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ARTICLE

Degrees of Care: Success, Recognition, and Completion

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Abstract

Care ethics has attracted much scholarly attention since its inception in the 1980s. As befits a moral theory, which is how it is frequently perceived, those working in the field have increasingly sought to clarify and make robust elements central to the project. This article hopes to offer a small but important contribution to this iterative process. I make a case for resisting what is characterized as the recognition claim found in the work of Joan Tronto, Nel Noddings, and Eva Feder Kittay. This is the claim that for an action to be caring it is necessarily recognized as such by whomever is being cared for. I explicate the arguments pertaining to this issue in these authors' writings and conclude that not only do the arguments fall short of showing the necessity for including this aspect in an ethics of care, but I make preliminary arguments as to the implications for resisting the inclusion of the recognition claim. The thrust of these suggestions is that care ethics is a better moral theory when it admits to degrees of care rather than taking a binary view.

Caregiving is ubiquitous; it is an undeniable part of the human condition. Compared with all other mammals, human children need adult support for a much longer period in order to survive. *Homo sapiens* is also the longest-lived land-dwelling mammal (Paine and Hawkes 2006, 3), and life expectancy typically measured in decades past the possibility of reproduction is found only in women and some whales (Hrdy 2009, 276). That people will be dependent on others at some point in their lives—typically in infancy, illness, and old age—is quite clear. Also clear is that most people will at some point be caregivers themselves; adult children often come to be caregivers to their aging parents. The pervasive nature and inevitability of human dependency that necessitates periods of both caregiving and care-receiving might be a contributing factor to certain confusions in what is known as the "ethics of care" or "care ethics." In this article, these terms will be used interchangeably.

Care ethics has its origins in the work of a number of scholars working from the 1980s onwards.[1] Sara Ruddick's *Maternal Thinking*, Carol Gilligan's *In a Different Voice*, and Nel Noddings's *Caring* all made vital early contributions (Ruddick 1980;

Gilligan 1982/1993; Noddings 1984/2013; Ruddick 1989). One source of confusion is the use of the word "care." It is potentially confusing because "care" or, strictly, "caregiving" is integral to human existence. Authors in the field sometimes slip between "care" and "caregiving" as if they were the synonyms they are under ordinary, quotidian usage. However, scholars developing an account of care that has normative import are claiming something more for "care." It is to have moral weight, to give reasons for acting, and so on. Many proponents of an ethics of care are seeking a moral theory as a proper competitor to, for example, virtue ethics, Kantian ethics, and consequentialist ethics. These three theories dominated moral philosophy at the end of the last century. There is much work to do in the ethics of care, fledgling as it is as a normative theory. Beyond resisting its subsumption into the moral theories already indicated,[2] cases are being made for additions, adjustments, and refinements within care ethics. Taking as examples some recent work in this area, as well as articles in this journal: Stephanie Collins readily embraces principles (Collins 2015), Steven Steyl adumbrates a theory of right action (Steyl 2020a), and Thomas Randall offers a novel justification for partiality (Randall 2020). Early care ethicists drew back from principles, detailed accounts of right action, and typically toocertain forms of partiality in ethics as given. This work and that of others aptly demonstrates that care ethics is very much a "live" area of inquiry.[3]

As a normative theory, care ethics has something to say about the way people should be and how people should act.[4] In this article I hope to contribute to the field by offering a refinement to just one aspect of accounts of care ethics, namely, the requirement of a number of care ethicists for the care receiver to recognize the caring action as caring in order for it to be classified as caring. Later, I will articulate this requirement with more precision. I will not deny this requirement's importance, rather that it is a mistake to make it a necessary condition for care. The article will start with a brief outline of types of definition and state how terminology is going to be used. This will provide some analytical tools for examining this "recognition requirement"[5] as it is found in the work of Joan Tronto, Nel Noddings, and Eva Kittay.

Just what is meant by "care" in care ethics has proved troublesome in its forty-year history. Often, both proponents and critics seem to be talking past each other. Before I highlight aspects of various ethics of care, I will take a brief tour of types of definition in philosophy. Undoubtedly, words may end up slipping between types of definition.[6] This can cause problems in philosophy, which typically attends to precision and clarification. Perhaps this slippage has been a factor contributing to uncertainties about the ethics of care in which descriptive, stipulative, and explicative definitions are found. A descriptive definition tries to provide the meaning for a word in its everyday use. A stipulative definition fixes the meaning for a new word or a new meaning for an old word. And an explicative definition is one that holds onto both an already existing meaning as well as adding a newer meaning. As Nuel Belnap puts it, "the philosopher neither intends simply to be reporting the existing usage of the community, nor would his or her purposes be satisfied by substituting some brand new word" (Belnap 1993, 116–17). Thus, an explicative definition might have both descriptive and stipulative elements (Gupta 2021).[7] I propose that "care" in care ethics is often explicative but that some authors are not necessarily explicit about defining care in this way.[8]

Related to this concern about the way "care" has been used in the literature is the nomenclature referring to the protagonists in caring actions. For clarity, I will use Noddings's conventions.[9] The caring agent—the one giving care—will be referred to as the "one-caring." The caring patient—the one being cared for—will be referred to as the "cared-for." Thus, "one-caring" maps to Tronto's "care-giver" and Kittay's

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"caregiver" or "carer." Similarly, "cared-for" maps to Tronto's "care-receiver." Kittay tends to use the same term as Noddings, that is, "cared-for."

In advance of identifying the precise element in some care ethicists' work that I see as detrimental to the wider project, I will say a little more about care ethics generally. This will serve to provide some background for those less familiar with this branch of ethics and help me to isolate the area to which I hope to contribute. Collins's meticulous engagement with the now extensive care ethics literature found a number of common claims. Her work merits quoting at length as it highlights the way care ethicists have problematized caring encounters. She found common claims to be:

> 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 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 more importantly than those of respect, non-interference, and tit-for-tat reciprocity (which care ethicists generally see as over-emphasised in other ethical and political theories). (Collins 2015, 4–5; emphasis and parentheses in original)

Collins is not suggesting that these claims are found in the work of every care ethicist nor that all care ethicists take each of these claims to be similarly weighty. An important area on which care ethicists differ is whether an ethic of care can be a comprehensive moral theory.[10] For what it is worth, I think that the jury is still out on care ethics' status among other normative theories. However, I am hopeful that with small accretions of scholarship, care ethics will reach such heady heights. For the purposes of this article, I am going to focus on just one aspect of care ethics. It is not seen in Collins's analysis above, suggesting that it is not sufficiently common to be considered a central claim of care ethics. This aspect is the normative extent of the role of the recipient of care in caring actions.

Care ethicist Eva Kittay, remarks, "After the many years I have spent trying to map out the as-yet-not-fully-charted territory of care ethics, I have finally come to appreciate that unless our actions are taken up by another as care, they are not yet care" (Kittay 2014, 33–34). There is precedent for such a claim. For Noddings, a caring relation between the one-caring and the cared-for is caring if and only if the one-caring cares for the cared-for and the cared-for recognizes that the one-caring cares for the cared-for (Noddings 1984/2013, 69). Kittay explicitly builds her understanding of the "completion of care" on Noddings's work (Kittay 2012). Such is the importance to Kittay of this element of care that she devotes a chapter on it in her recent book (Kittay 2019, ch. 8). Another early care ethicist, Joan Tronto, in her account of the ethic, delineates four phases of care that constitute caring action: caring about, taking care of, care-giving, and care-receiving. It is the final phase, "care-receiving," that takes the place of "completion" found in Noddings and Kittay (Tronto 1993, 107–8).

Given the prominence of these three authors in the field of care ethics, it might be tempting to take this stipulation as it stands and look for other avenues of inquiry. In

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the wider care ethics literature, there is no consensus[11] about what I shall henceforth refer to as the *recognition claim*:

> *A has cared for B if and only if B recognizes A's actions as caring.*

That there is no consensus is double edged. On the one hand, it could be indicative of fruitful ongoing debate and discussion, a resistance to ossified theory. On the other hand, it could be taken to be a theoretical weakness, a reason to take care ethics as an immature moral theory that fails to properly distinguish itself from other normative theories.

Tronto on Care-receiving

The *recognition claim*, as I have indicated above, is found in some form or another in the work of three major care ethicists. Their arguments converge in some aspects and diverge in others. Considering each of their lines of reasoning will help to build up a clearer picture of the problem, as I see it. In her seminal work, *Moral Boundaries*, Tronto articulates the four phases of care mentioned above. The phase of care she designates as "care-receiving"

> recognizes that the object of care will respond to the care it receives . . . it provides the only way to know that caring needs have actually been met . . . Even if the perception of a need is correct, how the care-givers choose to meet the need can cause new problems. . . . Unless we realize that the object cared for responds to the care received, we may . . . lose the ability to assess how adequately care is provided. (Tronto 1993, 107–8)

Some two decades later she says:

> Once care work is done, there will be a response from the person, thing, group, animal, plant, or environment that has been cared for. Observing that response and making judgments about it (for example, was the care given sufficient? successful? complete?) is the fourth phase of care. Note that while the care receiver may be the one who responds, it need not be so. Sometimes the care receiver cannot respond. Others in any particular care setting will also be in a position, potentially, to assess the effectiveness of the caring act(s). And, in having met previous caring needs, new needs will undoubtedly arise. (Tronto 2013, 22–23)

The importance of the "recognition of care" is shown in these passages through a set of questions that the recognition of care generates. First is a completion question: have the object of care's needs actually been met? Second is an assessment question: how well have the object of care's needs been met? And, third is a response question: are there now other needs to be met? These questions may be answered by the receiver of care or potentially by a well-placed third party.[12]

The first passage implies that the meeting of another's needs is a binary affair. Either the receiver of care's needs have been met or they have not been met. However, the second passage suggests that the meeting of needs admits of degrees. Needs might be partially or completely met, for example. Tronto is suggesting that these questions are best answered by the response of the receiver of care, or of a third party as proxy where the receiver of care is unable to respond. For the most part, I share this intuition. Who better to assess whether their needs have been met than the care receiver?[13] Tronto's account of care ethics

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has been taken as being in support of the pivotal role of the care receiver in caring action (Kittay 2019, 184), but I think that that this interpretation is misguided.

For Tronto, the concept of care, with its four phases, provides its own standard for assessing the adequacy of care, that is, by considering the extent that the process, the four phases, is well integrated:

> The absence of integrity should call attention to a possible problem in caring. Given the likelihood of conflict, of limited resources, and of divisions within the caring process, the ideal of an integrated process of care will rarely be met; although this ideal can serve us analytically as we try to determine whether care is being well provided. (Tronto 1993, 110)

This excerpt reveals Tronto's intent behind her account of care. There is an ideal of care that includes the four phases: caring about, taking care of, care-giving, and care-receiving. When this process works smoothly, that is, it is well integrated, then it is likely to result in good care; integration of the phases is arguably Tronto's success criterion for care, rather than any one of the phases. This ideal serves to inform analysis and assessment of care. It provides an exemplar against which to "measure" or "assess" the caring actions being considered. Undoubtedly, there will be impediments to care during any of the four phases, some of which are noted in the passage above. However, seeking the end of providing good care, the account Tronto provides helps both caring agents and care receivers reflect on the caring action. It may be considered good care, perhaps it is "good enough" care, or perhaps it reveals hitherto unacknowledged needs that will be met in future caring actions.

The point I am making here is that the ethics of care as construed by Tronto is explicative, rather than solely descriptive or solely stipulative. The four phases of care seem uncontroversial. They *describe* "analytically separate, but interconnected phases" (Tronto 1993, 106). That they are to be seen as an ideal against which to assess caring action is to *stipulate* their function. Thus, the definition of care is explicative. How does this affect my claim that Kittay is misguided to interpret Tronto as she has? It is not to say that Kittay is wide of the mark with respect to the importance of the involvement of the care receiver. It is, though, to say that because Tronto has argued for an explicative definition, it is not the case that, as under a purely stipulative definition, if the care-receiver did not receive as care the caring action, no care has in fact taken place. Rather, it is to reveal the more productive position that caring action may have taken place but perhaps not optimally. The conversation around the caring action in question can continue rather than cutting it short, as both Kittay's and Noddings's formulations seem to imply. Thus, though Tronto has been interpreted otherwise, her account does not in fact include the *recognition claim* that I am arguing is troubling for care ethics.

Noddings on Completing Care

I now turn to Noddings's account of care, one that claims that care is only care when the care receiver recognizes it as such; the *recognition claim* is indubitably present. For Noddings:

> Logically, we have the following situation: (W, X) is a caring relation if and only if i) W cares for X (as described by one-caring) and ii) X recognizes that W cares for X. (Noddings 1984/2013, 69)

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If X does not perceive W as caring, then Noddings asserts that

> the relationship cannot be characterized as one of caring. This result does not necessarily signify a negligence on my part. There are limits in caring. X may be paranoid or otherwise pathological. There may be no way for my caring to reach him. But, then, caring has been only partly actualized. (Noddings 1992/2005a, 68)

Noddings's use of "if and only if" seems to indicate that she is proposing a stipulative definition of care; it is a success term: one with necessary and sufficient conditions.[14] The justification for the *recognition claim* is made through an appeal to plausible, common-sense intuitions about what might happen if the claim is not fulfilled.

> To see just how vital the infant's response is to the caring relation, one should observe what happens when infants cannot respond normally to care. Mothers and other caregivers in such situations are worn down by the lack of completion—burned out by the constant flow of energy that is not replenished by the response of the cared-for. Teachers, too, suffer, this dreadful loss of energy when their students do not respond. Thus, even when the second party in a relation cannot assume the status of carer, there is a genuine form of reciprocity that is essential to the relation. (Noddings 1992/2005a, 17)

> These responses are essential both to the completion of a particular episode and to the health of future encounters. They are the means by which [one-caring] monitors her efforts, and they provide the intrinsic reward of caring. (Noddings 2002a, 19)

Fulfillment of the *recognition claim* has a dual function. That the responses can serve to inform future caring encounters is an idea also seen in Tronto's ethic of care. A difference—an important one, I argue—is the stipulation that care is *completed* by this response, that is, it is made successful by this response. Noddings provides further examples of responses in the care receiver, which receive a fuller treatment:

> The consciousness of being cared for shows up somehow in the recipient of care—in overt recognition, an attitude of response, increased activity in the direction of an endorsed project, or just a general glow of well-being. This response then becomes part of what the carer receives in new moments of attention. (Noddings 2002b, 28)

> What the cared-for gives to the relation either in direct response to the one-caring or in personal delight or in happy growth before her eyes is genuine reciprocity. It contributes to the maintenance of the relation and serves to prevent the caring from turning back on the one-caring in the form of anguish and concern for self. (Noddings 1984/2013, 74)

The difficulty of continued caring when the cared-for does not respond is likely to resonate with anyone who has cared for another. Does descriptive accuracy merit stipulative stringency? These passages suggest a broad understanding of "recognizing as care." It is not at all clear what actions or behaviors of the care receiver would reasonably be ruled out, or for that matter, ruled in. How would the agent giving care be able to distinguish a care receiver's "vigorous pursuit" of appropriate projects as catalyzed by the

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care *that* particular agent gave the recipient of care? Noddings might reply that this is not troubling because the caring agent has contributed to a context of care that has had a happy result for the recipient of care. Yet I do think that the vagueness remains problematic.

First, the vagueness renders it difficult, on Noddings's account, for those who give care to cultivate their caring actions. The caring agent is asked to rely on a response that might take any of multifarious forms that are themselves infinitely interpretable, all while stipulating that this and only this "completes" the caring episode. It is, of course, the case that innumerable actions/responses are more often indicative of care than not. However, one of the strengths of the ethics of care, according to its proponents, is its attention to the particular, situated recipient of care. Thus, on Noddings's account, there appears to be a shift toward generalized care, which runs counter to the commonly understood claims of care ethics seen in the opening paragraphs of this article.

Second, the waters are muddied further when, at points throughout *Caring*, Noddings states about the cared-for:

> he may contribute just enough of what the genuine cared-for usually gives to maintain relations that either look like caring relations or are actually half-caring relations . . . one may behave as cared-for in a relation where the necessary feeling is absent more or less accidentally and egocentrically. (Noddings 1984/2013, 77)
>
> When caring is not felt in the cared-for, but its absence felt, the cared-for may still, by an act of ethical heroism, respond and thus contribute to the caring relation. (78)
>
> the cared-for is free to accept or reject the attitude of caring when he perceives it. If the cared-for perceives the attitude and denies it, then he is in an internal state of untruth. (181)

On Noddings's account, it is not clear how the one-caring could know that their care had been received as care by the cared-for, who may simply happen to behave in such a way that it appears as though they have received the care as care. Further, what if the one-caring has in fact failed to care but this is hidden from them by the would-be-cared-for's "ethical heroism'? I am not suggesting that the scenario is implausible. Sparing the feelings of others, especially those who have made sincere efforts to care for you, is surely commonplace. Finally, the cared-for may indeed be in an "internal state of untruth" but how is the one-caring or, for that matter, the cared-for necessarily able to discern this? Noddings has not offered a solution to this. These parts of Noddings's account somewhat undermine her inclusion of the *recognition claim* in that same account.[15]

Third, there seems, under Noddings's stipulative definition, a conflation of "care" and "good care."[16] The running together of "care" with "good care" leaves very little conceptual space for the degrees of care already seen in the continuum implicit in Tronto's account. There is either care, for Noddings, or there is not. This does not resonate with everyday experience. In the day-to-day activities of caring, there is surely room for better and worse care, while still understanding these activities as care. Noddings's insistence that if the *recognition claim* is not fulfilled, care has not occurred departs from the ordinary experience she is drawing on to articulate her normative account.

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Kittay on the Achievement of Care

Kittay's project seeks to "envision a conception of care and an ethic that both people with disabilities and those who do caring labor can embrace" (Kittay 2019, 139). Hers is a normative account of care: "the normative content of CARE—that is to say, what distinguishes CARE from care—is that it is taken up by the other as CARING" (185).[17] For Kittay, "taking up" maps to "recognizes as" that is at the heart of the *recognition claim* being examined. The importance of this response in the cared-for, in Kittay's theory, shares similarities with the different accounts offered by Tronto and Noddings:

> When caring is sustained, a deeper relationship can develop through the ongoing interaction of the carer and cared for. If one approach fails, the skillful caregiver shifts. . . . In this dance where the caregiver leads and the cared-for takes the cue, caregiving can become a source of self-shaping. The carer comes to discover internal resources and new vulnerabilities. The carer may uncover a need more pressing than the originating one, but also more strengths. Carer and cared for form a catalytic relationship in which neither's flourishing occurs in the absence of the other's flourishing. We have here a dialectical relationality that can sustain us through the long haul. (Kittay 2012, 66)

This is a reminder of the inextricable importance of taking the one-caring and cared-for as contributing to the caring relation, an aspect of Kittay's ethic I do not contest. However, I depart from her argument relevant to the *recognition claim* that I am examining in this article. Below, I look at Kittay's theory in more detail. However, because of a particular aspect of Kittay's care ethics—that care is an achievement term—I will provide some philosophical groundwork first: "That care is an achievement term both determines the normative condition of an ethics of care and helps mark an ethics of care as a distinctive ethics, if not a self-standing theory" (Kittay 2019, 196). What are achievement terms and why does Kittay take "care" to be such a term?

In *The Concept of Mind*, Gilbert Ryle introduces the concepts of task words and achievement words (Ryle 1949/2009, 131–35).[18] The latter are typically episodic whereas the former are not. Achievement words include "score," "find," "cure," and "solve," and task words include "hunt," "treat," and "travel." For example, the absent-minded person casting about their house has either found their keys or they have not. The achievement "finding keys" is determined by whether the keys have been found. In the process of the achievement of finding their keys, the hapless agent can be described as "searching," a task word. The indeterminate nature of "searching" differs from the determinate nature of "finding."[19] Ryle claims that for achievement words, "some state of affairs obtains over and above that which consists in the performance, if any, of the subservient task activity" (132). If the key-seeker exclaims that they have found their keys but after further inspection realizes that they have found someone else's, the search may continue and it would be incorrect to say they had achieved what was intended, being reunited with *their* keys. This is not to say that every achievement entails a preceding task or to have been motivated by a particular intention. It is completely comprehensible to say "I found £20 on the counter while searching for my keys." The money was found (achievement) without searching (task). From the point of view that the finding of the money occurred by happenstance during the search for the keys does not render designating "finding" as an achievement word incorrect.

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Importantly, "while we expect a person who has been trying to achieve something to be able to say without research what he has been engaged in, we do not expect him necessarily to be able to say without research whether he has achieved it" (133). In the misplaced key scenario, the achievement of finding the keys is straightforward in its assessment: either the keys have been found or not. A novel mathematical proof may take more work to confirm. Moreover, Ryle is suggesting that in searching for and finding the keys, the person has done *one* thing with a certain result, rather than *two* things. Fleshing out the difference between task verbs and achievement verbs, Ryle asserts that the latter are

> not occurrences of the right type to be objects of what is often, if misleadingly, called "immediate awareness." They are not acts, exertions, operations or performances, but, with reservations for purely lucky achievements, the fact that certain acts, operations, exertions or performances have had certain results. (133)

In football, a player is said to be aiming to score a goal. That they have scored a goal indicates success, suggesting that the sentence "the player scored successfully" is a tautology not adding to the sense of the utterance. It would be nonsensical to use certain adverbs with achievement words but completely reasonable to use them with task words. The agent can be properly described as "assiduously searching" but not that they "assiduously found." In the latter case, presumably it was the searching that was assiduous that resulted in the finding.[20] Finally, that there are words that appear to behave in the same way, for example, "find" and "solve," and are both achievement words should not be taken to mean that they are alike in every respect. Arriving at a conclusion is not the same as arriving at one's destination in every respect (135).

Given this account of "achievement" terms, how does Kittay reach the conclusion that "care" is an achievement term? The uptake of care by the cared-for is contingent on the nature of the cared-for. It will matter whether an object, a living thing without subjectivity or a living thing with subjectivity, is the object of care. Thus, care of a broken table differs from the care of a plant, animal, or person. For people, care must aim at that person's flourishing for their own sake. If care is to be achieved, then uptake is necessary from the one being given care (Kittay 2019, 191). Drawing on Ryle's account, Kittay builds up her claim by analogy:

> Just as there must be a thimble in the place that a person indicates if we say that the person found the thimble, so the person caring must have something or someone in need of her care. Just as the doctor must not only treat a patient but the patient must be well again if we are to say that the doctor cured the patient, so must the carer not only attend to the cared-for, but the cared-for also has to receive these attentions as caring (something which is not always as clear cut as a cure, but is nonetheless something which we can articulate as sufficiently well for it to count as an achievement). Activities that are intended as caring must involve the achievement of caring or they are not yet CARE. (190)

Further:

> To insist that an action that fails to achieve its end (even when it is carried out with the intention to care or with the attitude of care) is insufficient to make it an act of care is not to propose a stipulative definition . . . insisting that care is an achievement

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> verb is based on a strong intuition that is widely shared. It is this intuition I am isolating in the use of CARE (that is, care in the fully normative sense) when I insist that the achievement of CARE requires uptake on the part of the cared-for (191).[21]

These passages demand some explication, though I propose to take up only three threads of Kittay's argument. I will first examine the analogy between care and medicine. Second, I will ask whether the intuition Kittay draws on is as strong and legitimate as she suggests. Third, I will question whether Kittay's denial that she has proposed a stipulative definition is plausible.

First, the analogy made with medicine. Rightly, if a patient, having been treated ("task") was not in fact well, then cure (achievement) would not be correctly used.[22] That "care" is "not always as clear cut as a cure" is indicative of the gap between the two. If it is said that a person is caring for another, then this is analogous to saying the doctor is treating her patient, *not* analogous to curing her patient. The sense in which treating may lead to curing does not follow through with caring. There is not an achievement of "caring" that makes sense in the same way that is indicated by "curing." Another way to look at the trouble with the medicine–care analogy is to recognize that a patient could conceivably be both "treated" and "cured" without being entirely aware of either taking place. Someone may not have the epistemic or experiential resources to comprehend what is happening to them but that would not mean treating and curing had not taken place. For example, a patient in a coma might develop pneumonia that is then treated, leaving them still in a coma but free of pneumonia. Further, care seems to be a much more diffuse concept than treating. So many actions could be caring, but in order to treat an infection, for example, there do seem to be many legitimate actions available to the medical practitioner. Relatedly, unlike treatment and cure, there is much less of an episodic nature about care, another reason it does not yield favorably to task-achievement analysis.[23] Finally, and perhaps most important, the notion of care as a task term suggests that it is something that is ongoing whereas as an achievement term it is something that might be finished or completed. There may be specific instances where the care needs of another are met and the caregiver has discharged their present duties. However, the one properly caring is likely to be in a position where they continue to attend to the cared-for lest future needs necessitate additional caring action. Thus, "unlike 'treatment' that is predicated on an assumption that its application will obviate the need that gave rise to it, care has no end point. People do not 'stop caring,' unless some fracture too great to overcome intervenes" (Barnes 2015, 41). The foregoing suggests that the analogy between treating and caring does not hold. On this line of argument at least, Kittay has not supported her version of the *recognition claim*.

The second thread in Kittay's claim is that "insisting that care is an achievement verb is based on a strong intuition that is widely shared." Of course, the existence of an intuition no matter how pervasive or deep does not in itself entail anything normative. It might serve as something against which to test an argument or thought process but does not necessarily show much more than that. The intuition alluded to comes from an example Kittay offers about a person caring for a plant by watering it with a nearby glass of colorless liquid. Unfortunately, the colorless liquid is in fact vinegar and not water, thus the plant dies. Kittay's point does have some force from the point of view of recognizing that the right intentions to care are not sufficient for care. Some sort of positive result for the care receiver is also necessary. The problem here is that the misplaced care for an object is different from misplaced care for a subject, that is, a person. This is in fact observed by Kittay herself. When exploring misplaced care, she says: "The one who is cared for may at

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once recognize her carer's sincere effort to care, while knowing that these efforts will fail to meet her actual needs. Sometimes merely experiencing the other's desire to care for oneself can be a contribution to one's flourishing" (Kittay 2019, 192). An object is unable to do this, that is, intentions are irrelevant to an outcome for an object. This is not the case for subjects; it matters that a subject can discern potentially misplaced care and gain from the feeling generated by the intention behind the caring actions.[24] Although there *may* be a shared intuition about the plant example, where care could be seen as an achievement term, it simply does not carry through for people. Thus Kittay's second argument in support of the recognition claim evaporates.

Finally, the third thread is Kittay's claim that she is not providing a stipulative definition. If the definition is descriptive and if I am correct in my assertions in the previous two paragraphs, then it could simply be that Kittay and I share different intuitions about the scenario. However, I would like to go further and suggest that, contrary to Kittay's explicit statement, the definition of care she has offered is in fact stipulative. This is due to the inclusion of the premise that care is an achievement term. In asserting that care is an achievement term, Kittay seems to be saying that only "successful care" is "care." This section and those preceding it have suggested that this identity and the identity of "good care" with "care" are misplaced in any ethics of care.

Implications for Care Ethics

Let me assume that the foregoing critical evaluations are somewhat plausible. What might be some implications for an ethics of care that does not stipulate the *recognition claim* as necessary to call an action caring? Does resisting the inclusion of this condition risk jettisoning the whole care ethical enterprise? In this concluding section I will advance some preliminary arguments as to it being preferable for an ethics of care to not include the *recognition claim*.[25] I will undertake this by considering Steven Steyl's recent interpretation of Kittay's and Noddings's arguments.

In his examination of caring action, Steyl interprets Noddings's and Kittay's accounts of care ethics as follows: "Care is not care, to Noddings, unless it *actually* meets needs. And Noddings is not alone in defending a view like this. Kittay too sees care as necessarily successful" (Steyl 2020b, 290; emphasis in original). He notes that "Success criteria also serve certain discursive ends. For instance, they highlight certain important and hitherto underexplored categories of care, including, in particular, *wise* care. An experienced caregiver who excels at means–end reasoning will be better able to care well" (291). I agree with much in Steyl's analysis. He is right to interpret Noddings and Kittay as stipulating care as having a success criterion. The foregoing work demonstrates the alignment of our thinking. However, where I depart from Steyl is the *nature* of this success criterion as distinct from the *utility* of success criteria. I consider each of these in turn.

Steyl appears to take Noddings and Kittay as holding the success criterion to be actually meeting the needs of the cared-for. I contest this reading of their work. As I have tried to show, the success criterion for both these authors in fact amounts to the *recognition claim* such that:

A has cared for B if and only if B recognizes A's actions as caring.

There may be an ethics of care whose success criterion is the meeting of needs,[26] but this is not the case for either Noddings or Kittay. Hence, though Steyl is correct to

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construe Noddings and Kittay as according only "successful care" as "care," he is mistaken about the way these care ethicists make their arguments. Kittay is adamant: "The point of care is not only to address needs. That is the means to an end. The end itself is to promote the flourishing of the cared-for"[27] (Kittay 2019, 137). Moreover, both Noddings and Kittay are explicit about how it might be the case that actually meeting the cared-for's needs may not be feasible or desirable:

> When we care for others, we attend and respond as nearly as we can to expressed needs. When we have to refuse a request—because we lack the necessary resources, find the request unwise, or even evaluate it as morally wrong—we still try to support a caring relation. It can be very difficult, but our purpose is to connect with the other, to make both our lives ethically better—not to overcome, defeat, ostracize, or eliminate him. (Noddings 1992/2005a, xxv)

> the carer has a moral responsibility to be alert to wants and desires that lack legitimacy. Recall that these are legitimate because they do not involve clearly immoral demands, demands that in order to be fulfilled means causing others intentional or foreseeable harms, and needs or wants that require unjust demands on the carer. If the cared-for's perspective requires us to participate, even indirectly, in behavior we know to be immoral, the carer has the moral obligation to refuse. (Kittay 2019, 204, note 46)

These two passages indicate that both Noddings and Kittay would *ex hypothesi* endorse at least some needs not being met. This should not come as a surprise; it would be an unusual moral theory that supported agents' evil projects.[28] My point is that, though the "right" needs and wants are a focus of care ethics, however "right" is understood,[29] both authors appear to acknowledge that one can still be caring while not necessarily meeting the needs of the cared-for. Thus, although Noddings and Kittay endorse a success criterion, it is not to be understood as their insisting that the one-caring actually always meets the needs of the cared-for.

Having shown my departure from Steyl with respect to the *nature* of the success criterion found in Noddings and Kittay, what can be said about the *utility* of success criteria? Having discussed Kittay's "watering" a plant with vinegar example, Steyl writes:

> In focusing on the outcomes of our efforts to care, we are led to ask whether there is anything the caregiver could have done better next time. Taking the actual satisfaction of needs as an end requires in part that we dissect cases of unsuccessful "care" with the aim of doing better next in future. So the motivation for endorsing a success criterion is a reasonable one.
>
> But I want to suggest here that consequences be left to *evaluations* of caring actions rather than *descriptions* of caring actions like those I have been discussing thus far. Success criteria are open to counterexamples[30] . . . [it] is right to think that morally praiseworthy care is sometimes unsuccessful. Caregivers who never commit any misdeeds may still have their efforts thwarted by luck. Failures to meet needs certainly represent some sort of disvalue, but that is not always the sort of moral value that ethicists usually attribute to actions. (Steyl 2020b, 291; emphasis in original)

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Whether or not a care ethics should include a success criterion,[31] it remains the case that if the cared-for's needs are not met, then there is the opportunity for improving care. However, is Steyl right to distinguish, as he has, between the (moral) evaluation of caring actions and their description? An initial concern I have is that "successful" and "unsuccessful" are themselves inescapably evaluative. This makes it less than clear how the posited separation improves the situation. Steyl remedies this to some extent when he later writes:

> Care ethicists ought to prefer accounts that afford moral praise for *acting as one ought* while simultaneously affording (a different sort of) value to successfully meeting needs. Successful care is a category of care we wish to retain, but it is one of several we ought to leave conceptual space for, including care that is non-culpably unsuccessful. We ought to prefer accounts of care that make a distinction between success and failure *within* their concept(s) of care, instead of exporting failure to some other moral concept that is not the ethic's keystone moral concept. (Steyl 2020b, 291–92; emphasis in original)

My worry is that using "success" at all with "care" takes the ethic toward a binary I have been at pains to argue against throughout this article. It is preferable for a care ethics to include degrees of care rather than care or not. Furthermore, I am not clear about two other elements in the above excerpt. First, how can meeting needs be a different sort of value? Second, why is meeting needs taken to be outside care ethics? I will take these in reverse order.

The meeting of the cared-for's needs has a significant place across the care ethics literature.[32] It is by no means readily apparent why to refer to the meeting of needs would be to take the care ethicist outside the general form of a care ethical theory. Given this, although I have been advocating against the inclusion of success criteria in a care ethics, the general drive toward meeting the cared-for's needs remains a fundamental aspect of that ethic. Thus, the second issue is rendered inconsequential. Now, to the issue of value. As Steyl indicates, various problems are associated with the meeting of needs. I may simply fail to meet another's needs due to moral luck, that is, had the situation been different I would have met the cared-for's needs.[33] Does this render my actions without any moral worth? Relatedly, the possibility of meeting another's needs and hence meriting moral praise is contingent on having resources at one's disposal. An ethic that consigns those who are not able to meet other's needs simply because of lack of resources flies in the face of the wider feminist project that seeks to be more sensitive to the circumstances in which agents find themselves (Steyl 2020b, 291). Having said all this, and I do not contest his points, his negative evaluation of meeting needs seems to stem from his classifying the meeting of needs as the success criterion of care ethics. If his focus were the *recognition claim* rather than the meeting of needs, then perhaps he would not be so concerned with the conceptual baggage of meeting needs.

According to Steyl, having some way to determine whether care has been successful enables different accounts of care ethics to be sorted into those that

> distinguish between something like "good" and "ideal" caring actions. Into the latter category falls care that actually meets needs, and into the former, actions that are marred by misfortune and yet are still caring. The latter takes into account *all* good-making features of caring actions, including both the agential and

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> nonagential. The former leaves room for action that is not successful, but not through the caregiver's own fault. We ought to hope that all care is ideal, and it is a pity when care is, for whatever reason, good but not ideal, but good care is still "good" in that the caregiver acted as they ought. (Steyl 2020b, 292; emphasis in original)

I find the use of "ideal" and "good" here troubling. Steyl is taking "good care" to be the sort of care expected of a particular agent, that is, the agent has acted as they ought. However, if "care" is taken to be those actions appropriate to the situation, namely an agent acted as they ought, then space is opened for the degrees of care for which I have been making the case throughout this article. By this I mean there might be "care," "good care," and "optimal care." Using "optimal" in place of "ideal" serves two purposes. First, it indicates that, all things considered about a situation, the one-caring has done all they can; it is the best possible outcome as things stand. Second, it is not suggesting, along perhaps Platonic lines, that there is some sort of essence of care that is being aimed toward. The use of "optimal" still admits of aspirational action but without the conceptual baggage that can accompany "ideal." All this suggests that there could be a care ethics open to actions that meet some sort of threshold to be called caring but also that some agents will be better at caring than others and, through their actions, start to approach "ideal" or as I have suggested, "optimal" care.[34] I will save for another occasion the opportunity to offer suggestions about how to assess these degrees of care or whether such a project would in fact even be desirable.[35] All this goes to say that the utility of success criteria may serve to improve care but only on an understanding of a care ethics that allows for degrees of care, rather than success criteria that insist on care or not-care.

This article has considered one aspect of the work of three prominent care ethicists, Joan Tronto, Nel Noddings, and Eva Feder Kittay. It has assessed what amounts to what I have called the *recognition claim* found in their writings. For Tronto, the phase of care she calls "care-receiving," though on the face of it bears a resemblance to the *recognition claim*, is not itself a success criterion. It is the integration of Tronto's four phases of care that appears to serve this purpose. For both Noddings and Kittay, the *recognition claim* is a vital aspect of their care ethics. In Noddings's writing, this takes the form of care being completed only if the cared-for recognizes the care as such. In Kittay's argument, the *recognition claim* is found where she takes care to be a Rylean achievement term. I offered a critique of their arguments and suggested that the main benefit to care ethics would be one that admitted degrees of care, possible when the *recognition claim* is resisted. By way of Steven Steyl's interpretation of Noddings and Kittay I started to flesh out why the idea of degrees of care would be a positive development in care ethics. Care ethics, nascent as it is, is ripe for philosophical clarification.[36] I hope that the arguments in this article can contribute in a small way to the accretions of knowledge that will cement the position of care ethics as a meaningful contender in the field of moral philosophy.

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Notes

1 Some authors were critical of the assumptions both implicit and explicit in moral theories, for example, a commitment to formal, abstract, and universalizable principles (Tronto 1993, 27) and a moral agent who is "detached and autonomous, willing to surrender special connections and circumstances when necessary to achieve a rationally justifiable account of morality" (9–10).

2 The relation of care ethics to virtue ethics is found in Putnam 1991; Halwani 2003; and Sander-Staudt 2006; to Kantian ethics in Bramer 2010; Miller 2012; and to consequentialist ethics in Driver 2005.

3 Related examples: Simon van der Weele offers insight into the differing ways "dependency" is used in care ethics (van der Weele 2021); Stacy Clifford Simplican explores the inherent risks in care ethics, risks due to the necessity of anticipating who the people being cared for will become (Simplican 2017); and Amy Marvin sets out to connect transgender studies with the ethics of care (Marvin 2019).

4 It also has much to say about how to bring up subsequent generations of moral people. See, for example, Noddings 2002b.

5 The use of "recognition" here should not be confused with work in the politics of recognition (Taylor 1994). "Recognition" of care is used by some care ethicists to indicate the way someone who is being cared for might assess, respond, or consider the care they are receiving.

6 Not to mention ostensive, real, nominal, or dictionary definitions (Gupta 2021).

7 The idea of an "explicative definition" is usually credited to Rudolf Carnap (Carnap 1947, 7–10).

8 Another way of understanding "care" might be as a "family resemblance" term, *pace* Wittgenstein. Collins makes this interpretation of Peta Bowden and Anca Gheaus (Collins 2015, 3; see Bowden 1997, 2–6; Gheaus 2009, 64). Frans Vosman wonders whether the resemblance holds given the wide range of scholarship (Vosman 2020, 18).

9 Further, this should reduce any ambiguity because of a resemblance to ordinary-language terms such as "caregiver." Noddings's use of the hyphenated "one-caring" and "cared-for" follows precedent in existentialist philosophy; an example from that body of scholarship is Sartre's "for-itself." Using these "allows us to speak about our basic entities without explaining the entire conceptual apparatus repeatedly . . . it prevents us from smuggling in meanings through the use of synonyms" (Noddings 1984/2013, 4). Also, Noddings uses the generic female for "one-caring" and generic male for "cared-for" in her writing. In actual caring relations, each of these roles could be either female or male. The influence of existentialist thought is felt throughout Noddings's work, not least in these hyphenated terms.

10 Joan Tronto's project suggests care ethics can speak to much of moral concern in her political theory of care that takes the ethic beyond traditional dyads (Tronto 1993; 2013). Virginia Held sees care ethics as a distinct moral theory (Held 2006, 9–28), Michael Slote that it can account for the whole of morality (Slote 2007, 1–4), and Collins assumes it is a moral theory and sets out why it is compelling as such (Collins 2015, 1–10). On the other hand, Noddings seems to suggest that care ethics is better understood as an account of the moral life than as a traditional moral theory (Noddings 2010, 125–56). These varied views are unsurprising, as Maurice Hamington instructively observes, "care ethics does not easily fit into the framework of traditional Western moral theory, resulting in struggles over categories, terms, and ultimately, acceptance" (Hamington 2015, 274). Given this, he contends that care should be understood as a performative way of being, resisting a Western construal of moral theory (274). Relatedly, Carlo Leget and colleagues draw attention to the interdisciplinary nature of the field of care ethics (Leget, van Nistelrooij, and Visse 2019). Currently, I submit, care ethics occupies a place between a Kantian systematic approach to ethics and a Murdochian moral view of the world.

11 The reality of the potential importance of the recognition of the cared-for is not in question; it is whether it should have the trumping effect claimed by some of its proponents.

12 Interestingly, given Noddings's insistence on the recognition claim explored below, she makes a similar acknowledgment to third parties (Noddings 1984/2013, 23).

13 Though there must be some openness to the idea that the cared-for could be mistaken about their needs.

14 I am limiting my attention to the condition that amounts to the *recognition claim*.

15 Moreover, recalling Tronto's explicative account above, one premise was that a well-placed third party could potentially recognize care as such, acting as a proxy for a care receiver who was unable to respond. Noddings's account does not seem to permit this. It could be argued that Noddings and Tronto have different overarching projects: Tronto is seeking an ethic suitable for the wider political domain, whereas

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Noddings is offering an ethic focused on dyads of care. Thus, it is not unexpected that Tronto's account allows for response and assessment by a third party. However, the absence of the potential assessment by a third party is a weakness of Noddings's account.

16 Collins also observes this running together of "care" and "good care" in the literature (Collins 2015, 69ff). I will return to her work in the concluding section. Connectedly, Held distinguishes between adequate care and good care (Held 2006, 42). Also, Tronto provides an important and perspicuous insight when she warns against defining all "care" as "good care," that it matters in which sociopolitical theories and structures the concept is used. It is *this* that speaks to care's normative import, rather than how clearly the concept has been articulated (Tronto 2013, 24ff).

17 When Kittay uses the orthographical from CARE, she is speaking of it as a normative concept. When care remains uncapitalized, it is to be understood more in line with everyday usage.

18 Ryle uses achievement "verbs" and "words" interchangeably. To these I will add achievement "terms."

19 That achievement words imply a sense of completion has ramifications in my later critique of care being an achievement term.

20 However, Ryle notes that tasks and achievements are often run together when there is a perception that the achievement is highly likely (Ryle 1949/2009, 132).

21 Kittay does concede "a point that makes the stringency of this requirement more palatable. We can still say that a person who fails to care only because her caring is not taken up by the other is praiseworthy in altruism, heroism or good-heartedness. But she cannot be morally praised as a carer" (Kittay 2012, 65).

22 "Curing" and "treating" are not necessarily so easily defined. See Broadbent 2019, 33–62.

23 Although a closer inspection of treatment and cure suggests that perhaps philosophers have focused on ordinary-language understanding of the terms rather than the way they are understood in actual medical practice. See Broadbent 2019.

24 Similarly, consider the cared-for who comes to realize that their one-caring had bad intentions.

25 Of course, it *may* transpire that the cared-for was quite right, the one-caring has in some way got it wrong. However, that is not the focus of this article.

26 Collins also interprets and rejects Diemut Bubeck as making the meeting of needs a success criterion in his ethics of care (Bubeck 1995, 129–32; Collins 2015, 69–70). Similarly, Roxanna Lynch interprets Daniel Engster in this way (Engster 2007, 28; Lynch 2016, 144–45). I do not offer comment on these interpretations. Furthermore, there are ethics of needs that dispense with care ethics entirely, for example, Reader 2007.

27 There is something slightly incongruous about the language in the final sentence of this excerpt. "Promotion" of a value is central to consequentialist moral theory and "flourishing" to virtue ethics. I leave open whether such overlap is significant.

28 Criticisms of care ethics on these lines came early on, for example, Card 1990.

29 I share Sarah Clark Miller's observation that the concept of "need" is not well theorized in care ethics (Miller 2012, 15). However, we part ways in how to address this lacuna.

30 The counterexample provided is Collins's (Collins 2015, 74), the detail of which is not pertinent to my argument.

31 One issue with the logic of a success criterion is that it has the potential to leave open that the action is in fact part of a larger project that itself may be bad.

32 See Collins 2015, 55 for an excellent summary.

33 It is apposite to include Collins's counterexample that illustrates the contribution of moral luck: "Imagine that you and I each separately stumble upon injured dogs. We each put the dog that we find into the back of our cars and attempt to drive them to the nearest vet. While your dog reaches the vet in good time and is healed, I get caught in traffic and arrive at the vet five minutes too late. It seems odd, one might think, to say that your action is more valuable than mine. Your action does a lot more good for your animal than my action does for mine. But we might think that this should not affect the *moral* assessment of the action" (Collins 2015, 74; emphasis in original). Moral luck may be better attributed to those cases where something completely unforeseen changes the outcome.

34 The idea of a threshold of care makes sense in professional roles such as nursing where there is arguably a better sense about what would constitute this threshold. Compare this to the role of being a parent, and the notion of a threshold of care is much less straightforwardly identified. This is an area ripe for further examination.

35 There are not only degrees of care but also varieties of context in which it is instantiated.

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36 Another area that merits further attention is the connection between "care ethics" and "practice." Vosman has remarked that early work in care ethics tended to focus on different caring practices, and he has advocated that it is once again "time to bind care ethics more radically to inquiries of practices and to the questions participants in those practices ask" (Vosman 2020, 38). However, "practice" can be understood in a number of ways. These include how practice is used in the phrases: "standard nursing practice," "a good example of a MacIntyrean practice," and "all very well in theory but a failure in practice." This last utterance will be put to one side as it does not have a significant bearing on the present discussion. Both the first and second utterances bear the implication that it is in principle possible to determine whether behavior accords with that practice. There may be the further implication that it is possible to determine the strength of that accord, that is, whether the behavior instantiates "good nursing" or "realizes the internal goods of that practice." If this is the case, then it would lend strength to my claim that it is better to understand care as admitting of degrees. Space does not permit my further exploration of care as a practice in either of these two senses. I direct the reader to Lynch, who identifies eleven care ethicists who describe care as a practice (Lynch 2016, 201) and examines the issue in detail (201–35), and Barnes et al. 2015 for explorations of care in specific practices. My thanks to an anonymous reviewer for raising the question of practice in their comments.

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