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Abstract

In *The Ethics of Care*, Virginia Held (2006) explores what values of care might fulfil normative criteria for evaluating the moral worth of relations. Held identifies seven potential values: attentiveness, empathy, mutual concern, sensitivity, responsiveness, taking responsibility, and trustworthiness. Though Held's work is helpful as a starting point for conceptualizing some normative criteria, two problems need addressing. First, Held does not provide sufficient justification for why these potential values ought to be considered genuine values in the care ethical framework. Second, Held overlooks two other potential values cited in the care literature: competence (Tronto 1993) and respect (Engster 2007). This paper builds upon Held's work to offer a more coherent understanding of the values of care. It does so by scrutinizing and conceptually organizing the above nine potential values. Of these nine, only four are considered genuine values: attentiveness, mutual concern, responsiveness, and trustworthiness. It is concluded that good caring relations are those that exemplify the four values of care in their deliverance of caring practices.

Keywords: attentiveness, care ethics, Engster, feminism, Held, mutual concern, responsiveness, Tronto, trustworthiness, values

1. Introduction

In *The Ethics of Care*, Virginia Held (2006) defines care as both a practice and a value. Caring, as a practical activity, has intertwined values that offer normative criteria for evaluating the moral worth of relations.[1] This allows for an *ethics* of care rather than mere naturalized care. Held (42) argues these values (once identified) can be abstracted and extended to evaluate all relations beyond the personal, offering not just a political argument of care but a cosmopolitan account too. Held identifies seven potential values: attentiveness, empathy, mutual concern,

[1] Held also calls these values "moral considerations associated with care" (2006, 158).

sensitivity, responsiveness, taking responsibility, and trustworthiness.[2] Though Held's work is helpful as a starting point for conceptualizing some normative criteria, two problems need addressing. First, Held does not provide sufficient justification for why these potential values ought to be considered genuine values in the care ethical framework. Second, Held overlooks two other potential values cited in the care literature: competence (Tronto 1993) and respect (Engster 2007).[3]

This paper builds upon Held's work to offer a more coherent understanding of the values of care that fulfil normative criteria for evaluating the moral worth of relations. First, Held's definition of care is defended as a persuasive middle ground for classifying good caring relations—a middle ground between Daniel Engster's (2007) narrow interpretation of care and Berenice Fisher and Joan C. Tronto's (1990) broad interpretation of care. Second, the above nine potential values of care are scrutinized and conceptually organized to determine which can justifiably be considered genuine values in the care ethical framework. Of these nine, only four are considered genuine values: attentiveness, mutual concern, responsiveness, and trustworthiness. It is concluded that good caring relations are those that exemplify the four values of care in their deliverance of caring practices.

2. Classifying Good Caring Relations

There are two components to good caring relations: a threshold of care to be met as a practical activity between two or more persons and normative criteria to guide such care. This section focuses on the first component, elucidating a suitable definition of care as a practical activity. To avoid prolonged engagement with the myriad of definitions offered in the literature, the following approach is taken: first, a narrow definition of care is analyzed (Engster 2007), then a broad definition (Fisher and Tronto 1990), before, finally, a reasoned conclusion is reached in the middle (Held 2006).

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[2] The corresponding page numbers in Held's (2006) *The Ethics of Care* are: attentiveness, trust, and responsiveness (15); mutual concern, trustworthiness, and sensitivity (42); empathy, sensitivity, and responsiveness (119); and mutual concern, trustworthiness, attentiveness, and responsiveness (158). Trustworthiness as a value is defended through pages 56–57. Held (2006, 38–42) does say other modes of normative criteria could be utilized from outside the care ethical framework, such as values of justice (fairness, equality, and so on). To keep this paper's argument bounded, it is only contextualized within the care ethical framework.

[3] The reader may think of more values of care that ought to be considered. Due to space restraints, this paper only scrutinizes the above nine potential values given their dominant presence in the literature already.

Engster's (2007) work on care and political theory provides a well-bounded minimalistic definition of care. Engster's definition takes three forms. First, "caring practices may be said to encompass everything we do directly to help individuals to satisfy their vital biological needs" (26). Second, care aids "individuals to develop and sustain their basic or innate capabilities, including the abilities for sensation, movement, emotion, imagination, reason, speech, affiliation, and in most societies today, the ability to read, write, and perform basic math" (27). In turn, Engster emphasizes his care theory does not prescribe any ideal of the good life; it merely outlines the minimum standards we need to survive, develop, and function to pursue a perceived good. This claim will have important ramifications, as seen below. Third, caring is "helping individuals to avoid harm and relieve unnecessary or unwanted suffering" (28). These three forms of care are guided through adherence to three virtues of caring: attentiveness, responsiveness, and respect (30–31).

Though Engster helpfully provides a specified threshold for care (intended as universal), there is a problem with it: this narrow definition risks undermining care ethics as a feminist ethic. Tove Pettersen defines a feminist ethic as a critical ethic "that focuses on suppression and dominance, and often pursues political aims" (2008, 24). A feminist ethic ought to have the tools necessary to ensure it can critically evaluate and challenge social and political conditions of subjugation. Engster's definition risks being indifferent to many sorts of issues that are affected by oppressive systems—issues that a care ethic should be sensitive to. For instance, consider Engster's (2007, 108) comments on same-sex marriage. Engster is aware that a symbolic public gesture of legalizing same-sex marriage would legitimize this practice as normal in the realm of viable options open to society. However, Engster's minimal definition of care cannot capture this symbolic recognition. Engster states the arguments for and against symbolic recognition "fall outside the scope" of his care ethic, due to his theory's resistance to prescribing ideas about the good (108). Consider another example of multicultural importance: Muslim women publicly wearing a veil. Again, Engster's narrow definition prevents his theory having something of substance to say: "Care theory is neutral on other issues of multicultural justice that do not directly affect the ability of individuals to give or receive care" (107). Engster admits his reformulation of care ethics removes it "somewhat from the feminist context in which it has developed" (vii). However, if care ethics wants to analyze the moral worth of relations, it must be able to say something noteworthy about the broader context in which these relations are embedded.

A broader definition of care is therefore preferable. Fisher and Tronto (1990) have perhaps offered the most influential broad definition of care. Fisher and Tronto tie the concept of care to labour, defining it as "a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can

live in it as well as possible" (40). An advantage of Fisher and Tronto's definition is that it eschews a dyadic understanding of care. If care ethics is to transcend into the political realm, care must not be understood as merely referring to a personal relation (especially the archetypical view of mother and child). By defining care as the continual processes of work committed by a wide range of society to maintain, continue, and repair the world (nurses, teachers, social workers, and so on), then care ethics is in a better position to critically evaluate the surrounding social and political institutions that impact how successful this labour is.

However, a common criticism of Fisher and Tronto's definition is that it is too broad to guide a moral and political theory. Both Engster (2007, 24) and Held (2006, 32) have argued that almost too much of society's laborious aspects are included in this definition. For if much of our daily life consists in maintaining, continuing, and repairing the world, caring becomes indistinguishable from any given kind of practice. Held specifically argues that almost any amount of economic activity could be included in this definition, such as "retail sales, house construction, and commercial cleaning" (2006, 32). Consequently, the distinctive normative features of caring could be lost.

Though this criticism has been influential,[4] more could be said to enhance its effectiveness. For instance, the examples of economic activity Held (2006, 32) provides could still be interpreted in a way that reveals something about the normative features of care. Customer service in retail, house construction, and commercial cleaning require the maintenance of caring relations between customer, employee, and employer: there should be no exploitation in this labour, nor hostility, mistrust, or negligence. To show why Fisher and Tronto's definition is problematic, what should be highlighted are those activities that are not referent toward the normative considerations of care yet are still activities that would fit this broad definition. For instance, a person might maintain, continue, and repair their world through sustaining a garden of a thousand blades of grass, which this person religiously counts and keeps updated.[5] This would seem to count as an activity of care under this broad definition (perhaps caring for the environment), but there are no real means of discerning what values or moral priorities of care can be derived from this activity alone that are relevant toward the care ethical framework. Care theorists need not deny that the concept of care can be used elsewhere in different ways and, indeed, that the normatively relevant aspects of care they want to focus on can fit under Fisher and Tronto's broad definition. The problem, though, is that this does not go the other way; for the purposes of care ethics alone, Fisher and Tronto's broad definition cannot fit.

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[4] Joseph Walsh (2017, 819) has most recently reiterated this criticism.

[5] The "grass-counter" example is adapted from John Rawls (1971, 432).

Required is a definition that offers ways to critique the social and political institutions that impact the level of care given in society while retaining focus on the minimum threshold of care Engster identifies. The following argues that Held provides this definition. For Held, care is both "a practice and a value" (2006, 42). Care as a practice is concerned with cultivating and sustaining morally worthy relations over time, with individuals having the ability to be attentive and responsive to contextual needs to provide a minimum threshold of care, build trust and mutual concern, and continually scrutinize and improve one's care through the actual lived experience of caring itself. Held understands "needs" broadly, as "innumerable subtle emotional and psychological and *cultural kinds*, as well as of completely basic and simple kinds, such as for sufficient calories to stay alive" (39; emphasis added). Here, it is possible to read into Held's definition the same minimum threshold of care Engster identifies. Where Held importantly differs is her mention of cultural needs. This inclusion will inevitably require care theorists to engage with different cultural perceptions of the good, engaging with the social and political context that surrounds caring relations. How care ethics deals with various kinds of cultural needs (especially in cases of nontrivial toleration in pluralistic societies) remains unclear. While those issues cannot be dealt with here, this route is at least open.

Held (2006) consequently interprets care as a *reflective* practice, whereby the provision and receipt of care are continually scrutinized through iterated efforts and communication.[6] In this way, Held's interpretation of care has a built-in critical component that ensures an *ethics* of care, not merely naturalized or traditional care: "the ethics of care does not accept and describe the practices of care as they have evolved under actual historical conditions of patriarchal and other domination" (39). Not only should caring practices can be appraised and altered if needed, their surrounding social and political context ought to be as well. Of course, this implies there are normative criteria to guide such evaluative assessments.

The normative criteria that Held (2006) offers for guiding relations toward being good and caring refers to the second part of her definition of care: care as a value. For Held, caring practices are morally evaluated through a cluster of values intertwined with good caring practices, abstracted to help evaluate and guide caring practices generally. Held's method for deriving caring values follows a process of reflective equilibrium, applied in the following way. Successful caring practices are those that ensure persons survive and flourish. Given the unique needs of different

[6] Held (2006, 20) writes that care ethics is hospitable to methods of discourse ethics. However, what Held should also emphasize is that by "communication" we ought to mean both verbal and nonverbal methods. Nonverbal methods of communication are particularly important to provide adequate caring for infants, or persons incapable of ordinary speech.

persons in different contexts, caring is a continual process of cultivation and learning. Caring practices deemed successful can be examined for the values intertwined with them. Those values persuasively considered essential to ensure a relation is good and caring can then be abstracted as normative criteria. Therefore, good caring relations are identified when they exemplify these values. To foreshadow the next section, a brief indication of what these values could look like are "mutual concern, trustworthiness, attentiveness, [and] responsiveness" (158). These are values usually identified through our personal relations first, given these values manifest most strongly there. Held's argument, though, is that these identified values can be extended to evaluate the moral worth of all relations we hold beyond the personal.

An initial problem with the process Held uses to derive caring values might be raised here. The need to continually analyze our relations to ensure they are good and caring implies that any attempt to classify a selection of caring values is a nonstarter. Given the potential for a state of flux in assessing which caring practices work, the sorts of values we may identify might also be in a state of flux.

The response to this initial problem is this: whereas caring practices may frequently change, the values that abstract from these practices do not. Instead, these values form a stable normative guideline that can be fulfilled in a multitude of ways, depending on the relational context and range of caring practices utilized. Consider an example: how we might care for a person's mental health. It is sometimes necessary to alter caring practices when attending to a person's mental health to determine the specific practice that will help that person. It is possible to abstract from this scenario some values that hold constant, which capture the purpose for why these practices are altered. For instance, there is a need for attentiveness (understanding the person's needs correctly) and responsiveness (determining which practices work better than others through examining the person's responses). Attentiveness and responsiveness, in this example, can then be useful normative criteria to help guide what caring practices are more effective than others—not only in helping a specific person's mental health but mental health issues universally. Such values, then, inevitably spill over into broader social and political relations—perhaps, in this example, to suggest making institutional changes that provide more resources to mental health issues so that the values of attentiveness and responsiveness can be better exemplified. As Selma Sevenhuijsen puts it: "How we can care depends to a great extent on how we give shape to our society" (1998, 151). Relations, and their surrounding institutional context, can be criticized and called for modification when they become "dominating, exploitative, mistrustful, or hostile", precisely because they undermine caring values and therefore the possibility for good caring relations (Held 2006, 37).

This is not to say there is a clear dichotomy between recognizing a good caring relation from an immoral relation. There is plenty of interpretative space for pinpointing how morally valuable a relation is. This point might raise two final questions: Does a relation foster good caring practices (and therefore satisfies the threshold of care listed above) but lacks associative caring values? Does a relation foster caring values but inadvertently provides poor caring practices? Though these are reasonable questions, the response is that it is inappropriate to prise apart the caring practice from its intertwined values. This is because such values are embedded in and exemplify good caring practices in and of themselves. Some caring relations may exemplify these values stronger than others; yet, without these moral considerations at all, no good care would be provided.

This section concludes that Held's classification of good caring relations is preferable: good caring relations are those that meet the threshold of care as a practical activity through evaluative guidance by the values of care.

3. Caring Values

This section elucidates what a caring value is and which caring values fulfil normative criteria for evaluating the moral worth of relations. Held (2006) identifies seven potential values: attentiveness, empathy, mutual concern, responsiveness, sensitivity, trustworthiness, and taking responsibility. However, Held does not provide sufficient justification for why these potential values ought to be considered genuine values within the care ethical framework. Moreover, Held overlooks two other potential values cited in the care literature: competence (Tronto 1993) and respect (Engster 2007). These values also need scrutiny.

First, some conditions are required for classifying a caring value. A good starting point is to consider the different language Engster (2007) and Held (2006) use when referring to moral considerations of care. As seen in the previous section, both authors refer to the concepts of attentiveness and responsiveness. However, Engster refers to these moral considerations as virtues of care while Held calls them values of care. What explains this difference? Whereas Engster focuses on the disposition of the individual, Held's central unit of moral analysis is the relation between individuals. This does not say Held pays no attention to individuals' dispositions; Held (2006, 44–57) argues that it is necessary for individuals to develop certain traits—including being attentive and responsive to others—to allow caring relations to flourish. However, for Held, this conceptualization does not go far enough. Focusing only on individuals' traits does not fully capture what Held thinks is normatively at stake with caring relations: the moral *value* of attentiveness and responsiveness (that is, their success in allowing caring relations, and therefore the individuals involved, to flourish) is only revealed through the relation of two or more persons—not the lone individual. Indeed, without a relational context, we would not

know that the virtues of being attentive and responsive are good traits to develop. Care ethics' emphasis, then, is on the relational value of the moral considerations of care, whereas virtue ethics focuses on perfecting an individual's virtues. This does not intend to label Engster as a virtue ethicist; it only says that Engster does not do enough to separate care ethics from virtue ethics.

Caring values are therefore not reducible to an individual's virtues or sentiments—they are *relational* moral considerations of care that form independent moral criteria for evaluating relations. This is to say, as Held (2006) does, that moral scrutiny ought to be critical and not phenomenological—after all, the value that some individual attaches to a relation may be misplaced if, for instance, that individual is being exploited for their obsequiousness or a relation is exemplifiable of structural injustice (such as household relations within patriarchies). Methods of discourse ethics (both verbal and nonverbal) ought to be employed by those internal and external to the relation to ensure some level of accuracy in the evaluation of that relation's moral worth.

Many potential values might be shortlisted from these above conditions. For parsimony in categorizing potential values, it is useful to also posit a caring value as a stand-alone and independently recognizable moral consideration, whereby such a value refers to a distinct moral issue of a relation. Where a potential value can be subsumed as a subtype of another perceived value, this ought to be pursued.

A caring value, then, is a standalone, relational moral consideration of care that guides relations toward successful caring practices. This classification provides a basis to now evaluate which of the nine potential values listed above are genuine caring values. Of course, in the following delineation of each value, it is not intended that each outline is complete—each value could fill the interest of a whole book.[7] These values are examined to the extent that they show whether they ought to be considered genuine values in the care ethical framework.

A note on the order of this analysis: though these values are listed alphabetically to provide some logical structure, these values are closely intertwined. A useful way of reading this analysis will therefore not necessarily be to evaluate each value in any strict order, but to examine them holistically as a cluster. For example, it is helpful to read the following values' analyses together: attentiveness, empathy, and sensitivity; attentiveness, respect, and responsiveness; and competence and responsiveness. This not a complete list of all the possible combinations, but a signposting of the most obvious ones.

[7] This is especially the case for trustworthiness. See Hardin (2002) and Potter (2002).

3.1 Attentiveness

Tronto offers the most straightforward definition of attentiveness in the care literature: attentiveness "requires the recognition of a need and *that there is a need to be cared about*" (1993, 127; original emphasis). While the nonitalicized part of Tronto's definition states the importance of recognizing the needs of others, this is not enough by itself to capture what is at stake with attentiveness. One could recognize a need without the normative pull to do anything about it. The italicized part of the definition completes this by emphasizing that identified needs require active intervention to be cared for.

This is a good start, but Tronto's definition can be enhanced. As Peggy DesAutels (2004) writes, attentiveness requires more than basic recognition of a need; attentiveness must also embody a "nonpassive vigilance of thought where we attempt to counter known psychological tendencies and subtle social influences that prevent us from seeing and responding to the demands of care" (72). Effective attentiveness requires a critical component, given our basic recognition of other's needs may be restricted or impeded in some way by potential biases in our subjective experiences. DesAutels' example concerns sexism: sexist influences may make us unaware of, or inattentive to, a particular moral demand for care. This has ramifications in both our personal relations and broader political society. As Tronto observes, in modern industrial societies tasks of caring (such as nursing and social work) "continue to be disproportionately carried out by the lowest ranks of society: by women, the working class, and in most of the West, by people of colour" (1993, 113). Social and political institutions can be evaluated by centralizing these caring practices, by assessing how far these carers are marginalized and held to the periphery of political life. Without attention to these issues, the interests and activities of the relatively powerless remain "omitted from the central concerns of society" (Tronto 1993, 20).

To counter these impediments, one must break out of one's subjective experiences to empathetically connect with the experiences of others in compassionate ways. This is not an easy task, though moral education of the kind advocated for by Engster (2007), Nel Noddings (2002, 2006) and Michael Slote (2007) may be especially helpful to enrich our empathetic capacities to this end. For instance, the promotion of prosocial behaviour through young children's curricula featuring social-emotional learning programs has been shown to broaden young people's empathic capacities (Cohen 2001). This could have significant consequences as these generations become politically active and demand greater support toward institutions of health, social care, and so on.

Attentiveness is a value, then, for it encourages and maintains successful caring practices within a relation. If a relation does not exemplify attentiveness, no effective care is being given—to the detriment of the individuals involved. If no

needs are identified, no needs can be properly cared for. As such, a relation exhibiting negligence through inattentiveness damages the flourishing of individuals involved. Deliberate inattentiveness is negligence in its clearest immoral form. Not only is care not being provided where it is needed, capable caregivers deliberately avoid providing this care. Unless a serious change occurs here, the relation almost certainly will break down—perhaps at the expense of the cared-for if they are particularly vulnerable. Yet given the complexity of our moral lives, degrees of immoral relations may begin emerging through the type of negligence that occurs. After all, not all negligence is deliberate. Providing wrongful but well-meaning care may be forgiven if there has been an honest mistake in its provision. Indeed, good caring practices result in part from making mistakes and learning through experience. Nonetheless, accidental provision of wrongful care is still indicative of a potentially poor caring relation, and better care ought to be provided in the future.[8]

What is harder to normatively pin down, as Tronto comments (1993, 129–130), is inattentiveness through ignorance. This refers to cases where a lack of knowledge leads to inevitable inattentiveness; we are not attentive because we do not even know there is something to be attentive about. DesAutels (2004) offers some guidance here: to overcome ignorance of a cared-for's needs is to be critically aware of whether certain prejudices are blinding us. But if we do not realize there is a prejudice blinding us, can moral blame still be attributed?

A distinction between honest ignorance and willful ignorance may make sense of how moral blame could be applied. Honest ignorance can be absolved insofar as positive changes occur in the caring relation once this ignorance is realized. However, to continue business as usual without making positive changes is acting through willful ignorance and deserving of moral blame. To illuminate this point, consider a parallel with Darrel Moellendorf's (2014) argument on historical injustice regarding climate change. Our ancestors of the industrial revolution had no idea about the impact their actions would have for polluting the planet. For that reason, Moellendorf argues that the locus of moral significance should not be on the decisions of our ancestors; it is instead with those people or industries that "voluntarily and knowingly create problems" (165). The injustice sits with those that continue to emit considerable greenhouse gases through willful ignorance. Willful ignorance is therefore synonymous with deliberate inattentiveness and consequently morally problematic: it entails a considered attempt to ignore

[8] Here, this discussion on attentiveness could move into questions on the justification of individual rights to protect from harmful interference in one's life. However, such questions on how caring values and individual rights could be made compatible move beyond this paper's purpose. For some discussion elsewhere in the literature, see Engster (2007), Held (2006), and Robinson (1999).

rectifying the plight and suffering of others when one is able and, consequently, to ignore one's responsibilities.[9]

3.2 Competence

Tronto (1993) lists competence as a moral consideration of care for the following reason: failing to provide good care "means that in the end the need for care is not met" (133). Competence arises as a moral consideration, then, in the practical provision of care. It is concerned with the consequence of whether successful caring practices have been effectively delivered, not necessarily the motive behind the care. If a knowingly incompetent person attempts to deliver a certain caring practice, Tronto argues, good care becomes "impossible" in this context (133). However, again, our moral lives are more complicated than this suggests. It is not always true that the locus of moral blame should be placed on an incompetent carer. Incompetent caring may point to broader structural issues that have prevented individuals from being able to provide good care. Tronto gives the example of an overrun teacher in a poorly funded educational system; the teacher is doing the best they can with the poor resources at their disposal (134). Yet if a better-qualified teacher is readily available, and the overrun teacher refuses help (or an administrator refuses such help), then perhaps moral blame can be justifiably attributed.

Regardless of these intricacies, it is not clear that the moral considerations of competence are enough to ensure it can be considered a stand-alone value. This is for two reasons. First, there is nothing in competence itself that indicates a normative pull toward caring. Competence is necessary for good care, but competence is also necessary for efficiently carrying out a practice of torture. As such, competence cannot be viewed as an intrinsic caring value. Second, it is difficult to see how competence could be a stand-alone value when contextualized with responsiveness. Responsiveness, as seen below, is a much broader concept than competence. Responsiveness has two principal components, with the first component being how successfully one has attended a cared-for's needs. Should an unsuccessful caring practice be poorly delivered, responsiveness as a value indicates we ought to be morally suspicious of this relation and evaluate it accordingly. Therefore, competence is subsumed by responsiveness: rather than being an independent moral consideration, competence is better understood as referring to the abilities of the carer in the broader moral picture of responding to a person's needs. As such, competence should be considered as an instrumental component for exemplifying responsiveness.

[9] For a detailed analysis of willful ignorance, see Wieland (2017).

3.3 Empathy

Michael Slote (2007) has offered the most sustained work on how empathy ought to be understood in the care ethical framework. To be empathic is to have "the feelings of another (involuntarily) aroused in ourselves, as when we see another person in pain. It is as if their pain invades us" (Slote 2007, 13). This is different from having sympathy for a person, which only entails "feeling *for* someone who is in pain" (13). Though empathy is a fundamental component of engaging in good care, it is not clear that empathy by itself can be considered a stand-alone value. This is for two reasons. First, empathy lacks an intrinsic normative pull toward the provision of good care. As Paul Bloom writes, empathy is necessary "for anyone who wishes to be a good person—but it is morally neutral" (2013, 57).[10] Empathy is morally neutral because, just as with competence, it is a consideration that could be manipulated to learn how to be a better torturer.

Second, empathy is straightforwardly subsumed into both attentiveness and responsiveness. As seen with attentiveness, empathy is required to understand the cared-for's own subjective experience. Furthermore, with responsiveness, empathy is necessary to determine how successful the provision of care has been. Importantly, attentiveness and responsiveness as values avoid the above criticism of empathy by stating: not only must we be empathetic to understand people's needs, *we also ought to care for those needs* and *respond appropriately and effectively*. Empathy, taken by itself, does not guarantee this conclusion. Therefore, empathy is better understood as a necessary component of attentiveness and responsiveness.

3.4 Mutual Concern

Mutual concern generally refers to a common interest shared and pursued by two or more persons. However, Held interprets mutual concern in a specific way. For Held, mutual concern as a caring value is expressed between relations when there exists a shared interest to make possible the cooperation required to develop and sustain association for the benefit of all involved. In other words, care ethics see the interests of individuals as "importantly intertwined rather than as simply competing" (2006, 15). As such, mutual concern ought not to be understood as merely when one person's self-interest happens to align with another's self-interest,

[10] Bloom's argument is to argue against what he calls "emotional empathy" in favour of rational compassion—that is, compassion rationally guided to make good moral decisions. While part of Bloom's argument helps show what is mistaken about Slote's claims, care ethicists would not go so far as to accept Bloom's conclusion. It is the marriage of our emotional and reasoning capacities together that needs emphasis, not one capacity having priority over the other. See Baier (1994), Held (1993), and Meyers (1994).

or when persons are "competitors for benefits" (Held 2006, 34). Mutual concern is therefore not synonymous with altruism: caring practices should not be interpreted as zero-sum games, and the surrounding institutional context of such practices ought to reinforce that. Given mutual concern refers to the success of caring practices through the intertwined interests of those individuals involved in the caring relation, mutual concern is a caring value.

Held defends her definition of mutual concern in her critique of the liberal contractual model of social relations. Writers in the contractual tradition have generally sought to derive principles to design fair, legitimate institutions that are "acceptable to us as free, equal, rational, and fully impartial persons" (2006, 81). In this context, persons are conceptualized as seeking to further their self-interest; relations between these persons are contractual to this end. Held (80–81) makes several influential arguments against this contractual model of social relations, though one pertinent argument can be singled out: mutual concern cannot only refer to contractual relations between self-interested strangers because this would degrade many types of relations that have shared interests beyond the individual. Friendships are one example: although some aspects of friendship are beneficial to each individually, "if self-interest is all that motivates them" to continue their association, this friendship would be "superficial at best" (81). Mutual concern in friendships (and other intimate relations) is instead focused on the amalgamated interests that result through persons coming together in association—interests that are constitutive of all the individuals involved.

Mutual concern as a value is undermined when these shared interests are severed. This is straightforwardly seen in cases of domination. If a person exploits their naïve friend, this relation no longer is a good caring one. Yet, again, our moral lives are more complicated than this suggests. For instance, if mutual concern is undermined due to cases of paternalism, to what extent can a relation be immoral? Paternalism occurs when we interfere in another person's life because we believe our interference will make their life better, even if it is against that person's will. There is no *prima facie* mutual concern here, but the destruction of a relation may not immediately follow. Relations are complex and are usually not built upon a single issue—a paternalistic act may not lead to the relation's end (such as a parent stopping their child gorging on sweets). Perhaps mutual concern as a value may simply recognize the potential for paternalism to produce immoral relations and consequently require greater communicative effort to improve the way caring practices are delivered. This is especially true if the paternalistic act sought to achieve the threshold of another's care (as with a parent's care for their child).

Of course, sometimes communication does not go well, or circumstance prevents communication happening. In serious cases of domination, the relation could cause severe harm to the individuals involved. Care theorists do not tolerate

domineering relations of this kind, and when options to repair the relation fail, the relation ought to be ended to the extent possible (although sometimes this is only a limited extent: we will never stop "being the sibling of our siblings, or the ex-friend or ex-spouse of the friends or spouse with whom we have broken a relation" [Held 2006, 96]). Ultimately, in this rich ethical milieu, an appeal to care ethics' moral epistemology is necessary. To effectively analyze each scenario of paternalism and domination (and the grey space between these concepts), "sensitivity to the multiple relevant considerations in particular contexts" is required (Held 2006, 20). Without a fuller picture of the normative situation surrounding a paternalistic or dominating act, offering a universal "right answer" would be a dubious promise. However, the general point is this: if there are no clear intertwined interests between two or more parties, but one side pushes to keep the relation going in its present state, we ought to be morally suspicious of this relation and evaluate it accordingly.

3.5 Respect

Respect is listed as one of Engster's (2007) three virtues for guiding care. By respect, Engster does not mean anything as strong as "equal recognition of others," but simply the recognition that "others are worthy of our attention and responsiveness, are presumed capable of understanding and expressing their needs, and are not lesser beings just because they have needs they cannot meet on their own" (31). Respect as a virtue is practised through treating others in ways that do not "degrade them in their own eyes or the eyes of others" (31). This is a good start for clarifying respect as a concept, but it is not clear that respect is best understood as a virtue in the context of care. This is because respect is object-generated rather than subject-generated. That is, respect involves "a deontic experience"—we respect something because the object of attention demands our attention, not merely because we want to give it (Birch 1993, 315). As John Rawls writes, respect is the recognition of something "as directly determining our will without reference to what is wanted by our inclinations" (2000, 153). Consequently, it would be better to say that respect is a relational moral consideration that emerges through our interactions with others.

However, though respect can be interpreted as a relational moral consideration, it may not be a stand-alone caring value. Instead, respect would appear to be subsumed into attentiveness and responsiveness. On respect being subsumed into attentiveness, the following argument can be made. Respect entails a deontic experience, whereby the individuals involved in a caring relation have a need to not be demeaned or degraded in their own eyes or the eyes of others. Attentiveness is the recognition of another's needs and that these needs require caring for. If we are not attentive to the need for not being degraded or demeaned

through caring practices, then the value of attentiveness is undermined. Therefore, if the value of attentiveness requires the need for not being degraded or demeaned to be recognized, respect forms an important component of attentiveness.

A similar argument can be made for why respect is subsumed by responsiveness. Responsiveness as a value is exemplified if a person's needs are successfully cared for. Part of responding successfully is not degrading or demeaning the them in their eyes or the eyes of others. If that person does not respond positively to care given to them because they have been degraded or demeaned, then the value of responsiveness would be undermined. Therefore, respect also forms an important component of responsiveness.

3.6 Responsiveness

Whereas attentiveness refers to the successful recognition of needs that require caring for, responsiveness indicates how successful attending to those needs has been. Responsiveness has two major features. The first feature involves the ability of responding to a person's needs. Here, competence is an instrumental component of providing good care. The second feature is how attentive the carer is to the response given by the cared-for to determine if the care provided was well received. This second feature deserves emphasis: when we are inattentive to how well received care is, good care could degenerate if we do not know the care provided is appropriate. Therefore, this feature of responsiveness "requires that we remain alert to the possibilities for abuse that arise with vulnerability" (Tronto 1993, 135). It is one thing to respond to a person's needs; it is another whether this response was appropriate. Given this normative pull toward promoting successful caring practices, enabling evaluation of the moral worth of a relation vis-à-vis the interactions between the individuals involved in the provision and receipt of care, responsiveness is a value.

An important implication of responsiveness is how responsive the carer is to their own well-being. There is a need "to keep a balance between the needs of care-givers and care-receivers" (Tronto 1993, 135). Unless the carer also receives suitable amounts of rest and other resources to pursue opportunities and projects that give meaning to their life, two undesirable outcomes result. First, the care given will become less effective as the carer burns out. Second, and perhaps most important, there is a risk the carer becomes conceptualized as merely a tool of care provision. A prominent criticism of Noddings's interpretation of care ethics was just this: Sarah Hoagland argued that Noddings's carer seems only to be a "martyr, servant or slave" (1991, 255). The danger is the carer's sense of self could be lost if the only reason they rest is for providing better care. Therefore, to be responsive to oneself is to acknowledge that the reasons for rest are not merely to improve one's care but also to develop and reinforce self-respect.

While Hoagland (1991) raises an important point, it is still possible to provide some defence to Noddings. Though the reasons for being responsive to our well-being do not entirely encompass being better carers, it is the case that upholding our caring responsibilities is also a source of meaning and reinforcement of self-respect. Caring practices include a wide range of activities, from attending biological needs to serving cultural needs. The successful iterations of these relational activities grant confidence in one's abilities and a positive outlook of the self. Consequently, it does not necessarily follow that resting to partake better in caring practices entails the denigration of the self into a tool of care. However, when caring practices within a relation become a negative burden upon the carer and do impact upon a carer's self-respect, this relation ought to be treated with moral suspicion and evaluated accordingly.

3.7 Sensitivity

Held (2006) understands sensitivity as the capacity for being considerate to a person's complex needs. Though mistaken interpretations of needs "are usually frequent on both sides," steady progress moves us toward learning how to respond best and how to avoid the frustrating of these needs (53). Here, sensitivity is not empathy. Sensitivity only requires us to become more attentive to a person's needs to better understand them. This does not require an empathic connection, given this might be impossible in some cases. Instead, sensitivity is closer to sympathy—feeling *for* someone through the better recognition of their needs. Moreover, sensitivity is not quite attentiveness. While sensitivity reflects the first part of attentiveness (the recognition of a need), there is no inherent normative pull in sensitivity that requires one to then do anything about that need.

This latter point is important for establishing whether sensitivity is a caring value. For as Held continues, sensitivity "is not always an admirable capacity: It can be used to inflict pain more effectively" (2006, 54). This criticism is barely distinguishable from one of the major problems levied at empathy above: it is possible to manipulate sensitivity for improving non-caring practices, such as the torture of another person. Consequently, sensitivity is not a caring value. However, sensitivity does play an important role in two other values: attentiveness and responsiveness. While sensitivity embodies the first part of attentiveness, it is also important for the second part of responsiveness: knowing whether one's caring was positively received. Unless we are sensitive to this facet of caring, responsiveness will be undermined as a value.

3.8 Taking Responsibility

Responsibility is a difficult concept to define. Indeed, Tronto writes, "responsibility is among the handful of concepts that require constant evaluation"

(1993, 131). This is because of the ambiguity that undergirds who has what responsibility of care to fulfil: responsibility "has different meanings depending upon one's perceived gender roles, and issues that arise out of class, family status, and culture, including cultural differences based on racial groupings" (133). However, a general definition can be derived: to take responsibility is to be made accountable for the successful fulfilment of a caring practice. What this responsibility is made up of depends on one's context.

However, when understood this way, responsibility seems instead to be the product of what relations generate for the individuals involved. For instance, we might have responsibilities to respect our shared interests, to maintain trustworthiness, to be attentive to other's needs, and to be responsive to those needs (including our own). To avoid one's responsibility is to ignore these caring values and risk damaging one's relations. Taking responsibility is therefore not a value in and of itself—it is rather the manifestation of undertaking what responsibilities caring values generate. Of course, some questions can be raised here: how exactly are these responsibilities generated through our relations, and what is the nature of these responsibilities? Moreover, as Tronto writes of *The Ethics of Care*, "Held's concern to establish the moral qualities of caring does not help us answer the question: for any given caring need, *Who is responsible?*" (2008, 215; original emphasis). Unfortunately, this paper does not have the space to engage with these questions. Instead, this paper hopes to have provided a normative foundation for such engagement to begin.

3.9 Trustworthiness

Trustworthiness characterizes the expectation that persons in a relation will remain loyal and not pursue deceitful or hostile actions toward each other. Through successful iterated caring practices, trustworthiness in a relation is exemplified to a stronger degree; this enables greater intricate engagement between the individuals involved. As Annette Baier (2004, 177) has argued, these activities of trust-building are mutually reinforcing, creating a "climate of trust" in which relations become increasingly meaningful over time.[11] When this climate of trust is undermined through betrayal, the poisoned relation can be evaluated on its poor moral worth accordingly. Should there be a desire to reconstitute this damaged relation, rebuilding the climate of trust is a fundamental component to ensure its success: the process of relational repair requires "restoring or creating trust and hope in a shared sense of value and responsibility" (Walker 2006, 28). If there is no expectation a person will be able to continue rebuilding such trust, forgiveness and

[11] Cf. Baier (1994) and Harding (2011).

restoration of the relation dissipates. Given the importance of trustworthiness to begin, maintain, and strengthen caring relations, trustworthiness is a value of care.

There are different accounts of trustworthiness that can emerge here, which Karen Jones (1999) labels "risk-assessment" and "will-based." A "risk-assessment" account of trustworthiness underpins nonintimate relations. This view describes a climate of trust between persons in a formal or professional context when there is mutual concern to act in a particular way. Consider an example of "formal caring": a relation between a nurse and patient. If a primary purpose of nursing is to provide aid to its patients through guidance by the Hippocratic oath, this "contract" produces a normative expectation that the trustee—the nurses, and broadly the health care system—will fulfil this purpose. Without this background condition of expectation, there would be no possibility for trust (McLeod 2002, 19). As Held writes, "To achieve whatever improvements of which societies are capable, the cooperation that trust makes possible is needed" (2006, 42). Ignoring, refusing aid to, or worsening the plight of others poisons the climate of trust between these persons, and thereby the possibility for good care.

A "will-based" account of trustworthiness allows for more intimate relations to unfold within this broader risk-assessment image and follows Baier's (2004) interpretation of trust outlined above. On a will-based account, trustworthiness emerges through a trustee motivated by goodwill to another person: the trustee acts to reinforce trustworthiness because they are engrossed with that other person. This account of trustworthiness is better suited for "informal caring," such as between a parent and child. Whereas the risk-assessment account does not assume that persons care for each other intimately, the will-based account does assume the possibility of such intimacy. Both accounts align by holding a normative expectation that the trustee does what they should do, and not a predicative expectation that they will (Jones 2012).

3.10 Summary

Following this section's analysis of nine potential caring values, four are concluded as genuine values in the care ethical framework: attentiveness, mutual concern, responsiveness, and trustworthiness. Competence, empathy, respect, sensitivity, and taking responsibility are rejected as stand-alone values. Competence, empathy, respect, and sensitivity are subsumed by the four genuine values, while taking responsibility is the manifestation of undertaking what responsibilities our relations generate.

4. Conclusion

This paper sought to offer a more coherent understanding of the values of care that demarcate the threshold of good caring relations. Of the nine potential

values identified, only four are concluded as genuine values within the care ethical framework: attentiveness, mutual concern, responsiveness, and trustworthiness. As such, good caring relations are those that exemplify the four values of care in their deliverance of caring practices.

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