Chapter 1: Introduction

Moral theories tend to have slogans. Consequentialists maximise (or satisfice) the goodness of their actions' consequences; deontologists respect certain rights and abide by certain duties; virtue ethicists cultivate flourishing characters. This book is about the slogan of a hitherto under-explored moral theory: care ethics.

Care ethics seeks to explain the imperative to enter into and maintain caring relations. This book aims to provide a new synthesis of the normative commitments that have emerged, over the last thirty years, as being central to care ethics. The goal is to use the tools of analytic philosophy to specify, unify, and justify these normative commitments, in a way that sheds new light on the theory.

To that end, Part I the book surveys the vast literature that has arisen over the last thirty years within care ethics. It seeks to construct -- in a way that is clear and accessible to those unfamiliar with the theory -- the most plausible version of the key normative commitments that have emerged within that literature. Part I ultimately arrives at four key claims of care ethics, explaining how this version of care ethics arises out of critical reflection on the existing literature. These four claims, though, will be somewhat under-specified and only loosely connected.

Part II seeks to give a justification of these four claims that will serve to both specify and unite the claims, thus removing their under-specified and loosely connected appearance. The aim is to bring these four claims under a single theoretical slogan. Although the slogan of care ethics remains elusive, most care ethicists agree that relationship*s* -- between caregivers, care recipients, supporters of caregivers, and caregiving institutions -- lie somewhere near the normative heart of the theory. Part II makes this general claim more precise, arguing that care

ethics' slogan is 'dependency relationships generate responsibilities.' I start Part II by presenting a new, detailed vision of precisely what dependency relationships consist in. I then use that conception of dependency relationships to unify, justify, and further specify the four claims developed in Part I.

As well as providing a unified systematisation of care ethics, this book has another, subsidiary aim: to bring care ethics into the mainstream of analytic theory. Scholars have recently explored the similarities between care ethics and the mainstream theories of consequentialism (Driver 2005), Kantian deontology (Bramer 2010; S.C. Miller 2012), and, most often, virtue ethics (Halwani 2003; Slote 2007; though see Sander-Staudt 2006 and Noddings 2010, ch. 5 for rebuttals). Care ethics' fraught relationship with liberal social contract theories has also been assessed (Kittay 1999; Silvers and Francis 2005; Stark 2007; Bhandary 2010). And scholars have explored the relation between care ethics and non-mainstream moral theories, such as Confucian ethics (Li 1994; Luo 2007; though see Star 2002; Yuan 2002; and Noddings 2010, ch. 5 for rebuttals) and African ethics (Harding 1987). At a more applied level, the care ethical approach has been used to great effect in analysing real-world ethical and political problems (Barnes 2012; Robinson 2011; Sevenhuijsen 1998; Tronto 2013).

Despite this, we do not have a precise analysis of care ethics' central normative commitment. Care ethics remains a somewhat shadowy entity at the outskirts of debates in analytic moral philosophy, often mentioned in connection to feminism and to virtue ethics, but without a definitive statement of precisely what its advocates are committed to -- without a slogan. (See, for example, chapter 12 of James Rachels' (2003) widely-used textbook on moral philosophy, where care ethics is described as an ethics purely of the 'home and hearth' before being folded into virtue ethics.) My hope in writing this book is that we can bring care

ethics into the framework of mainstream analytic moral philosophy by crystallising its conceptual core, without simplifying (or worse, ignoring) its key feminist and phenomenological insights.

Some readers -- some care ethicists -- will be wary of the task I have set myself. Care ethicists have tended to deride the idea that their theory might be explicable in terms of a precise, unitary, abstract slogan. Marian Barnes is correct when she says '[i]t is those philosophers who have responded to the real life and often messy moral dilemmas that people have struggled to make sense of in their everyday lives who have developed an ethic of care, not those who seek to determine moral principles through a process of logical argumentation.' (Barnes 2012, 17–18) And Anca Gheaus is correct when she asserts that ''care,' as it is employed in the feminist ethics of care literature, is better understood as a group of concepts with strong family resemblance but no essential trait in common.' (Gheaus 2009, 64; see similarly Bowden 1997, 2–6) Care ethicists seem to suspect something important would be lost in the assertion of a slogan, so do not even attempt to provide a clear statement of *the* normative core of the theory. (This is not to say theorists do not give clear definitions of 'care' itself. Those abound, as we shall see in Chapter 3. And a few have given general formulations of the imperative to care but, again as we shall see, this tends to be done in a derisory or not wholly general fashion -- see Chapter 2.)

It is my contention that the gulf between Barnes' two sets of philosophers is not so wide -- indeed, that almost all moral philosophers aim to respond to messy details *and* use logical argumentation to determine principles -- and that the insights of the former can be translated into the language of the latter. Contra Barnes, I believe that care ethics can be 'encompassed in abstractions' (2012, 18) -- or at least, its core normative commitment can. And while I agree with Gheaus about how the notion of care *has been employed* in the

literature, contra Gheaus, I believe the group of care ethical concepts *does have* an essential trait in common. The aim of this book is to defend these beliefs.

Why should we want to crystallise care ethics in this way? There are two main motivations. The first is that, unless care ethics has a core normative commitment, we might wonder whether it is a moral *theory* in any meaningful sense. As long as care ethics is simply a collection of statements that have been made by people who happen to call themselves 'care ethicists,' it will be unclear what is in the theory and what is out. There is no way to know if a new claim made by a self-proclaimed care ethicist is true to the theory's guiding commitment, and no way to know whether existing claims should be rejected as not truly care ethical. The second motivation is more humble. This is that we should not simply *assume* care ethics lacks a slogan. We should at least hear out attempts to establish a unified, precise, explanatory statement of care ethics' core slogan. This requires that someone attempts to establish the theory's slogan. If my proposed slogan does not work, the ball is back in the court of the anti-unifiers.

This introductory chapter proceeds as follows. In the next section, I give a broad overview of the range of claims typically associated with care ethics. This will serve to give the reader a 'feel' for the view that is to be unified, specified, and justified as the book proceeds. The following section makes some methodological remarks about the relationship between care ethics, ethical and political philosophy, feminism, and the history of philosophy. The chapter closes by giving an overview of the argument that is to come.

1.1 Care Ethics: The General Picture

Care ethicists start by taking the experience of decision-making as crucial data for ethical and political theorising. They point out that, when deliberating about what we morally ought to do

in some concrete scenario, we typically take account of the particularities and complexities of the relationships between the unique persons in the dilemma. We do not apply abstract rules or perform regimented calculi. These decision-making processes often strike us as coldly lacking in moral qualities or not quite suitable for the given situation. Rather, we consider concrete, particular others in complex webs of relationships. Because of their complexities, our relationships with particular others (and those particular others themselves) seem to be an irreducible part of moral justification and deliberation. Principles -- understood as conditionals ('if X, then Y' statements) with an imperative ('do this') consequent -- are at best insufficient, and at worst distortive, for proper moral justification and deliberation.

Famously within care ethics, this approach to moral deliberation is revealed by the data of psychologist Carol Gilligan (1982), who investigated the thought processes of women facing moral dilemmas. In contrast to findings about men in earlier studies (Kohlberg 1973), Gilligan found that many women did not appeal to general principles or make categorical assertions about right and wrong. They instead used 'the responsibility conception,' which 'focuses on the limitations of any particular resolution and describes the conflicts that remain.' (Gilligan 1982, 22) This seeming lack of decisiveness was a result of women subjects' perception that each dilemma involved many conflicting responsibilities. Paradigmatically, Gilligan described 'Amy,' a subject who saw a particular dilemma as 'a narrative of relationships that extends over time' in 'a world that coheres through human connection rather than through systems of rules.' (1982, 28–9) (The approach of using real people, facing real problems of care, is more recently deployed by Barnes (2006).)

Through reflection on such thought processes, care ethicists are led to the following general claims: that responsibilities derive directly from relationships between particular people, rather than from abstract rules and principles; that deliberation should be empathy-

based rather than duty- or principle-based; that personal relationships have a moral value that is often overlooked by other theories; that at least some responsibilities aim at fulfilling the particular needs of vulnerable persons (including their need for empowerment), rather than the universal rights of rational agents; and that morality demands not just one-off acts, but also certain ongoing patterns of interactions with others and certain general attitudes and dispositions. Most importantly, care ethicists claim that morality demands actions and attitudes of *care*, in addition to or even in priority to those of respect, non-interference, and tit-for-tat reciprocity (which care ethicists generally see as over-emphasised in other ethical and political theories). These views will be elaborated upon in Part I.

Not all care ethicists hold all of these views, different theorists define them differently, and different theorists emphasise different ones. Nonetheless, this loose cluster of claims gives us some sense of what care ethicists believe matters morally. It is difficult to be more precise, as there is no generally agreed-upon statement of what care ethics *is* -- providing a much more precise statement is the aim of this book, and refining this preliminary cluster of claims is the aim of its early chapters.

It is equally hard to specify exactly what care ethics is not. From early in its history, care ethics was contrasted to 'traditional' (e.g., utilitarian and Kantian) approaches to moral theorising. (Gilligan 1982; Noddings 1984; Ruddick 1980; Ruddick 1989) It is sometimes unclear exactly which other theories or theorists are being opposed here: the derogatory term 'traditional' is attached by those writing on care ethics to the views that caring is not morally required (Engster 2005, 57), that morality is impartial through and through (Driver 2005, 183, though Driver defends consequentialism against this charge), that all moral demands are demands of justice (Held 2006, 17), that infants do not contribute to the moral value of parent-child relationships (Noddings 1999, 36), and that humans are autonomous and

independent (S.C. Miller 2005, 140). Of course, many contemporary self-described

utilitarians and Kantians would reject some or all of these claims. And almost all

contemporary (and some early) care ethicists accept that care must be in some way fused or

combined with its early opponent, justice, where 'justice' can be understood as primarily

concerned with liberty and reciprocity (Clement 1996; Held 2004, 65, 68; Held 2006, 15–17;

Pettersen 2008, ch. 6 (Pettersen also discusses Gilligan's ambiguous attitude towards the

care/justice distinction); Robinson 1999, 23ff; Ruddick 1998; Tronto 1987, 167).

We should, I suggest, see care ethicists as attempting to point out certain important

moral truths that tend to have been neglected by other theories. We should not see them as

claiming that other theories get nothing right. It is consistent with care ethics to think that

non-care ethical considerations are appropriate in some circumstances. It is also consistent

with care ethics to think that some combination of care and non-care considerations is

appropriate in *all* circumstances. This is important: as I read them, care ethicists do not take

themselves to be giving an account of the *whole* of morality.[i] Care ethicists rather take

themselves to be pointing to an interrelated set of concerns that have hitherto been

inadequately appreciated. The aim of this book is to clarify what makes those concerns

interrelated -- what, that is to say, makes care ethics a *theory*, even if a theory of only part of

the moral landscape.

1.2 Care, Ethics, Politics, Feminism, and History

In opening this chapter, I mentioned one political theory (liberalism) and five ethical theories

(consequentialism, Kantianism, virtue ethics, Confucian ethics, African ethics). This might

lead one to ask whether care ethics is a political or an ethical theory. The distinction between

ethical and political theory is generally thought to lie in their guiding questions. Ethical

theories answer the question 'what is the right thing for me to do?' or 'what is the right way for me to live?' while political theories answer the question 'what is the right thing for us to do?' or 'what is the right way for our shared life to be organised?'

Care ethics eschews this distinction. Building on the feminist insight that 'the personal is political', care ethicists tend to believe experiences in our individual ethical lives must inform the principles that guide our political institutions, and that the nature of our political institutions condition possibilities within our individual ethical lives.[ii] Care is both an ethical and a political value. One only needs to consider the titles of key books within care ethics to see this. Consider Joan Tronto's *Moral Boundaries: A Political Argument for an Ethic of Care*, or Eva Feder Kittay's *Love's Labor: Essays in Women, Equality, and Dependency*, or Nel Noddings' *Starting at Home: Caring and Social Policy*. Part II of this book will similarly run the gamut of individual and institutional life, by explaining exactly how and when it is possible for (what I will argue is) the core slogan of care ethics to generate responsibilities for institutions. To keep the terminology straightforward -- though at the risk of departing from the standard meanings of the terms -- I will use 'moral theory' or 'moral philosophy' to include normative theories of both ethics and politics.

Another important initial clarification concerns care ethics' relation to feminism. As stated earlier, this book will argue that care ethics' conceptual core is the view that dependency relationships generate responsibilities (I will say much more about what these relationships are in Part II). Care ethics, we might say, is therefore a *relational* ethics. It claims that obligations derive from relations between persons. Not all ethical or political theories that are used to further feminist ends are relational. Much liberal feminism is characterised by the concepts of individual autonomy and individual rights (Baehr 2004). These feminists choose not to focus on relationships (especially *dependency* relationships),

the value of giving and receiving care, and the role that caregiving inevitably plays in all societies. It would therefore be incorrect to say that all feminist moral theorists do or should embrace care ethics, or that most care ethicists endorse all feminist moral theories. To describe care ethics as *the* feminist moral theory is to present only one understanding of the theory behind feminism, and to present only one understanding of the proper political and social uses of care ethics. (See similarly Pettersen 2008, ch. 2.) Not all feminist moral theories are relational, and relational moral theories -- including care ethics -- can legitimately be used for non-feminist purposes. (I say 'non-feminist' rather than 'anti-feminist': it is difficult to imagine a relational moral theory that had upshots that were opposed to, rather than simply different from, the ends of feminism(s).)

Yet it cannot be ignored that care ethics arose as a theory that speaks to moral life as experienced by women, and particularly as experienced in the 'private sphere' of the home and family. Indeed, the paradigm examples of what, in Part II, I will call 'dependency relationships' are relationships in which the vulnerable party is a young, elderly, or infirm person. As many care ethicists note, these are all dependents that have traditionally been cared for by unpaid *women* -- and when that work has been paid, it has been done mainly by poorly paid women of colour. For that reason, care ethics was early on conceived of as a *women's* morality; giving voice to women's experiences. (Though see Tronto (1993, Part II) for an early rebuttal of this conception.)

This connection between care ethics and feminism is a double-edged sword. On the one hand, by drawing 'private sphere' care responsibilities into moral philosophical debates and by demonstrating the centrality of dependence to all human lives, care ethics has drawn attention to the burdens that care responsibilities have traditionally placed on women. It has thus helped to advance some feminist goals. On the other hand, feminists have argued that

care ethics entrenches women's subordinated caregiver role, since it suggests that such roles

are necessary for the achievement of morally good ends. By valorising practices of caring for

dependents, the thought goes, we implicitly endorse unjust power structures between care

workers and others in society. (Hoagland 1991; Calhoun 1988; Bartky 1990; Card 1990)

There is truth in the latter edge of the sword. Care ethics' valorisation of care -- and

the gendered and racialised power dynamics that often accompany it -- is an important

criticism of the theory. Partly in response to this criticism -- and partly because I, like many

care ethicists, do not view the theory's insights as restricted to 'traditional' carers such as

mothers (Tronto 1987; Tronto 1993, esp. ch. 3; Romain 1992) -- my aim in this book is to

view care ethics as a theory that applies not only to 'care work' and 'caregivers' as those

terms are used in social policy. Rather, I want care ethics to be recognised as a moral theory

that applies to *everyone*, all of the time. Care ethics' intersectional and feminist influences

and upshots are important, and will be discussed where appropriate. But by describing care

ethics as a universal moral theory -- a moral theory which generates responsibilities for all --

my hope is that those who are the usual 'caregivers' are seen as doing what we all already

should be doing, rather than as doing what *only they* should be doing.

Some will worry about this universalising approach. Virginia Held, for example,

states that

> to include nonfeminist versions of valuing care among the moral approaches called
>
> the ethics of care is to unduly disregard the history of how this ethics has developed.
>
> … The history of the development of the contemporary ethics of care is the history of
>
> recent feminist progress. (Held 2006, 22)

Undoubtedly, care ethics' development constitutes *part of* the progress of *some* feminist ideas. These ideas include the (undermining of the) distinction between private and public; the unavoidability of dependency relationships; the connection between care, autonomy, and empowerment; the sometimes questionable value of personal relationships; and the negative correlation between performing care work and enjoying political and economic power. But the interaction between care ethics and feminism is not straightforwardly mutually reinforcing. My project is not to deny or ignore care ethics' special concern with feminists or feminists' special concern with care ethics. Rather, I aim to show how these ideas -- whether properly called 'feminist' or not -- can be incorporated into a moral philosophy that is broad in scope, and properly applicable to all moral agents.

Others will worry that a full defence of care ethics cannot be achieved until we have considered how it plays in out in practice (Clement 1995, 45–6 expresses something like this worry). Perhaps this would require examining specific ethical and political issues -- wealth redistribution, say, or reproductive rights -- and assessing the verdicts that care ethics gives us on these. If these verdicts are inimical to women's emancipation, or are otherwise unsatisfactory, then care ethics is a poor moral theory. This may be correct. With that in mind, my aim in this book is not to give a complete and bulletproof *defence* of care ethics. My aim is instead to establish what care ethics *is* as a moral theory and to show that it is at least a *prima facie* compelling theory. Having achieved this, the next task -- a big one that I do not attempt here -- would be to assess its real-world upshots for specific agents and systems. (That said, I believe my proposal will contain the resources to deal appropriately with practical issues, including feminist ones.)

Finally, it is worth saying something about care ethics' history. As has been implied, I am interested in the care ethical cluster of concerns as they have been expressed by those who

self-identify as care ethicists (or who self-identify as writing about care ethics) over the last thirty years. The beginning of this period is marked by the 1982 release of Gilligan's data on moral reasoning, mentioned above. But the origins of care ethics arguably go back further than this. Wendy Rogers (2004) points out that we find endorsement of 'feminine' ideals of emotionality and altruism in the late nineteenth century thinkers Marietta Kies and Lucia Ames Mead, who were themselves influenced by GWF Hegel and Immanuel Kant respectively. Sarah Clarke Miller (2012) further develops the connections between care ethics and Kant. Joan Tronto (1993, ch. 2) finds the origins of her version of care ethics in the moral theories of David Hume (see also Noddings 2010, ch. 6), Frances Hutcheson, and Adam Smith. Groenhout (2004, ch. 2) sees continuities between care ethicists' conception of human nature and that of Augustine. And Howard Curzer (2007) finds praise of caregiving in the writings of Aristotle, whom Tronto also follows in some places (1993, 9, 145; 2013, 21).

That we can trace care ethical themes in the history of moral philosophy should not be too surprising: Hegel is famous for his emphasis on human intersubjectivity (as illustrated by the master-slave dialectic); Kant is famous for his account of the duty of beneficence; Hume is famous for seeing reason as the slave of the passions; Aristotle is famous for his idea of man as a social animal; and so on. These views all buttress, in some way or other, the general claims of care ethics as described in the previous section. But such historical sources -- while potentially rich and rewarding -- are not the focus of this book. The aptness for care ethics of such historical figures is something that one would have to argue for rather than assume. My intention is to sidestep such arguments, and focus instead on what unites self-identifying care ethics scholarship. Until there is a consensus on the role of different historical figures within that scholarship, it would be presumptuous to include them as part of the care ethics canon.

1.3 Chapter Overview

The book's argument will proceed as follows. Part I aims to develop a statement of the four key normative claims of care ethicists. To this end, chapters 2, 3, 4, and 5 will each develop one of these four key claims. Each of these four chapters will engage in an critical examination of the existing care ethics literature, in order to explain how one of the four key claims is both (a) a reasonable reconstruction of that literature and (b) plausible on its own terms. By the end of Part I, we will have arrived at the following four key claims of care ethics:

Claim 1. Ethical theory should positively endorse deliberation involving sympathy and direct attendance to concrete particulars.

Claim 2. To the extent that they have value to individuals in the relationship, relationships ought to be (a) treated as moral paradigms, (b) valued, preserved, or promoted (as appropriate to the circumstance at hand) and (c) acknowledged as giving rise to weighty duties.

Claim 3. Care ethics sometimes calls for agents to have caring attitudes, that is, attitudes that: (i) have as their object something that has interests, or something that might affect something that has interests; and that (ii) are a positive response (e.g. promoting, respecting, revering) to those interests; and that (iii) lead the agent's affects, desires, decisions, attention, or so on to be influenced by how the agent believes things are going with the interest-bearer.

Claim 4. Care ethics calls for agents to perform actions (i) that are performed under the (perhaps tacit) intention of fulfilling (or going some way to fulfilling) interest/s that the agent perceives some moral person (the recipient) to have; (ii) where the

strength of the demand is a complex function of the value of the intention, the

likelihood that the action will fulfil the interest, and the extent to which the interest is

appropriately described as a 'need.'

Each of these four claims constitutes a distinctive feature of care ethics. They are also claims

that (in some form or other) are rife in the care ethics literature. I hope that my phrasing of

the four key claims will ring true to those familiar with care ethics, and will be informative to

those new to it. Thus, the first part of the book is intended to be somewhat more descriptive

and expository than the second part. For this reason, readers who are interested purely in a

survey of the care ethics literature may choose to read Part I only.

Although my aim in Part I is partly descriptive, I have no doubt that some care

ethicists will think that the claims should be divided differently, or specified differently, or

that different claims should have been included. For this reason, Part I is not wholly

descriptive. As Part I assesses various arguments and disentangles various positions, some

positions held by care ethicists will be rejected, and some potential care ethical claims will be

left by the wayside. I argue that these four claims constitute the *most defensible* set of

propositions that can be naturally derived from the existing care ethical literature -- not that

they constitute the *only possible* reconstruction of that literature. The four claims should be

plausible, independently of who has or has not expounded them.

I should emphasise that Part I deals with normative claims, not descriptive ones. This

is important, as care ethicists often make descriptive claims. For example, they note that

'traditional' ethical theory has problematically ignored the care work typically done by

women in most societies; that humans are deeply relational creatures; that humans' resources

for care are limited; and that humans' embodiment makes them extremely fragile for much of

their lives. (E.g., Kittay 1999; Groenhout 2004, 24–40; Sevenhuijsen 1998, 28; Tronto 2013, 28-9) Obviously, care ethicists view these empirical facts as lending support to certain normative claims. (At the extreme, we have Noddings (2010), who seeks an evolutionary basis for the caring impulse and, from there, the imperative to care. More moderately, we have Groenhout (2004), who argues that our ideas of what humans are is not entirely separable from our ideas of what they should be.) And as I contemplate the normative claims in Part I, I will have recourse to assessing some of these empirical claims' ability to justify the normative claims. But my concern will be with the prescriptive conclusions of care ethics, not its descriptive premises. By and large, I will take care ethicists' descriptive claims -- particularly those about the inevitable and extreme vulnerability of all human beings -- to be self-evident.

At the end of Part I, we will be left with a collection of four key care ethical claims that is fragmented and still indeterminate. Part II's task will be to unify and specify -- as well as explain -- the loosely related and somewhat vague claims that Part I has produced. In order to do that, it will first be necessary to introduce some heavy theoretical machinery: the dependency principle, and its application to groups. The dependency principle is care ethics' core slogan -- or so I will go on to argue. Chapter 6 develops the dependency principle. In its brief version, this principle can be understood as asserting that a moral agent, A, has a responsibility when three conditions are met: (1) moral person B has an important interest that is unfulfilled; (2) A is sufficiently capable of fulfilling that interest; and (3) A's most efficacious measure for fulfilling the interest will be not too costly. A incurs an even more weighty responsibility if (1) to (3) are true and (4) is also true: (4) A's most efficacious measure for fulfilling the interest will be the least costly of anyone's most efficacious measure for fulfilling B's interest. Chapter 7 explains how this principle can produce

responsibilities for groups, from small-scale informal groups to nation-states. This will be important for making sense of care ethics' application to politics (as seen in, e.g., Sevenhuijsen 1998; Engster 2007; Tronto 1993; Tronto 2013).

Having developed this machinery independently of care ethics, Chapter 8 returns to care ethics. It uses the machinery of Chapters 6 and 7 to re-examine the four key claims that were developed in Part I. I explain how the dependency principle unifies, specifies, and justifies these four claims. Specifically, I address three questions about each of Part I's four claims. First, does the dependency principle give us *some* responsibilities of the kind alluded to in the claim? Second, by care ethical lights, does the dependency principle give us *enough* responsibilities of the kind alluded to in the claim? And third, by care ethical lights, does the dependency principle give us the right *explanation* of the responsibilities alluded to in the claim?

I expect the latter part of the book to be most contentious among those familiar with care ethics. If I am correct that the dependency principle is the best way to unify, specify, and justify care ethics' key claims, then we will find that care ethics suggests the truth of a few claims that have not yet been examined by those writing on the theory. The acceptance of the dependency principle as the theoretical heart of care ethics will thus require adding some new claims to the periphery of the theory -- as well as rejecting some peripheral claims that are sometimes associated it. It will require tidying up the periphery of the theory. But the theory's core will, I suggest, be all the stronger, clearer, and distinctive for this.

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[i] My reading here accords with (at least) the views of Engster (2007, 61–2), Held (2004, 65, 68), and Tronto (1993, 126); though Clement (1996, 1) claims the ethics of 'care' and 'justice' are 'more fundamental than other possible ethics because they thematize ... basic

dimensions of human relationships.' I'm sceptical that other theories can't be said to be doing the same.

[ii] See Okin (1991, ch. 6) for one statement of the many ways in which the personal is political; though see Sevenhuijsen (1998, 73-80) for a criticism of Okin's use of gender binaries and her relegation of care. See Clement (1996, ch. 4) for a care ethical dismantling of the public/private divide, and Tronto (1993, esp. 6-11) for discussion of shifting the boundaries between moral and political, and private and public.