purpose, such that the agent can answer a question about what he's doing couched in terms of that description" (Vogler 2013, 245). Swinging one's arm can be a token of numerous act-types, depending on whether one is hacking wood, dancing, gesturing, or bowling a ball. Each description is isolable, able to be disentangled from other actions of which it might be an element or with which it might form a sequence (or one complex action). Each description also makes for an intelligible response to the question "what are you doing?" And each of these descriptions represents an aspect of an exterior act that is performed on purpose (unlike a reflex) and is determinately describable, such that it can be explained in detail. In the case of care, we might say that if one were to ask pedestrians picking up litter what they were doing, "recycling cans" would be a perfectly intelligible response, as would "taking care of the environment" or "impressing a love interest," all of which can refer to the very same act-token.

A subset of act-types is intentional. Anscombe tells us that intentional actions "are the actions to which a certain sense of the question "Why?" is given application; the sense is of course that in which the answer, if positive, gives a reason for acting" (Anscombe 1963, 9; and note that Anscombe does not think that the question needs an answer, just that it be applicable). Anscombe then spends a large part of *Intention* describing what exactly is going on when one asks "why?" and what is

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going on when the agent answers it. She offers the following summary of her conclusions:

> The answer may (a) simply mention past history, (b) give an interpretation of the action, (c) mention something future. In cases (b) and (c) the answer is already characterised as a reason for acting, i.e. as an answer to the question "Why?" in the requisite sense; and in case (a) it is an answer to that question if the ideas of good or harm are involved in its meaning as an answer; or again if further enquiry elicits that it is connected with "interpretative" motive, or intention with which. (24–25)

Anscombe is cognizant of the variety of reasons we can offer in explanation of an intentional action, and she deliberately leaves room for this.

Anscombe does not think that applicable descriptions of particular actions are all isolated from one another. Rather, she suggests that intentional actions can sometimes be described with increasing abstraction or remoteness by what she calls an "A-B-C-D order." Anscombe writes that a man "moving his arm up and down with his finger round the pump handle *is*, in these circumstances, operating the pump; and, in these circumstances, it *is* replenishing the house water-supply; and, in these circumstances, it *is* poisoning the household" (46). In performing each of these actions, Anscombe's man also performs the next—Anscombe is making an identity claim about these distinct act-types. B, C, and D also give some explanation of why I am A-ing. So it makes sense, on an Anscombean view, to say both that *S* bandages a wound in order to heal a patient, and that in bandaging the wound she *is* healing the patient. Anscombe also does not think that in order for an action to qualify as a particular act-type one must succeed in bringing about its intended consequences (§23). On Anscombe's view, I A by B-ing whether or not I *succeed* at A-ing *or* B-ing—Anscombe's man can be described as poisoning the household even if, unbeknownst to him, some filtration mechanism had purified the water before it could be pumped into the house's cistern.

Care Ethical Philosophies of Action

Care ethicists are not committed to this account of action, but here I shall argue that what care ethicists have given us of a care ethical theory of action is largely consistent with Anscombe's, and that Anscombe's theory of action provides a suitable conceptual scaffold for an account of caring actions. Establishing consistency is not a straightforward comparative project, however, since care ethicists have not devoted much time to developing a theory of what actions are. But it remains possible. Though they have not yet advanced a comprehensive theory of action, care ethicists have, in the course of developing their theory of *practice*, offered several means of distinguishing actions/activities from practices, and in doing so have made some contributions to an account of caring action. Virginia Held, for instance, maintains that practices are one species in a broader genus, activity, into which care falls. In *The Ethics of Care*, she writes: "An activity must be purposive to count as work or labor, but it need not incorporate any values, even efficiency, in the doing of it. Chopping at a tree, however clumsily, to fell it, could be work. But when it does incorporate such values as doing so effectively, it becomes the practice of woodcutting" (Held 2006, 37; see also Held 2014, 111–12). Though the two concepts may come apart, Held does not seem to distinguish

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between action and activity. Here I take her to be treating the two as synonymous, in part because she draws on examples similar to those drawn on by philosophers of action (including Anscombe) to illustrate the phenomenon she is describing (see also, for example, Held 1990). Held understands both labor and practice as subcategories of action. For Held, work and labor are *purposive* activities, and a practice is a *value-laden*, *purposive* activity.

Of course, there are questions as to whether Held's "purposiveness" is synonymous with Anscombe's "intentional," and there is almost certainly not enough in Held's corpus to make an incontrovertible claim either way. But to say that an action was performed purposively *suggests* that there is some answer to the question "why?" because acting toward some purpose seems to involve acting for the sake of bringing about some desired or otherwise sought-after end (it might even entail this, since one homonym of "purpose" is synonymous with "aim" or "end"). Held's example of chopping at a tree *with the aim of felling it* (to wit, with an answer to the question "why?") is illuminating here, and her subsequent definition of practices as value-laden is certainly not inconsistent with Anscombe's theory of action—an Anscombean would simply interpret felling the tree as the reason for chopping at it. Her understandings of "work" or "labor" are also obviously especially broad—perhaps so broad as to be coextensive with intentional action, though they need not be so broad in order to be compatible with Anscombe's account thereof. What fragments we have of Held's theory of action do not, consequently, rule out Anscombe's philosophy of action as a philosophical underpinning for a theory of caring actions.

Held is not the only care theorist to have made contributions to a theory of action. Joan Tronto also sees the practice of care as a set of activities coupled with a particular "habit of mind" (Tronto 1993, 127), which Tronto tells us includes purposes (Tronto 2010, 161) but presumably also includes such things as values, though with the caveat that those activities are *ongoing*. Again, I see nothing in Tronto's discussion of practices to suggest that she is hostile toward an Anscombean philosophy of action. We have already seen how Anscombe's philosophy of action can accommodate purposiveness conditions. Moreover, like Anscombe, Tronto thinks that practices can be nested according to their proximate ends, and like Anscombe she suggests that particular practices, defined by their proximate ends, can be attached to a variety of distant ends (Tronto 2013, 21).

Sara Ruddick is another care ethicist who has contributed to a care ethical theory of caring actions. In *Maternal Thinking*, she writes: "Practices are collective human activities distinguished by the aims that identify them and by the consequent demands made on practitioners committed to those aims. The aims or goals that define a practice are so central or "constitutive" that in the absence of the goal you would not have that practice" (Ruddick 1995, 13–14). Ruddick views practices as a subcategory of activities undertaken collectively, and distinguished teleologically (see Sevenhuijsen 1998, 21 for a similar definition). Anscombe's Aristotelian predilections are mirrored in Ruddick's teleological method of delineating practices, and the Anscombean can make sense both of Ruddick's additional proviso that practices are defined in part by the demands their *telê* impose on the practitioner, and her proviso that practices are collective undertakings, simply by treating practices as a subcategory of actions with additional features. That practices necessitate particular act-types—that mothering necessitates tending to wounds, for instance—coheres perfectly well with the Anscombean claim that actions admit of increasing levels of abstraction in A-B-C-D order, just as it would make sense on Anscombe's view to say that the act of killing

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the inhabitants of a household necessitates that one inflicts some harm upon them. So Ruddick's (fragmentary) philosophy of action and Anscombe's do not seem to be inconsistent. Indeed, the synergies suggest that the two would mesh well.

II. CARING AS AN ACT-TYPE

Perhaps the most significant question here, however, is whether care ethicists are equivocating when they use the terms *care* or *caring* to classify actions they typically discuss. There is no doubt that Anscombe has left room for the sorts of act-types care ethicists prescribe, but there is a separate question regarding whether those act-types all belong to a unified genus. Are we justified in suggesting that the actions of nurses, parents, friends, and Samaritans are all tokens of a single type, or do we equivocate when we describe all of these actions as "caring"? In this section, I use the Anscombean theory of action laid out in section I to defend a theory of caring actions as those whose proximate end is to meet a need and mount an argument for a eudaimonistic understanding thereof.

If care is to be a distinct and unified kind of action, then it must aim at some particular end, which is to say that it must have a particular intentional structure. That caring actions always have a proximate end is uncontroversial among care ethicists. Caring actions are always, on Held's view, purposive in the sense that they are performed to bring about particular states of affairs. Consider also Daniel Engster's definition of care as "everything we do directly to help individuals to meet their vital biological needs, develop or maintain their basic capabilities, and avoid or alleviate unnecessary or unwanted pain and suffering, so that they can survive, develop, and function in society" (Engster 2007, 28–29). Care ethicists typically define care, at least in part, in terms of its particular aims or ends (see, for example, Tronto 1990; Bubeck 2002; Collins 2015). Definitions often make use of the teleological infinitive marker "to," and mention specific motivations (goals, intentions, aims, and so on) to indicate that care is purposive (see, for example, the meta-analysis in Engster 2005). Thus, caring actions seem to be intentional *by definition*, such that one can always answer the question "why?" by reference to some motivation or end.

What is it that unifies these caring actions such that they are, in Vogler's words, "isolable" and "determinately describable?" Held suggests that care ethicists all define care as a response and/or a responsiveness to need. At the outset of *The Ethics of Care*, she tells us that "the central focus of the ethics of care is on the compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibility" (Held 2006, 10). Held is not the only care ethicist to make this observation. Engster writes:

> most care theorists agree that caring at least entails helping others to meet their basic needs, develop their basic capabilities, and avoid unwanted suffering and pain. Building upon this minimalist approach, caring may be defined as everything we do directly to help others (1) to satisfy their basic needs for food, sanitary water, clothing, shelter, rest, a clean environment, basic medical care, and protection from harm; (2) to develop and maintain their basic capabilities for sensation, emotion, mobility, speech, reason, imagination, affiliation, and literacy and numeracy; and (3) to avoid harm or alleviate unwanted suffering and pain. The most general goal of caring is to help others to survive and function so that they take care of themselves and others and pursue some conception of the good life (Engster 2006, 522; see also Engster 2005, 51; 2007, 48).

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Held and Engster are correct in noting the universality of need across competing definitions of care. Tronto's work, which has been equally influential among care ethicists, is also just as emphatic about care being concerned with need. In explicating her concept of care, Tronto writes, "what is definitive about care . . . seems to be a perspective of *taking the other's needs as the starting point for what must be done*" (Tronto 1993, 105; see also 137–41; and Tronto 2013, 162–63). Diemut Bubeck defines care as "the meeting of the needs of one person by another person" (Bubeck 1995, 129; see also 132), and Selma Sevenhuijsen defines it as "an ability and a willingness to 'see' and 'hear' needs, and to take responsibility for these needs being met" (Sevenhuijsen 1998, 83; see also 60). Need also features prominently in the definitions offered by Nel Noddings, Tove Pettersen, Eva Kittay, Sara Ruddick, Alison Jaggar, Maurice Hamington, Anca Gheaus, Sandrine Berges, Sarah Clark Miller, and many others besides (Jaggar 1995, 180; Kittay 1997, 234; Ruddick 1998, 11; Kittay 1999, 133, 233; Noddings 2002b, chap. 3; Noddings 2007, 42; Pettersen 2008, 101; Gheaus 2009, 64; Clark Miller 2010, 141, 150; Noddings 2010, chap. 7; Berges 2015, 125; Engster and Hamington 2015, 4). Even among care ethicists who opt not to define care in their work (Clement 1996 and Bowden 1997, for example), response to need is treated as a fundamental component of care. One need not offer or endorse a full definition of care in order to admit that some elements of care are essential after all.

We might, therefore, claim that caring actions are those whose proximate end is to meet a certain sort of need. Stephanie Collins's view of care in *The Core of Care Ethics* meshes well with such a theory of caring actions. On her view, "all caring actions are intentional under the description 'trying to do what I believe is good for someone'" (Collins 2015, 67). Collins's understanding of intentionality is reminiscent of Anscombe's. According to Collins: "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 a tacit belief that the action is good for the recipient in some way" (68). Collins also rejects definitions that require anything more than "trying" to meet a need, offering a counterexample in which a small child cares for a pet rock despite the pet rock not having any discernible needs or interests (67). On Collins's account, we naturally call this behavior caring. From this, Collins distills the following definition of caring actions: "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" (69).

Of course, interests are not necessarily identical to needs (though it may always be in someone's interests to meet their needs). I shall return to this topic in the next subsection. But for now, it is worth noting that Collins understands intentionality in a way similar to Anscombe. She understands caring actions teleologically and sets out to include paradigmatic cases of need within her theory of care. So it seems that there is already some momentum behind the thought we have advanced here.

Drawing on Anscombe's philosophy to develop a theory of caring actions in this way has the advantage of enabling those actions and their proximate ends to be nested. On this view of care, the statement "*S* is bandaging the wound, and she is thereby caring for her patient" is perfectly intelligible. If she were bandaging a wound for the sake of keeping her hands busy, then she would not be *caring*, because caring actions must aim to meet a need; they must treat that need as something to be alleviated. This coheres with everyday moral language. Moreover, caring actions can then be nested within a variety of other actions. It makes sense, in this case, to say that *S* is bandaging a wound, and in

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doing so is caring for her patient, and that this in turn is part of a wider professional activity. But it is equally possible to say that *S*'s bandaging the wound is an element of a wider activity that is *mothering* (indeed, on Anscombe's view, the two are identical—bandaging the wound *is* mothering). The proximate end defines *S*'s bandaging as care regardless of whether *S* is nursing or mothering. And this seems to be the sort of claim that care ethicists wish to make about care (see, for example, Tronto 2013, 21). Caring for others takes place in a variety of contexts, and we want our definition of caring actions to be versatile.

To say that caring actions are intentional is also, in this case, to leave adequate conceptual space for the variety of reasons that might motivate care. It is platitudinous that there is no one reason why we care. Indeed, we often appeal to all of the explanations Anscombe suggests for intentional actions in explaining why we care. We might cite past history when we explain that "last time she was hurt" or "she didn't do anything to deserve this." We might reinterpret the action when we explain that "it's my job" or "that's what grandparents do." And we cite the future when we explain, for example, that "she'll get sick if I don't." Each of these explanations appeals to a different answer to the question "why?" which satisfies Anscombe's conditions for intentionality. So it seems that Anscombe's theory of action is flexible enough to explain a whole host of markedly different cases where we say that an action was caring. In what remains of this article, I shall assume that this Anscombean picture of care is a defensible one.

There may be some temptation, upon considering Held's claim that caring practices are value-laden, to go beyond this and claim that caring actions must involve a particular sort of motivational underpinning. This is not an implausible claim. Care always involves disvaluing states of need, and valuing states where needs are either met or do not arise in the first place. Indeed, one could argue that caregivers *cannot* care without making such value judgments. In meeting her child's need for food, a mother must first ascribe a certain sort of disvalue to the state of hunger, such that she sees it as something to eliminate. If she thought that such states were *good*, or at least *unevaluable*, then she would have no reason to meet her child's need. For that reason, at minimum, care as an act-type might be thought to involve a value-judgment about a state of need. But this is not to say what *sort* of value or disvalue caregivers ascribe. An apathetic nurse certainly sees her patients' states of need as disvaluable, but only insofar as they threaten her job if they go unmet. So one might wish to add that caring involves value judgments relating specifically to how a state of need figures *in the life of the needy* (or perhaps that the state of need is not merely instrumentally disvaluable to the caregiver). Roxanna Lynch, for instance, defends such a view, contending that caring actions are performed for the care-recipient's sake (Lynch 2016, 140–43). But this seems to veer closer to a theory of *good* care than a theory of *mere* care. As Sevenhuijsen puts it, "caring for others can also stem from less noble motives, such as the urge to meddle or control others" (Sevenhuijsen 1998, 20; see also Clark Miller 2012, 3). Care seems to involve value judgments, but we ought not to be too specific about the nature of that value.

The Heterogeneity of Care and Eudaimonistic Needs

"Although 'need' has been the central concept of the ethics of care from the very beginning," Gheaus writes, "it has so far remained relatively under theorized. Various authors on care have intuitively used it to refer to most of what we usually call 'needs' in common language, that is biological as well as emotional needs" (Gheaus 2010, 621; see also Clark Miller 2012, chap. 1). Many of care ethics' earliest and most renowned

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proponents define need ostensively, pointing to cases that any plausible theory of need will admit. Needs for food and shelter have thus gone unargued in the literature, as have needs for mothering, education, and healthcare. Ruth Groenhout exemplifies the strategy, listing mothering, "the active tending of infants and children," tending to the elderly, and friendship (Groenhout 2004, 28–29; see also, for example, Tronto 1993; Held 2006). Peta Bowden and Grace Clement are also noteworthy, as we have seen, for refusing to define care and opting instead for the use of paradigmatic examples like these (Clement 1996; Bowden 1997). Engster does not describe them as such, but he offers a similar list of what we might take to be paradigmatic cases of care (Engster 2005, 55–56). Engster relies on this strategy repeatedly in fact, elsewhere offering the following list: "feeding the hungry, providing medication to the sick, teaching a child to walk or talk, sheltering or clothing someone, and helping a person to regain basic functioning after an accident" (Engster 2006, 522). This approach has its advantages. As Tronto puts it, "the question of trying to define and to specify 'needs' is a difficult problem, both politically and philosophically" (Tronto 2013, 162), and thus it is reasonable to "articulate another approach that avoids 'needs' and focuses instead on 'basic human capabilities'" (162; cf. Tronto 1995). The care ethical strategy of using ostensive definitions in lieu of formal definitions supplying necessary and sufficient conditions is also reasonable in light of this.

Yet Gheaus offered the remarks above a decade ago, and care ethicists have done work in the intervening years to develop a philosophy of need. Clark Miller offers one account of care according to which caring actions meet "fundamental needs," defined as "needs that threaten agency in the sense that if they are not met, the serious harm of compromised agency will result" (Clark Miller 2012, 17). Fundamental needs, in other words, "must be met in order to establish, maintain, or restore agency" (17). Clark Miller has a relatively permissive understanding of agency, moreover, which includes not only the familiar set of needs such as freedom from certain sorts of interference or coercion, but also certain emotional and relational needs. This set of needs is thus fairly expansive, and Clark Miller's account of needs yields one elegant solution to the problem of care's heterogeneity: define care by reference to need, but define need broadly. Yet even this more permissive account of care seems vulnerable to a number of counterexamples. Consider the following case:

> *A* is working late into the night. *A* is tired and would like nothing more than a slice of her favorite cake, but *A* cannot spare the time to go to the supermarket and get one, and it does not matter all that much anyway because *A* can get along perfectly well without it. *A*'s partner, *B*, sees that *A* is hard at work and realizes that *A* could do with a treat. So *B* goes and buys a slice of *A*'s favorite cake, returns home, and gives it to *A*. Her spirits lifted, *A* completes her task.

It is perhaps a little jarring to suggest that *A* needs the cake, since she can complete her work without it and will not be much worse off. It is less odd to say that *A* desires it. But it still seems natural to describe *B*'s actions as caring. Consider also another counterexample:

> *C* is a high school student who is just about to graduate. *C* has decided to go to college, and has begun submitting applications to schools of varying quality. Her chosen career is one for which there is not much competition—the odds of employment do not vary all that much between top-tier schools and

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upper-mid-tier schools. *C* is almost certain to get into a respectable school on her own. But her parents are confident that *C* can be admitted into a top-tier university and get a first-class education with their help. So they sit down with *C* and help her write a terrific application. *C* is admitted to a top-tier university as a result.

Once again, we have a case where it seems natural to describe an agent as a caregiver, and to describe the actions they perform as caring. But the aid *C*'s parents give her does not seem to count as meeting a *need*—*C* is perfectly capable of leading a rich and fulfilling life if she attends a mid-tier school. Nevertheless, we seem to think that there is something caring about *C*'s parents acting *in her interests* (that is, benefiting her or giving her some advantage even if it is not needed).[2]

On the view I have just presented, care represents a distinct and unitary act-type because its purpose/intention is to meet needs. But if the counterexamples above are convincing, then the definition of need we have just offered seems to run up against everyday locution. Care, as we use the term in ordinary language, also aims sometimes at satisfying desires or furthering interests, and one could surely come up with cases where one cares by accommodating preferences. Accounts like Clark Miller's identify a subset of objects that care might aim at—indeed, they are some of the most morally demanding, and Clark Miller is right to focus on them—but care's scope is broader than accounts like these admit. Much care consists not in meeting fundamental needs but in bringing joy, doing small favors, and otherwise making slight improvements in the lives of those for whom we care. Desires, interests, and preferences may not be as morally *demanding* as fundamental needs, but it does not follow either that they are not objects of care or that they are morally inert, and this is not how ordinary language would have us define care. And if this is the case, then we still appear to have several distinct act-types with several distinct proximate ends. In other words, we do indeed equivocate in describing all of these actions as "caring." One option here is to simply bite the bullet and accept that the care ethical lexicon diverges from ordinary moral language, and to give the actions in the counterexamples above a different descriptor. In this section, however, I would like to defend an account of need that enables us to explain the unity of caring actions despite the apparent heterogeneity of the items in care's ambit.

Anscombe advances a theory of "Aristotelian necessity" according to which a statement that some person *P* needs *x* is to say that she will not flourish unless she has *x*. On this view, "to say that [an organism] needs that environment is not to say, for example, that you want it to have that environment, but that it won't flourish unless it has it" (Anscombe 1958, 7). Anscombe's Aristotelian-Thomistic account of flourishing is one of many we might draw on, but I shall not commit to one specific concept of flourishing here. The usefulness of the concept can be shown by reference to elements of flourishing that are mainstream.[3] Eudaimonistic understandings of need can encompass all of the paradigmatic cases of care identified by care ethicists. Children cannot flourish unless they have a loving parent who takes care of them. The infirm cannot flourish unless they have medical professionals like nurses and doctors to heal them. Because human beings cannot flourish outside of loving relationships, and because they are corporeal beings who can be injured or harmed, they need caregivers to help them grow and recover from injury. This is not to say that needs *only* make sense within this eudaimonistic framework. There is no need here to suggest that a child's claim to need a toy is nonsensical, since they may well need it in order to maximally enjoy their afternoon. But before we regard indulging the child as *caring* for them, we ask eudaimonistic questions—is this child leading a good life? Have they been spoiled? Is the money better

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spent on food or warm clothing? What's more, it is only once we answer such questions that the need exerts normative force. Whether that need is morally compelling—that is, whether that needs-claim accurately represents some state of affairs that we ought to factor into our moral deliberation—turns on whether the toy is necessary for flourishing. So eudaimonistic accounts of caring actions appear to be particularly useful as foundations for ethical theorizing.

Concepts of flourishing thus cover what care ethicists would like care to cover, but they also solve the problem of heterogeneity. This conception of need broadens care's scope significantly. In particular, it is no longer clear that care cannot aim to satisfy needs and desires, interests, and preferences. One could now argue, quite reasonably, that the flourishing life involves at least *some* satisfaction of desires, *some* aid in the pursuit of one's interests, and *some* accommodation of one's preferences. Indeed, this is a standard view among philosophers who discuss flourishing. Julia Annas, taking flourishing to be synonymous with happiness, writes: "Happiness must involve our enjoying the good things in life. . . . [We] demand that happiness involve what we normally take to be enjoyment of life's advantages, and to the extent that we do, we will make happiness dependent on external goods" (Annas 1993, 365). If this is the case, then one can care for others by satisfying their desires. But notice that because the approach here includes desires only insofar as desire-satisfaction is an element of the flourishing life, only certain kinds of desires are morally salient, and they ought only to be met in certain circumstances. Because the claim is that meeting desires is an aspect of care only because desire-satisfaction is one aspect of *eudaimonia*, one does not care if one satisfies wicked desires. The desire to torture puppies would never feature in a flourishing life (and should certainly never be *satisfied* in one), and one therefore does not care for others in enabling them to do so.

This, however, seems like a reasonable limitation on the claim that care involves desire-satisfaction. The sorts of desires we would hope to accommodate in allowing for desire-satisfaction include such things as the desire to catch up with an old friend, to make one's parents proud, and so forth. We are surely not going to admit that care can include satisfying desires to get revenge on a rival, to murder one's elderly parents for the sake of an inheritance, and so on. *Good* desires may not always need to be satisfied either, however, and here again the ancients can contribute to care theory. On one view popular in ancient Greece, to say that a person is flourishing is to make an evaluation of her life *as a whole* (Annas 1993). Yet it is clear that particular desires, even when they are such as a temperate, honorable, classically virtuous person would have, are not typically serious enough to affect an evaluation of one's life as a whole. If Jane wants a specific book and never receives it, we do not think she is much worse off. But it does seem that the assessment changes if we say that Jane is an avid reader and *never* receives any of the books she would most like to read. Thus care may not require us to satisfy every good desire we encounter—we do not fail to care if we do not satisfy every good desire we are confronted with—but it does seem to require us to meet desires *sometimes*. So it appears that construing flourishing as care's end enables us to treat desire-satisfaction as an aspect of care without (a) equivocating, (b) endorsing the satisfaction of all types of desires, or (c) claiming that good desires must always be met.

III. GOOD CARE, CONSEQUENCES, AND COMPLETION

The account presented above may not appear to be of any special interest to ethicists whatsoever. In laying out this theory of caring actions, I have argued that an action

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that is caring is not, *eo ipso*, morally good or right. I have also suggested that caring actions do not always involve morally good value judgments or motivations. If this is the case, however, then it seems that the account here is wholly detached from the ethics of care and that (this sort of) care is no longer a normative concept. This, as we have seen, is a major departure from care ethical orthodoxy. It is true that on the view presented here, caring actions *simpliciter* are not morally good and thus are ill-suited to a number of ethical ends including the provision of moral exemplars and standards for right action. But it is not clear that we want them to be categorically morally good. Actions we loosely refer to as "caring" are not all morally praiseworthy. If some caring actions are performed by the likes of Bonnie and Clyde or Dickens's Mrs. Jellyby, then we ought to prefer an account that allows for some caring actions to be morally wrong, all things considered. Second, there is room on the account defended here for a distinction between something like care and *good* care, the latter of which could still form the basis of an ethical theory. Here, I want to add to the discussion of good care—the sort of care we want an ethical theory to be founded upon—by commenting briefly on the evaluation of caring actions. First, I want to show that there is room on the Anscombean account for the care ethical emphasis on consequences and completion, and indeed that the resulting picture thereof is an intuitive one. Second, I shall argue that the concept of practice remains a useful lens through which to examine and evaluate caring actions.

Consequences and Good Care

Noddings once provocatively claimed that "care theory is consequentialist" (Noddings 2002b, 30). In doing so, she did not intend to align care ethics with thinkers like Bentham, Mill, and Sidgwick. Rather, she meant to emphasize the import of caring successfully. For Noddings, care ethics "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" (30). Thus: "We cannot reasonably leave the description of caring at the purely phenomenological level. We want some sort of positive result for the cared-for, perhaps growth, as Mayeroff suggests, or happiness and reasonable comfort, as Butler suggests, or at least freedom from unnecessary suffering" (41). Care is not care, to Noddings, unless it *actually* meets needs. And Noddings is not alone in defending a view like this. Kittay too sees care as necessarily successful, writing: "I may intend to care for a parched plant by watering it, but if unbeknownst to me, the glass of clear liquid I pour in the plant contains vinegar, not water, most would agree that, despite my good intentions, I have failed to care for it" (Kittay 2011, 612).[4] If caring actions are always successful, then it follows that good caring actions will always succeed too. These statements about the nature of care sit in opposition to the Anscombean theory of care I have laid out in the preceding sections. According to the view I have defended, actions are caring if their proximate end is to meet eudaimonistic needs. This, I have said, does not entail anything about whether that action succeeds in bringing about its end. A nurse cares for a patient by administering medication whether or not that patient recovers; a parent cares for a child by helping her with her homework whether or not that child learns.

What is not in doubt, however, is that care theorists, like other ethicists, must make sense of consequences in their account of good care. On the one hand, the emphasis here on consequences reinforces what seems to be common sense. As John Rawls notes in *A Theory of Justice*, "all ethical doctrines worth our attention take consequences

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into account in judging rightness. One that did not would simply be irrational, crazy" (Rawls 1971, 30). Success criteria also serve certain discursive ends. For instance, they highlight certain important and hitherto underexplored categories of care, including, in particular, *wise* care. An experienced caregiver who excels at means–ends reasoning will be better able to care well. A wise caregiver in Kittay's scenario will be cognizant, for example, of the fact that she was cooking with vinegar earlier, and left a glass of it on the table near the plant. She may think first to smell or taste the liquid in the glass to see whether it is indeed water. A less wise caregiver may not be so thoughtful or perceptive, and thus be more culpable for the same failure to meet needs. In focusing on the outcomes of our efforts to care, we are led to ask whether there is anything the caregiver could have done better next time. Taking the actual satisfaction of needs as an end requires in part that we dissect cases of unsuccessful "care" with the aim of doing better in future. So the motivation for endorsing a success criterion is a reasonable one.

But I want to suggest here that consequences be left to *evaluations* of caring actions rather than *descriptions* of caring actions like those I have been discussing thus far. Success criteria are open to counterexamples:

> Imagine that you and I each separately stumble upon injured dogs. We each put the dog that we find into the back of our cars and attempt to drive them to the nearest vet. While your dog reaches the vet in good time and is healed, I get caught in traffic and arrive at the vet five minutes too late. It seems odd, one might think, to say that your action is more valuable than mine. Your action does a lot more good for your animal than my action does for mine. But we might think that this should not affect the moral assessment of the action. (Collins 2015, 74)

Collins is right to think that morally praiseworthy care is sometimes unsuccessful. Caregivers who never commit any misdeeds may still have their efforts thwarted by luck. Failures to meet needs certainly represent a sort of disvalue, but that is not always the sort of moral value that ethicists usually attribute to actions. Collins thus seems right to suggest that an account of care that attaches value only to successful care is inadequate as the foundation for a normative theory.[5]

Collins's counterexample also raises a descriptive point. It is not *obvious* that cases like Collins's, where I fail through no fault of my own to meet needs, are failures to *care*. At least as far as my own intuitions are concerned, it is jarring to describe one scenario's actions as caring and the other's as noncaring (or perhaps uncaring) given that they are identical except for the contributions of moral luck. The leap from the intuitive evaluative significance of consequences to the descriptive necessity of success in care is not one that can rest on common sense, since there is surely no consensus here. But given that we want the concept to act as a foundation for a *moral theory*, Collins's counterargument seems to render accounts that eschew all-encompassing success criteria preferable to those that include them. A third, related danger in including a success criterion for care and then using that concept as the foundation for a normative ethic is that it may yield an ethic antithetical to feminist aims. What such an account seems insensitive to is the extent to which successfully meeting needs comes down to the resources one has at hand. In many parts of the world, meeting needs requires material goods and the ability to purchase them: transportation, medical bills, and education often incur some (typically financial) cost. If an action must be successful to qualify as caring, and caring actions are morally praiseworthy, then a great deal of care-related praise will be reserved for the well-off *because* they are well-off. Care ethicists ought

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to prefer accounts that afford moral praise for *acting as one ought* while simultaneously affording (a different sort of) value to successfully meeting needs.[6] Successful care is a category of care we wish to retain, but it is one of several we ought to leave conceptual space for, including care that is nonculpably unsuccessful.[7] We ought to prefer accounts that make a distinction between success and failure *within* their concept(s) of care, instead of exporting failure to some other moral concept that is not the ethic's keystone moral concept.

These considerations seem to point us in the direction of those accounts that distinguish between something like "good" and "ideal" caring actions. Into the latter category falls care that actually meets needs, and into the former, actions that are marred by misfortune and yet still are caring. The latter takes into account *all* good-making features of caring actions, including both the agential and the nonagential. The former leaves room for action that is not successful, but not through the caregiver's own fault. We ought to hope that all care is ideal, and it is a pity when care is, for whatever reason, good but not ideal, but good care is still "good" in that the caregiver acted as they ought. Care ethicists would not be the first to distinguish between actions that are morally good but fail to achieve their ends, either. Virtue ethicists since antiquity have argued for a distinction between actions that are morally praiseworthy but not successful (Aristotle 2004), and even utilitarians, according to whom an action is morally right just if it maximizes utility, have come to distinguish between actual and expected utility in their moral assessments (Brandt 1959; Jackson 1991). Care ethicists might therefore choose to borrow this distinction from ethicists in other camps.

Caring Practices

Care ethicists, we have seen, often view caring practices as a subset of caring actions. In this section I explore the usefulness of this category for evaluations of caring actions. Whether and how care qualifies as a practice depends on which account of practice one buys into. In contrast to approaches like Held's, Tronto's, and Ruddick's, Alasdair MacIntyre defines a practice as:

> any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended. (MacIntyre 2014, 166)

This is a far higher standard than Held's or Tronto's, and MacIntyre has thereby excluded a number of activities that we might intuitively call practices (see, for example, Brewer 1997; Dunne 2003).[8] Rather than attempting to show that care qualifies as a sort of practice using one particular theory of practice or another, my strategy will be to argue that theories of practice remain analytically useful by appealing to certain widely accepted elements thereof.

Practice's social dimensions are one of the more interesting of these. The fact that a subset of caring actions is social adds several layers of complexity to the account of good caring actions. As Tronto points out, care's social nature introduces a set of external power dynamics to caring relations (Tronto 2010; 2013). One thought underpinning her work, and the work of care ethicists like Held and Fiona Robinson, is that caring

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relations are subject to authorities beyond the caregiver–recipient relation (Robinson 1999; Held 2006; 2011; Robinson 2011). Caring relations are caught up in the power dynamics of the wider family, community, profession, state, and even the international community. Most obviously, these relations bear upon the success or failure of our efforts to care. Care is subject to a variety of norms, standards, and laws, which make it nigh on impossible to care successfully in some cases (consider, for instance, same-sex partners in societies where homosexual relationships are forbidden). Societal oversight of care can thus perpetuate injustice and actively harm those in need of care. It can lead members of some communities to be neglected, exacerbating existing issues and creating new ones. Tronto rightly points out that care work is both undervalued and done primarily by the underprivileged (Tronto 2013). Because they are so undervalued, caregivers are denied social mobility, and their own families and communities are denied care. This is not to say that care's immersion in a complex web of power relations is always to its detriment. We expect nurses and teachers to be held to certain professional standards because we want the vulnerable to be protected to some extent by institutional standards for caregivers' conduct. Indeed, it seems to be the case that structuring care will often make it easier. In subjecting certain caring practices to sets of norms, we afford caregivers a set of practical and epistemic shortcuts by making particular decisions for them and by pointing them in particular deliberative directions. Professional codes of conduct, for instance, enshrine prohibitions that enable smoother decision-making for those occupying the role of caregiver in morally thorny situations. Thus, when these issues are dealt with well, healthcare professionals do not have to shoulder the burden of moral decisions about confidentiality or patient autonomy—in such cases the imposition of norms by entities external to the caring relation are beneficial. The point here is simply that regarding care as a practice sensitizes us to these sorts of power dynamics.

A related, less explored point here is that *definitions* of care, good care, and particular subcategories thereof are often subject to power dynamics. As MacIntyre notes, in taking on social dimensions, practices are subjected to communal norms or standards of excellence (MacIntyre 2014). Good care is no different. The gold standard for care is, in many practices, determined in large part by a community of practitioners or supervisors, sometimes with little or no consultation with the care-recipients (consider here recent debates over what good care of detainees at the southern US border consists in). The dangers here are both obvious and grave. To act caringly cannot be to act paternalistically in trying to meet needs or without concern for the intended beneficiary's own perspective. Feminist philosophers in general have been adamant that minorities and marginalized groups ought not to have their needs determined for them. Nancy Fraser complains of "struggles over the who and how of need interpretation, struggles to empower women to interpret their own needs and to challenge the anti-participatory, monological practices of the welfare system" (Fraser 1987, p. 118). Although some professionals, such as doctors, might have special insights into what is required for human flourishing, it does not follow that they are omniscient, as though they could perform perfectly caring actions without ever consulting those for whom they care. For though they might have unique knowledge about what some element of our flourishing requires, it is often the care-recipients themselves who know what will best promote their overall flourishing. Even caregivers with special insights must be attentive and willing to listen and learn if they are to best promote the flourishing of their charges.[9] Concepts of practice remind us not only that care's success is determined by external power relations, but also that our *notion* of successful care can also be

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determined by those relations, and consequently they remind us that we ought to be cautious about such moral-hierarchical authority.

It is also interesting to note that practices are often thought to involve benefiting one's community in some sense. MacIntyre's understanding of communal benefits is restricted to that community of people who partake in a particular practice. Building on his discussion of internal goods, MacIntyre writes:

> Internal goods are indeed the outcome of competition to excel, but it is characteristic of them that their achievement is a good for the whole community who participate in the practice. So when Turner transformed the seascape in painting or W. G. Grace advanced the art of batting in cricket in a quite new way their achievement enriched the whole relevant community. (MacIntyre 2014, 190–91)

Similar examples can be thought of in caring contexts. Florence Nightingale excelled in her field and as a result revolutionized nursing, enriching the medical profession and the lives of those dependent upon it. Nightingale's example will be interesting also to those who think that practices contribute not only to the good of the community of practitioners, but also to the good of the wider community. The practice of care is noteworthy because, unlike some MacIntyrean practices (chess, for example), we depend upon it to meet basic survival needs, and these *everyone* has. Excellent care, as we see in Nightingale's case, can be a contribution to one's society or to the community of the needy as a whole, and if we treat care as a practice, we introduce this as an additional yardstick for the evaluation of caring actions (though not necessarily as a yardstick for those features of the action for which the agent is responsible, since other social/political impediments may exist).

IV. CARE AND THE PHILOSOPHY OF ACTION

Care ethical philosophies of action have seen increasing attention in recent years, and this is a positive development for care theory. In this article, I have aimed to contribute to this discussion a theory of action and an account of care plugged into it. I began with a study of Anscombe's work in philosophy of action. I argued for compatibility between that theory and the fragmentary definitions care ethicists have offered of caring actions. I followed care ethical orthodoxy in arguing that care aims at meeting needs, but suggested that eudaimonistic conceptions thereof were best suited to capturing the complexity of care. I then went on to consider how caring actions are to be evaluated. First, I showed how the account can accommodate the care ethical emphasis on consequences/completion and argued that it outperforms accounts that define care as necessarily successful. I then went on to consider how notions of practice might be evaluatively useful. I hope thereby to have contributed on a number of fronts. Not only do analyses like these help care ethicists distinguish their ethics from similar ones, they also unearth philosophical resources and set the discursive path. If the account defended here holds water, work on other understandings of care—as work, labor, or personal service, for instance—come into focus, and the theory of right/good action takes center stage. Hopefully, care ethicists will continue to explore the various topics at this juncture.

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Notes

1 Care ethics is not nearly as readily mistaken for a kind of deontology or consequentialism, though a great deal of work has been done to import deontological concepts like duty into care ethics (see, for example, Clark Miller 2012) and to defend Kantianism from care ethical objections (see, for example, Bramer 2010). In section III, I discuss the role care ethicists have afforded to consequences in their ethical theory.

2 If these examples are not convincing, consider two others. In the first, a parent buys their daughter, *E*, an ice cream on a day out—*E* certainly does not *need* an ice cream, but they desire it, and it makes for a nice ending to a wonderful day out. In the second, *F* would dearly like to read *Wuthering Heights*, but cannot find a copy anywhere. *F*'s mother goes out and buys them the novel for Christmas, and *F* spends the rest of their December holidays immersed in the book. It seems to me that we naturally describe both of the parents' actions as caring, despite the fact that neither case seems to involve meeting *needs*.

3 There are, to be sure, detractors, most notably the Stoics, who believe that virtue is sufficient for human flourishing.

4 Collins takes Bubeck to hold a similar view, and Lynch claims that Engster also endorses a success criterion (Collins 2015; Lynch 2016, 143–46). It is a separate question whether those needs must be met in a specific way—one can imagine situations where I act with the aim of meeting a need, and succeed in doing so, but not in the way I intended.

5 An open question remains regarding the moral assessment of cases where I act *uncaringly*, but unwittingly meet needs. Consider a case where a parent is abusive, detached, and spiteful, but through this their child learns patience, compassion, and grit.

6 Noddings herself acknowledges this (Noddings 2002a, 57).

7 There are also, as I shall argue in the next section, serious concerns about how we determine what successful care is.

8 MacIntyre offers "the making and sustaining of family life" as an example of a practice, so he might not exclude parental or romantic caregiving.

9 This is one of the most difficult elements of care: squaring one's own judgments with those of the care-recipient. On the one hand, we do not wish to suggest that children, "anti-vaxxers," or members of cults have an infallible grasp of what their flourishing consists in. On the other, it is clearly the case that caregivers are not always correct about what a care-recipient's flourishing consists in. There is a grey area in between these poles, but their difficulty does not count against care ethics. Ethics is not supposed to be easy.

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Steven Steyl is a PhD candidate at The University of Notre Dame Australia. His research interests include feminist philosophy, ethics of care, virtue ethics, and political philosophy, and his recent publications can be found in *The Journal of Business Ethics, Hypatia*, and *The Acorn*. (stevensteyl@hotmail.com)

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