

Modernising Social Work and the Ethics of Care

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by

Gabrielle Meagher and Nigel Parton

Gabrielle Meagher is Senior Lecturer in Political Economy at the University of Sydney. Her research focuses on the recognition of caring work in professional discourse in the social service occupations, in performance measurement systems, in the institutions and processes of industrial relations, and in society more broadly.

Nigel Parton is Professor in Child Care and Director of the Centre for Applied Childhood Studies at the University of Huddersfield. His most recent book is (with Patrick O'Byrne) *Constructive Social Work: Towards a New Practice*, Basingstoke, Palgrave.

Abstract

While recent attempts to 'modernise' social work have emphasised the importance of collaboration, partnership and participation with individual users of services and the wider community, it is the increase of managerialism which has proved dominant. A major feature has been the failure to develop the importance of the notion of care for bringing about positive change. The focus of this paper is to demonstrate how a closer attention to the debates concerning the feminist ethics of care can make a significant contribution to not only rehabilitating the notion of care for social work but also to moving forward the modernisation agenda itself.

Introduction

Recent years have witnessed a major reassessment of the nature, focus and organisation of social work and social care services in much of the English speaking Western world. In England, under the auspices of a New Labour government, this has been taking place under the rationale of ‘modernising’ public services (see, for example, DH, 1998). In many respects the modernisation agenda can be seen as a reaction against the inflexibility, inefficiency and aloofness of both large scale bureaucracies and the professionals who play key roles in the delivery of services. The changes introduced are seen as making a serious attempt to improve collaboration, inclusiveness and transparency, by a much greater emphasis on involving citizens in decision-making at both a local strategic level and in individual cases. The visions for the future are articulated in the language of community and citizenship, reciprocity and responsibility, justice and fairness, partnership and participation, and crucially recognise that a variety of state, voluntary and informal services provide vital contributions to the care and support of individuals and thus the health of society more generally.

At the same time the way in which such changes have been introduced has very much been of a top-down nature (Jordan with Jordan, 2000). More particularly, the process of modernisation can be seen as furthering the growing managerialisation of social work and social care via its intense focus on performance and efficiency targets, together with the growing emphasis of centralised and formulaic regimes of inspection and scrutiny (Newman, 2001). Thus while many of the more liberatory and radical elements of social work theory and practice can be seen, at one level, to have received official endorsement and to have entered the mainstream, at another level they can be seen to

have been transformed into a variety of mechanisms for the increased regulation of both social workers and the people with whom they work (Langan, 2002).

In recent years, governments have imposed and refined systems of audit and new operational and administrative procedures. Social work practice has become more legalised, and notions of 'evidence-based practice' have become pervasive. These developments, which emphasise practitioner accountability to stakeholders other than clients, seem to dominate the nature of what it is to be a practitioner, particularly in the public sector. As Stepney has argued, there seems little doubt that practitioners experience these initiatives as increasing managerial control. Moreover, '[t]he emphasis on technical recording, systematic information gathering, performance indicators, all tend to reinforce mechanistic practice rather than creativity and innovation' (Stepney, 2001, p. 12). Social workers are required to take a more instrumental and impersonal approach to their work, and perceive that care for service users is little more than labour in the service of economy, efficiency, and effectiveness.

Recent years have also witnessed the publication of a number of texts which have attempted to develop perspectives which are explicitly critical and reflexive and which, to varying degrees, draw upon insights offered by a number of postmodern perspectives (see, for example, Fawcett et al, 2000; Fook, 2000; Parton, 2002; Pease and Fook, 1999). Peter Leonard (1997) characterises these developments as 'reconstructing the emancipatory project'. Partly drawing on Leonard, Jan Fook (2002) and Karen Healy (2000) see the essential elements of these emerging critical social work approaches as emphasising a: commitment to standing alongside oppressed and impoverished populations; the importance of dialogic relations between workers and service users; the

significance of social, economic, and political systems in shaping individual experiences and social relationships, including interactions within the practice context; an orientation towards the transformation of processes and structures that perpetuate domination and exploitation, and thus emphasises the importance of social justice and equality. Significantly for our purposes, Healy notes that proponents of critical social work have ‘persistently challenged the occupational self image of social work as a *caring* profession by emphasizing the complicity of social workers in the reproduction of the oppressive conditions within the practice context and beyond it’ (Healy, 2000, p.3, our emphasis).

Beyond this it seems that discussions of *care* within the critical social work literature, until very recently, have been remarkable only by their absence, such that it has seemed there has almost been an assumption that social work is so tainted by its associations with care that the word should be expunged both from its lexicon and rationale. In our view this is unfortunate. Not only has the notion of care been at the core of social work values, theory and practice since its inception but it is the central part of our argument that its rehabilitation can provide a key counterweight to the increasing processes of managerialisation which seem so pervasive. Further, however, we argue that the dominance of the managerialist discourse has deleterious effects on attempts to modernise social work and social care. Unless care is relocated at the centre of debates, policies and practices, the elements which can be seen to make social work and social care more generally distinctive will be lost.

That social work practitioners value care, and perceive that their desire to prioritise it in their practice is not shared by government funders is illustrated for us in a recent study

comparing practitioners' perceptions of their own and their funding department's priorities in non-government family support services (Meagher and Healy, 2002). Experienced family support practitioners were offered a list of eight characteristics from which to choose those they considered to be the three most important characteristics of effective services. The characteristics included client, legal, management, and worker orientations. Practitioners ranked first the client-oriented characteristic that 'the service enables clients to achieve their goals', with 80 per cent of those surveyed (n=59) including this criterion in their top three. Practitioners perceived that the funding department's top priority was the legally oriented characteristic that 'the service complies with legal obligations, such as child protection legislation', with 91 per cent of practitioners including this in their list of the department's top three. Whereas 44 per cent of practitioners included the characteristic 'workers are compassionate and caring' among their top three, only five per cent perceived it to be a priority for the Department. Other studies aiming to imagine the ideal organisational context for caring work emphasise how professional and other caregivers need room to exercise both their *judgement* and their *emotional commitment* to those they care for (see Meagher, 2002). That service users highly value care is confirmed in numerous studies over the years demonstrating the importance of the relationship and the caring approach of the worker to service user experience of social service quality (see, for example, Howe, 1993; Berresford and Croft, 2001; National Institute for Social Work, 2000).

At the same time, we are aware that the early years of the new millennium have witnessed the publication of a number of texts which have underlined the importance for social work and social care of seriously engaging with feminist thinking about the 'ethics of care' (see in particular Banks, 2001; Brannen and Moss, 2003; Clifford, 2002;

Froggett, 2002; Orme, 2002; Parton, 2003). It is our view that such developments provide us with a real possibility for not just rehabilitating the notion of care to the centre of social work but in a way which contributes to and builds on the arguments developed within the critical social work literature. More particularly it seems to use that the epistemological arguments within the discourse of the ethics of care, together with its more 'politicised' conceptions, can provide an important resource whereby social work can engage with the modernisation agenda. Of particular importance is the capacity of the discourse of the ethics of care to offer ways of conceiving and representing those aspects of social work which are obscured by the rational technical focus of the managerialism that has come to dominate the way social work and social care is increasingly thought about, organised and practised.

Gender, Managerialism, and the Rationalisation of Social Work

While religious convictions about the nature of human struggles shaped social work during its development in the latter part of the nineteenth century (Forsythe and Jordan, 2002), the twentieth century saw increasing attempts to professionalise the role. The main protagonists aspired to mimic the traditional professions, particularly medicine, but at no time has social work achieved this level of authority, status or legitimacy. Rather, although its organisation differs internationally, the development of social work during much of the twentieth century is better characterised as a 'bureau-profession'; certainly bureaucratisation as much as professionalisation has shaped its development, particularly in the state sectors.

As models of organisation, decision-making, and practice, professionalism and bureaucracy, have shaped social workers' capacity to enact care. One way of seeing the 'problem' these approaches pose for the theory and practice of social work is to look through the lens of gender. If we see masculinity and femininity not as attributes of individuals in any essentialist sense but as cultural representations, it is possible to explore the gendering of social institutions in a way that makes some of the dilemmas of caring, and in particular the ambiguities and paradoxes of professional care, much more explicit.

As a normative cultural project, masculinity entails separation from others, the creation of a strongly bounded sense of self, an emphasis on individuality, a wish for power, agency and action, and for being a subject—making a difference in the world; whereas femininity involves a continuing experience of connection with others, a focus on interdependence, and a sense of self in relation to others, rather than as always autonomous and apart. Masculinity is crucially concerned with establishing relations of domination and ensuring their stability and predictability. The public world created by men with its visions of rational action and appropriate rules of behaviour, corresponds directly to this. Autonomous, controlled individuals are brought into ordinary relations with each other in pursuit of agreed goals. Emotions, enthusiasms, and vulnerabilities are seen to be an impediment. It is not, however, that they have been done away with but they have been confined to the private sphere that is seen as primarily dominated by women.

In its ideal typical form, the bureaucratic approach emphasises formality and distance as the only routes to rational decision making. The impartiality of the decision, the

impersonality of the bureaucrat, and the unequivocal authority of its hierarchy are the key characteristics of bureaucracy. It is not difficult to see that the ideal typical bureaucracy is a masculine, not a neutral institutional type as its advocates assume. Masculinity's version of rational action conceives itself as autonomous and independent of the other. The impartiality, impersonality, formality, and distance characterising the ideal typical bureaucracy reflect these masculine cultural characteristics. Bureaucratisation is the attempt to enact a normative framework which prioritises the atomistic, autonomous, self-contained individual, thereby marginalising the relational and contextual nature of the work carried out within the organisation.

In apparent contrast, the ideal typical professional appears to have all of the flexibility that the rule and hierarchy bound bureaucrat lacks. The true professional acts autonomously, refers difficult cases to a more experienced colleague, and is not required to bow to hierarchy as the bureaucrat would be. However, as Celia Davies (1995a, 1995b) has argued, while bureaucratic and professional approaches may seem at first sight diametrically opposed, on closer inspection the notion of the professional is similarly gendered masculine. The ideal typical professional is detached, treats each patient or client with a correct professional concern, and is not bound up with their crises or their pain. Again, there is a strong element of the need for distance and impersonality. Expertise derives from formal training, which is itself based on rational science. Perhaps most crucially, autonomy stands at the very heart of traditional concepts of the professional.

In many respects, therefore, and as Davies argues, the ideal types of the professional and the bureaucratic forms of practice and organisation share much. Both are oriented to

control and mastery; to establish order through implementation of an abstract decision set of processes. Both rely on hierarchical relations and promote distance from their clienteles. The application of expert knowledge, whether associated with the office of the bureaucrat or the person of the professional, retains a mysterious character and calls forth deference on the part of the client. Both the bureaucrat and the professional are invested with an authority for decision making as if they inhabit a sovereign court, where their decisions are rarely questioned, and where those on the receiving end are (or should be) grateful.

Social work has never had this kind and level of authority and power. The designation 'bureau-profession' is simply one sign of its failure to achieve full professional status. More particularly, the nature of social work, particularly its engagement with the most marginalised and deprived members of society, meant that it had difficulty in fulfilling the characteristics required to fulfil this status. Traditionally, social work has emphasised the importance of the worker-client relationship (see, for example, Biesteck, 1961), rarely falling back on a narrowly defined, autonomous approach to its operations. It is not a coincidence that social work—a predominantly female occupation—has traditionally emphasised the relational and caring aspects of its work, characteristics that do not lend themselves easily to either the professional or the bureaucratic models.

More recent years have seen an important shift in its trajectory of development. The alleged failures and problems of social work that became apparent in a series of child abuse tragedies and public inquiries during the 1970s and 1980s (Parton, 1985, 1991) prefigured the increasing criticisms of most health and welfare professional occupations that emerged in the political and public arenas during the 1990s. Both the bureaucratic

and professional approaches to health and welfare which became so dominant in the post-war period were seen to be wanting. Simultaneously, there occurred increasing questioning of the welfare state and the growth of a new approach to health and welfare which placed the notion of managerialism at its centre (Clarke and Newman, 1997; Clarke, Gewirtz and McLaughlin, 2000; Newman, 2001).

This context of failure has provided the key ideological impetus for criticising and trying to move beyond the models of both the bureaucracy and the profession which were central to the way health and welfare services were thought about and organised in the second half of the twentieth century. Governments have sought to remedy this failure with a new governance model: managerialism, often referred to as the ‘new public management’ (Horton and Farnham, 1999). While the thrust and emphases of policy differ under different political regimes, managerialism has risen to dominance in most advanced liberal societies in the Western world, particularly North America, the United Kingdom, and Australia in recent years.

From the managerialist perspective, professionals and bureaucrats are self interested and untrustworthy. Both need to be ‘managed’ by new mechanisms that establish clear lines and criteria of accountability, to restore the integrity of and community trust in public services. Amongst other innovations, managerialist governments have developed and implemented a variety of practices designed to monitor, assess, and regulate the performance of both organisations and workers delivering public services, and those in receipt of them. These practices and their supporting ideas aim to promote a cost-conscious performance culture. Concepts—and often practices—of competition

between providers and choice for customers have proliferated, as if service provision occurred in a quasi-market.

Proponents claim that these innovations remedy the problems of the old bureaucratic or professionalised approaches. However, importantly for our argument, the social relations managerialism represents and aims to institutionalise have many of the masculine characteristics already discussed. Like the bureaucrat and the professional, the ideal new manager remains distant and controlled. He takes a critical stance towards the arguments presented and the established practices of others, drawing his own conclusions based on designated general decision rules (risk assessment, cost-benefit analysis, and so on), rather than being swayed by sympathy to particular cases.

Managerialism seems to celebrate critique, distance, and the ability to make difficult decisions, such that there is no attempt to hide potential hostility and warring in the way professional and bureaucratic approaches might have. The cultural codes of masculinity seem even more explicit and are celebrated in a much more obvious way in a climate which is seen as driven by concerns about risk, increased globalisation, and the recognition that no one can be seen to fall back on traditional notions of authority. In this context debates about the ethics of care can provide a vital critical framework for not just understanding some key elements of the current contexts and realities of day-to-day practice, but also for helping us move beyond them.

Gender and Moral Knowledge: An Overview of the Ethics of Care

In the early 1980s, feminist philosophers and political theorists began to overcome their historical uneasiness about engaging in debates about morality and ethics, to develop an

explicitly gender-sensitive approach to moral inquiry. Perhaps the most significant product of feminism's engagement with moral philosophy has been the discourse of the ethics of care. In the ensuing twenty years, debate about the ethics of care has itself burgeoned. Our purpose here is not to provide a detailed exposition of the evolution of the discourse of the ethics of care or to account for the emergence of different strands (for which, see Held, 1995; Sevenhuijsen, 1998). Rather, we aim to set out the shared assumptions and characteristic ways of thinking of proponents of the ethics of care, and to highlight some points of contention of particular importance to assessing the usefulness of the ethics of care for the theory and practice of critical social work, and to demonstrate its potential for providing both a counterweight to the managerialist dominance to current attempts to 'modernise' social work and social care in England and elsewhere.

The shared assumptions of the ethics of care are a set of interwoven arguments about the nature of the good in human interactions, and of how moral subjects generate and act on knowledge about the good. First among these shared assumptions of care ethics is what Selma Sevenhuijsen calls a 'relational ontology' (2000: 11): the ethics of care places at the centre of moral inquiry the *interdependence* of humans and their responsibilities to each other, rather than individuals and their rights. Second, the ethics of care recognises the equal moral worth of all persons, and holds that their informal and interpersonal relations are an appropriate object and ground of moral deliberation. Third, the ethics of care emphasises caring as moral posture or *disposition*: moral subjects should attend to others with compassion, responding to each person as unique and irreplaceable, and recognising each moral decision as taking place within a specific context. This contrasts with conventional rights-based ethics, in which the aim is to 'rise

above' personal attachment, to consider right action from the standpoint of a disinterested and disengaged moral actor (Tronto, 1993: 9). Fourth, the nurturing at the heart of care ethics requires that caring is also a *process* that fosters the growth of those participating in caring relationships, and their willingness to take on open-ended responsibilities in regard to each other. Significantly, these assumptions reject the masculinist norms of traditional rights-based moral theory, norms shared with the culturally masculine forms of organisation discussed in the previous section.

The emphasis on caring as a disposition and a process has several corollaries. From the perspective of care ethics, certain emotions, particularly empathy and compassion, are not fetters on clear and objective moral judgement, but rather are fundamental to the development of moral understanding itself. Moreover, if a moral subject is to attend to another in their concrete specificity—that is to say, to take into account both the uniqueness of the person, and the complex details of their life situation—moral decision-making will require much more than the application of principles. Feelings, the capacity to recognise 'the separate consciousness of another making its own sense of the world' (Ruddick 1984, cited in Walker [1989] 1995: 141), and communication are all required. This adds up to what Margaret Walker calls:

an *alternative moral epistemology*, a very different way of identifying and appreciating the forms of intelligence which define responsible moral action. This view does not imagine our moral understandings congealed into a compact theoretical instrument of impersonal decision for each person, but as deployed in shared processes of discovery,

expression, interpretation, and adjustment between persons' ([1989] 1995: 140, emphasis in original).

Although theorists of the ethics of care agree on these matters of substance and method in moral reasoning, there remain several significant, well-recognised, and related points of contention. These include the way the role of gender, particularly femininity, is conceptualised in different strands of care ethics, the relationship between the ethics of care and traditional justice or rights-based ethical theories, and the extent to which a framework for moral reasoning modelled on personal relationships can address broader social problems of injustice and oppression. It is worth exploring different views on these issues among theorists of care ethics, because, as we will argue, different constructions of these aspects of care ethics pose different opportunities and risks for social work.

Some theorists of care ethics such as Nel Noddings ([1984] 1995) construct an avowedly 'feminine' ethic of care in explicit opposition to rights-based ethics. Noddings, Sara Ruddick, Virginia Held, and other influential early contributors to the discourse of the ethics of care were motivated to counter the at best patronising, at worst entirely dismissive way women and the feminine had been treated in conventional ethical inquiry. These thinkers relied heavily on the mother-child relationship as a model for thinking through an alternative model of moral reasoning, placing personal relationships in the private domain at the centre. Nel Noddings, for example, in a web of arguments about gender, human nature, and moral obligation, constructs a naturalistic and expressly anti-rule and anti-political ethics of care. The central role of the mother-child relation, and her observations about gender differences in approaches to moral

problems (that is, women's preference for making moral decisions based on contextual information and personal ideals, rather than abstract rules) prompt Noddings to call her ethic of care a 'feminine ethic'. Although she does not 'imply a claim for all women or ... exclude men' ([1984] 1995: 24) from her ethics of care, Noddings does argue that 'there is reason to believe that women are somewhat better equipped for caring than men are' ([1984] 1995: 24). Thus the ethics of care are tied, in this formulation, to femininity and women's experience of the private sphere.

Noddings's account is naturalistic because she links the development of a 'moral imperative' to care to what she sees as an innate 'impulse to act on behalf of the present other' ([1984] 1995: 12). This innate impulse is fostered into the capacity for moral awareness and judgement by a cycle of caring relationships that starts with the natural care a mother gives a child. When we are confronted with someone in need, she argues, the 'memory of our own best moments of caring and being cared for sweeps over us as a feeling—as an "I must"—in response to the plight of the other and our conflicting desire to serve our own interests' ([1984] 1995: 10). However, she continues:

we are not compelled by this impulse. We have a choice; we may accept what we feel, or we may reject it. If we have a strong desire to be moral, we will not reject it, and this strong desire to be moral is derived, reflectively, from the more fundamental and natural desire to be and to remain related ([1984] 1995: 13).

When we are faced with moral decisions about how to act as 'one-caring', Noddings argues that reference to moral principles can be a positive barrier to care; hence our

designation 'anti-rule'. Discussing moral conduct by exploring language and reasoning, she contends, takes us

away from an assessment of the concrete events in which we must choose whether and how to behave morally. Indeed we are often led far beyond what we feel and intuitively judge to be right in a search for some simple and absolute guide to moral goodness ([1984] 1995: 22).

We characterise Noddings's approach as anti-political because of the way she constructs the scope and limits of our obligation to care as 'limited and delimited by relation':

We are never free, in the human domain, to abandon our preparedness to care; but, practically, if we are meeting those in our inner circles adequately as ones-caring and receiving those linked to our inner circles by formal chains of relation, we shall limit the calls upon our obligation quite naturally ([1984] 1995: 15).

Constructing the scope of moral action in this way emphasises the local and contingent, placing a strong imperative on moral agents to engage practically with our fellow human beings in very day-to-day ways. This leads Noddings to express active hostility to institutions ([1984] 1995: 26), and to claim that a child whose mother teaches him moral reasoning well will go out into the world 'skeptical, vulnerable, courageous, disobedient, and tenderly receptive' ([1984] 1995: 21).

Other feminist theorists of the ethic of care take issue with approaches like Noddings's, which emphasise the role of natural care and the mother-child relationship, suspect reasoning and rules in moral inquiry, and narrowly circumscribe the limits on the obligation to care to personal relationships. Instead, more recent contributions by Selma Sevenhuijsen (1998, 2000) and Joan Tronto (1993) to the discourse of the ethics of care have emphasised the need to move beyond oppositional thinking (masculine versus feminine, care versus justice, relationship versus rules) in debates about feminist ethics, to 'denaturalise' the ethics of care, and to integrate thinking about the ethics of care with political theory and activity on a much broader stage than interpersonal relationships.

Again, the metaphor of a web is useful to capture the key arguments and their relationships. Much that distinguishes the contributions of these theorists ramifies from their position that care is necessarily a *political* as well as a moral concept, such that *power* and *difference* are central. From this perspective, answers to the questions of 'who cares?' and 'whose needs are met?' go well beyond identifying the dyad of the 'one-caring' and the 'present other in need'. Rather, at the 'macro' level of society as whole, and at the 'micro' level of interpersonal relationships, the 'politicised' approach to the ethics of care explores how the ethics of care both can illuminate problems of power and difference in existing social arrangements (including arrangements for the giving and receiving of care), and can help overcome some of the characteristic problems and dilemmas of care that unequal power engenders.

At the macro level, answers to these questions explore how class, gender, ability and race interact to distribute both the getting and giving of care. Typically, the powerful

‘are more often in a position to receive or demand care than to provide it’, while those with less power often find themselves ‘in situations in which they provide care without much power over the conditions and the means, and often in positions of invisibility and voicelessness’ (Sevenhuijsen, 1998: 24).

This recognition also allows these theorists to shed light on the ‘dark side’ of care at the micro level. Tronto highlights two ‘dangers of care’: paternalism/maternalism and parochialism. She describes the first as follows:

Often care-givers have more competence and expertise in meeting the needs of those receiving care. The result is that care-givers may well come to see themselves as more capable of assessing the needs of care-receivers than are the care-receivers themselves.

...Especially when the caregivers’ sense of importance, duty, career, etc., are tied to their caring role, we can well imagine the development of relationships of profound inequality (1993: 170).

Parochialism results from care when we see the caring relationships in which we are engaged, and which we know best as the most important (Tronto, 1993: 170). Here Tronto highlights the particular hazard of the use of the mother child relationship as the founding metaphor of the ethics of care. She writes ‘A Mother who did not think that *her* child’s needs were more important than another child’s would seem incompetent’, yet if we construct a political ideal on this basis, care ‘could quickly become a way to

argue that everyone should cultivate one's own garden, and let others take care of themselves, too' (1993: 171).

However, Tronto and Sevenhuijsen argue that a political approach to the ethics of care also offers remedies for these problems of care. For example, the relational ontology of the ethics of care exposes the inequality and oppression in the existing social division of caring by highlighting that all humans are dependent on others; yet the distribution of the costs and benefits of care does not adequately reflect need and capacity to give. In a similar vein, the emphasis on what Walker, cited above, called 'shared processes of discovery, expression, interpretation, and adjustment between persons' reflects the democratic impulse of the ethics of care. As Tronto puts it, care

can serve as a political concept to prescribe an ideal for more democratic, more pluralistic politics...in which power is more evenly distributed. ... care can [also] serve as a strategic concept to involve directly the relatively disenfranchised in the political world (1993: 21).

Finally, in addition to linking caring to critiques of current social structures, and to new ways of thinking about negotiating power, privilege, and difference, politicised constructions of the ethics of care do not reject rights and justice as categories of moral and political discourse. Rather, theorists like Tronto and Sevenhuijsen both seek to bring to bear the insights and methods of the ethics of care to reframe justice ethics, and see that care requires rights to be fully realised.

Social Work and the Ethics of Care: Opportunities and Risks

Engagement between social work and the ethics of care involves both opportunities and risks for both social workers and service users. In this concluding section, we tease some of these out, to open up the issues for debate.

Many social workers would recognise their working relationships with service users either in reality or in aspiration in the descriptions of the nature of moral response and action offered in the discourses of the ethics of care. The insights of the ethics of care support and articulate social workers' self-understanding as moral agents in caring relationships with service users. As a feminist discourse, the ethics of care provides the conceptual space and a vocabulary for recognising and valuing care absent from rational-technical approaches to knowledge and practice, whether professional, bureaucratic, or managerialist. This has implications for the recognition of the value and efficacy of social work both in service management and wider social contexts, including current attempts to 'modernise'. As an account of decision-making in interpersonal interactions, the ethics of care also provides a gender-sensitive, moral ground to concepts of reflective practice to develop further existing alternatives to rational-technical models. Thus, the ethics of care offers social work theory and practice what might be called an 'epistemological' opportunity. In describing interactions as 'shared processes of discovery, expression, interpretation, and adjustment between persons' (Walker [1989] 1995: 140), the ethics of care also supports social work's commitment to dialogic relations between social workers and service users. In effect, the ethics of care enhances social workers' capacity to achieve the goals of those with whom they work and the recognition of the value of social work as both a service discipline and a

set of practices. It offers a sophisticated framework for including aspects of social work practice and experience that have recently been difficult to encompass, and so to teach, learn, justify, and develop.

However, despite the ‘opportunities’ described above, it is probably not a coincidence that the notion of care has received little recent attention in social work. As the quotation from Healy (2000) in our introduction illustrated, the critical social work literature comes close to identifying care with oppression. At a minimum it is seen as patronising, paternalist, and marginalising. Historically care has been associated with ‘the welfare’, being ‘looked after’, or ‘protected’ so that service users are seen as little more than dependent recipients of care. Care is also associated with charity for which those on the receiving end should be grateful. More recently, service user activism and social work discourses have emphasised the importance of user involvement, partnership, participation, rights, and, perhaps most significantly, empowerment (Thompson and Thompson, 2001). The contemporary use of the term ‘service user’ as opposed to ‘client’ symbolises this change in emphasis. From this perspective, care is very much associated with a past that social work is trying to ‘modernise’. To suggest that social work should look afresh at ideas about care, even in the context of debates about the ethics of care, could be seen as at best naïve and at worst dangerous. Not only might it have the unintended consequence of reinforcing the existing prejudices and problems arising from the cultural and political devaluation of the feminine in a context where caring work is female dominated, but it may deflect attention from what service user movements say they want (see, for example, Beresford and Holden, 2000; Beresford and Croft, 2001).

Focussing on the disability movement, Fiona Williams (2001) has recently explored some challenging critiques of the ethics of care that focus on the risks of conceptualising service interactions as care from a service user perspective. First, she notes that rejecting care, Wood (1991) argues for *empowerment* particularly where it emphasises *choice* and *control*, while Finkelstein (1998) argues that care is now so laden it should be replaced by *support*. Secondly, Williams points out that while the ethics of care emphasises *interdependence* and the *relational*, ‘disabled people have argued for the strategic centrality of independence, tying it to the practical demand for independent living in which autonomy and control over one’s life are key’ (2001: 479). So, for example, rather than dependence on a professional or a case-manager for services, direct payments and personal assistance schemes provide service users with the power to ‘purchase’ their own services. Thirdly, she considers Silvers’s (1995: 42) argument that to propose that the mutuality and closeness of family life become the paradigm in social life fails to grasp how the power inherent in *extra-familial* care relationships is not attenuated by the tenderness of intimacy. Williams sees Silvers’s conclusion to be that the ethics of care deflects from the paradigm of equality, and it is *equality*, not care, ‘that can both contain the demands for civil rights for disabled people, as well as connect to the struggles of other marginalised groups’ (Williams, 2001: 479).

These critics are responding to what Tronto identifies as the ‘dark side’ of care.

However, we agree with Williams (2001) that service user critiques of the ethics of care share more common ground with the views they seem to oppose than may first appear, particularly when the diversity of positions within the ethics of care debate is taken into account. Moreover, Williams identifies a problem with some disability movement

theory, which, she argues, overestimates the extent to which relationships are fixedly structured around domination (by carers) and subordination (of the cared for). As proponents of the ethics of care suggest, ‘we can in practice be carers or cared-for in different situations and do not always occupy one single position in this binary’ (Williams, 2001: 480). Further, both the ethics of care approach, as elaborated by Tronto and Sevenhuijsen, and the empowerment approach, as elaborated by writers like Beresford, operate within an equality paradigm (Williams, 2001: 480). As we have argued, in their ‘politicised’ version, both Tronto and Sevenhuijsen stress the importance of the principles of equality and justice in the development and application of the ethics of care. Care is not simply a micro-moral issue but is necessarily political and is intimately related to wider structural issues concerned with class, gender, ability, and race.

Williams also points out that despite different emphases in their understandings of autonomy/independence, writers from within the disability movement and proponents of the politicised ethics of care both make the important distinction between the inadequate conceptualisation of autonomy as self-sufficiency, and autonomy/independence as the capacity to have choice and control over one’s life (2001: 480). Williams herself argues that the concept of *interdependence*, which is so central to the ethics of care, needs to recognise that recent collective struggles around care place a premium on independence. She continues:

it is possible to argue that, in the longer term, disabled peoples’ (and older people’s and children’s) interests would be better served by a society that valued interdependence and acknowledged the vulnerability

of all, the more immediate strategy for disabled people is for rights to secure the conditions for independence. The task then becomes less one of arguing against autonomy as a liberal concept than one of redefining the concept of autonomy to fit with a notion of interdependence’ (Williams, 2001: 481).

Finally, Williams explores how the issue of professional versus non-professional paid care for disabled people exposes another risk and opportunity of the ethics of care. Too much emphasis on the quality of the relationship between the carer and the person cared for rather than the carer’s training and expertise, and the assumption that *professional* carers are ‘inculcated with ... paternalism ... overlaps dangerously with arguments that have kept women workers low paid for generations—that they bring with them skills which are ‘natural’ and need not be valued’ (Williams, 2001: 482). Rather than seek the putatively unsullied care of untrained carers, Williams argues that the skills of care (described above as the moral *disposition* advocated in the ethics of care) should be claimed as skills, ‘and that the issue is how to develop training so that the knowledge and experience of disabled people and other service users influence work practices’ (Williams, 2001: 282). From this perspective, the risks of the personalised version of the ethics of care can be avoided by a more politicised approach.

Work in the UK by the National Institute for Social Work and Peter Beresford and his colleagues in this context is very instructive. As part of the debate on the future of social work in England (NISW, 1999; 2000), social work practitioners, people whose primary responsibility was to work with and be in close contact with service users themselves, came together to identify what was seen as the key characteristics of best social work

practice (Beresford and Croft, 2001). There was considerable overlap and consistency in terms of: a holistic approach to social and personal problem solving; a relationship based on respect; attention to the experience of individuals, groups, and communities and to their expertise, culture, and religion; recognition that the process and the relationship is part of what determines a good outcome for service users; access to independent information on which to think through options and reach decisions; service users retaining as much control as possible over their lives and the choices they make. From this, Peter Beresford then argues that ‘practice that is emancipatory and liberating needs a value base that is shared between practitioners and people using services. A jointly developed human rights and citizenship framework offers this possibility’ (Beresford, 2001: 305).

While debate about the ethics of care has been significantly informed by fundamental criticisms of the individualised liberal ethics of rights (Held, 1993), it is our view that, in drawing on the politicised variant of the ethics of care, it is not helpful to see approaches based on rights/empowerment in such stark antithesis to those based on care. As Orme (2002) has recently argued, drawing on Gilligan (1995), Jagger (1995) and Hekman (1999), justice and care are logically compatible and indispensable to each other, and that a dialogical approach challenges binaries not only of the carer/cared for, the public/private, but that between care and justice and rights. Justice without care becomes a harsh and impersonal justice, while care without justice is inconceivable in the politicised ethics of care we have argued for here.

It is in this spirit that we feel the ethics of care provide a key critical framework for both analysing and moving beyond the current dominance of the managerialist approaches to

social work. In doing so not only are we more able to see the central relevance of grappling with care theoretically and practically, but the attempts to ‘modernise’ will themselves have a greater chance to deliver on a range of key objectives and principles which are currently in danger of being lost. The aim to overcome the divide between rationality and the emotions in much moral, political, and epistemological thought can prove productive in the current climate. As we have shown, it proposes a different kind of moral decision-making, in which both a different ‘cognitive attitude’ and a different ‘form of action’ (Sevenhuijsen, 1998: 4) underpin different kinds of moral decision-making where experience, relationships, and contexts become key.

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