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1). Introduction: Who Cares?

This chapter examines a range of philosophical and social-scientific issues that fall under the rubric of 'care'. The theme of care raises questions about how the needs of people are defined, and how responsibility for meeting those needs is distributed between different social actors. Care is often thought of as a positive value that designates values of co-operation, sociability, and collective responsibility. Thus, it is easily aligned on one side of a set of evaluative oppositions between individual and society, autonomy versus community, or rights and responsibilities. Care easily becomes associated with the latter terms in each of these pairs, but this tends to simplify what is in fact a much more complicated set of relationships. By keeping in mind the question 'who cares?', this chapter will focus attention on the contested process of defining the nature and scope of needs, and of defining where obligations to meet needs should fall.

  Care has become an increasingly important topic of research in human geography (see Conradson 2003; Staeheli and Brown 2003; Smith 200?). In this chapter, there are three ways in which questions of care are connected to issues of space, place, and scale. Firstly, there is a tendency in discussions of care to suggest that the value of caring is necessarily partial – that it follows from intimate concerns for concrete others, rather than an abstract concern for generalised others. This implies that care is associated with spatial relations of proximity, and makes it very difficult to imagine how care can be extended over spatial distance. Secondly, geographers have emphasised that caring tends to take place in particular spatial locations – in the home, at school, in hospitals. Indeed, spaces of care are often sequestered away from the spaces of ordinary life, and this gives rise to the impression that care is something that only special classes of vulnerable people – children,the sick, the elderly, and so on – are in need of. Thirdly, once one recognises the diversity of caring practices, then the geography of care can be seen to involve not only specific practices taking place in particular locations, but also the coordination of these specific practices into routines of care that are spatially and temporally complex. Each of these geographical dimensions is dealt with in this chapter. The chapter is divided into three main sections. In 'The value of care', feminist arguments about a so-called "ethic of care" are discussed, with particular attention given to the extent to which the value of care is at odds with the value of justice. In 'Spaces of care', the chapter considers a more complex account of the different practices that go to make up care, and then considers how the geographies of the caring practices can be usefully analysed using the concept of "carescapes". In 'Care unbound', the chapter considers the extent to which values of care can be extended across space and to strangers. The chapter then concludes with a reflection on the main points covered.

2). The Value of Care

<u>A Feminine Ethic of Care?</u>
One place to start our consideration of care is by considering a set of debates amongst feminist social theorists and philosophers on the moral significance of care. This will help us clarify what is at stake in focussing upon the contested definition of the scope and location of responsibilities to provide care. Feminist thinkers have been at the forefront of

promoting he supposee value of care, or what is often called an ethic of care. An ethic of care is often contrasted with the supposedly abstract principles of justice and autonomy. The idea of an ethic of care is most closely associated with the work of Carol Gilligan (1982). There are, she suggested, two ways of thinking about the self in relationship with others (Gilligan 1986). One of these ways supposes a separate and autonomous individual, and thinks about responsibility in terms of a commitment to abstract obligations. The other supposes 'a psychology of love', or what is sometimes called a 'relational' notion of the self. This view sees the self as thoroughly interdependent, and is rooted in the experiences of attachment and vulnerability rooted in the parent/child relationship (ibid, 282). Drawing on extensive empirical work on the ways in which men and women, and boys and girls, discussed notions of moral responsibility, Gilligan argued that these two moral dispositions – of a self defined through separation, and of a self defined through connection - were fundamentally incompatible (1982, 35). She further argued that women were inclined towards thinking and acting in relation to the injunction to care, while men were inclined to accord highest value to respecting the rights of others, a principle of non-interference (ibid., 100). Gilligan presented an ethic of care (based on values of attachment, engagement, and intimacy) as more contextual than abstract notions of justice, rights and obligations. Through this comparative analysis of the way in which different social actors talk about morality, Gilligan arrived at a specific definition of care: "the ideal of care is thus an activity of relationship, of seeing and responding to need, taking care of the world by sustaining the web of connection so that no one is left alone" (Gilligan 1982, 62).

Gilligan's arguments concerning the tendency of men and women to display different moral dispositions towards their responsibility to others have been highly influential in social psychology, in educational theory, and also in moral philosophy. The strongest and most important emphasis of Gilligan's work was on the ways in which people's moral dispositions emerged from the social roles in which they were involved. There are not naturally 'feminine' or 'masculine' dispositions to favour care or justice, but rather socially constructed dispositions. Nonetheless, despite this emphasis, this line of work certainly does affirm the value of relations of care by reproducing an image of relationships of intimacy and attachment off-set from a realm of abstract, impersonal relations. In so doing, the value and meaning of care is, however inadvertently, associated with a longer tradition that conflates care with an apparently natural pattern of obligations whose model remains family relations. This inadvertent idealization of caring is most evident in the work of the other key theorist of a feminine ethic of care, the educational theorist Nel Noddings. For Noddings, caring is about being focussed on and absorbed by other people. It implies a sensitivity to the specificity of the needs of other people. On this definition, the value of care seems to mitigate against the extension of care to anonymous others. Accordingly, Noddings makes a distinction between 'caring for' others and 'caring about' others:

  "I can "care about" the starving children of Cambodia, send five dollars to hunger relief, and feel somewhat satisfied. I do not even know if my money went for food, or guns, or a new Cadillac for some politician. This is a poor second-cousin to caring. "Caring about" always involves a certain benign neglect. One is attentive just so far. One assents with just so much enthusiasm. One acknowledges. One affirms. One contributes five dollars and goes on to other things" (Noddings 1984, 112).

There is a clear spatial inflection to this distinction – caring-for is direct, up-close, and implies relationships of close proximity.

Caring-about is, on the other hand, indirect, mediated, and undertaken over distance. Caring-about others seems to be a little too easy. The strong implication of Noddings rendition of this distinction is that caring-for is more a authentic disposition, based in direct and unmediated response to the cared-for and a detailed attentiveness to how caring is received by the cared-for. Caring-about, in contrast, can actually lead to self-righteousness, she suggests, because it can be undertaken out of a self-interested motivation to be seen to be a good person. This intrusion of self-interest into the scene of care is enough to disqualify this style of concern as a form of authentic care.

Justice and the relational value of care

The feminist political theorist Joan Tronto has challenged the association of caring with women's distinctive moral disposition that Gilligan and Noddings have been so important in establishing as an element of feminist thought. Tronto's argument (1987, 1993) is that this line of work, rooted in the empirical methodologies of social psychology and educational theory, which emphasise dynamics of inter-personal interaction, tends to ignore the wider political frameworks which help to determine which matters are defined as matters of public or private concern, and in turn help define these matters in distinctively gendered ways. In particular, Tronto challenges the tendency of this version of feminist theory to present caring as necessarily an intimate and direct practice rooted in specific relations of dependence and vulnerability. She suggests the relationship between values of care and justice, interdependence and autonomy, need not be thought of as a clear and stark opposition. Rather, it is a matter of clarifying the appropriate contexts for the application of different normative principles in particular contexts.

Here, it is worth considering the moral philosopher Bernard Williams' argument that the deepest loyalties of human life should be expected to be governed by the sorts of justification which universalising theories of morality tend to favour. Williams' (   ) famous example is that of whether a husband, faced with the choice of saving his own drowning wife or the life of a drowning stranger, could justify saving his wife. Williams suggests that the idea that the husband requires such a justification is, as he famously put it, "one thought too many". Williams' point here is that what it means to be a good person, to act ethically, exceeds the model of a person whose actions are only guided by adherence to moral principles or rules. Indeed, Williams' suggestion is that in lots of situations, an excessive concern with principle can actually get in the way of caring and acting out of concern for others.

Now this seems, on the face of it, to support the distinction between care and justice, contextual ethics and abstract judgement, discussed already. However, the idea that the value of care should be elevated over the abstract value of justice, might easily turn into an excuse for caring only for a narrowly defined range of people – one's family or friends, or perhaps an exclusively defined set of members of the same ethnic or national group as oneself (see Smith 2000, 97). A narrow delimitation of the scope of caring relations might be embedded into broader institutional structures such that the pursuit of the positive values of care by individuals can, nonetheless, lead to the reproduction of unjust and unequal outcomes. This indicates that the significance of Williams' argument is not that matters of principle or moral rules are never relevant, only that one needs to be

sensitive to when it is appropriate to apply them, and when other 'virtues' such as compassion, generosity, or care are more appropriate responses.

In short, the value of relationships of care cannot be separated from the judgements of social justice. If care is embedded in concrete networks of social relationships, from which its moral value as an alternative moral disposition is derived, then nonetheless there are situations in which acting according to this positive value might lead to outcomes that are difficult to square with our broader moral intuitions about what is right and good. If one were to think of relations of care - of loyalty, mutual obligation, reciprocal attachment, and trust - as morally good in and of themselves, then this would imply thinking of organisations such as the Mafia or the Ku Klux Klan as the epitome of moral worth. In contrast, it would imply that sitting on a jury, along with a series of anonymous fellow citizens, and casting judgement on another person based solely on the evidence before you, is somehow not a morally worthy practice, and nor is voting, which is a practice undertaken wholly in secret and, furthermore, one in which one's own actions are not tied to any expectation of reciprocal obligation (voter's are not normally held responsible to the government's they elect into power). In short, judgement as to the value of particular care relationships depends then, on the broader webs of social relationships and institutional structure into which these partial relationships are embedded.

We seem to have arrived at the point where we can see that impartial values of justice, equality and fairness, and partial values of care, concern and responsibility, might not be so easy to separate as the distinction itself might imply. And nor do these two families of values map straightforwardly onto matters of public concern versus matters of personal or private concern. The relationships between care and justice, individualism and community, partial concern and impartial judgement, the private sphere and the public sphere are, in fact, ones of multiple and cross-cutting connections. The importance of the feminist literature on an ethics of care is that it points towards the embeddedness of moral dispositions in social practices and inter-subjective relations.

Summary

Taken in isolation, care can be seen to be an important, perhaps even necessary element of any practice of moral or political judgement. But the key issue is to track the broader patterns of inter-subjective, social and institutional relations in which caring is learnt and practiced.
Practices of care are necessarily embedded in wider patterns of social, economic, political and cultural power.
If the value of care lies in its being a set of partial relations, then this raises the problem of how to square the value of care with other values such as justice, altruism, or humanitarianism.

3). Spaces of care

Unpacking Care
In the previous section, we saw that it is important to locate the analysis of care in wider

patterns of social life, rather than idealise particular sorts of intimate social relationship as the essence of caring:

> "caring is a process that can occur in a variety of institutions and settings. Care is found in the household, in services and goods sold in the market, in the workings of bureaucratic organizations in contemporary life. Care is not restricted to the traditional realm of mother's work, to welfare agencies, or to hired domestic servants but is found in all of these realms. Indeed, concerns about care permeate our daily lives, the institutions in the modern marketplace, the corridors of government. Because we tend to follow the traditional division of the world into public and private spheres and to think of caring as an aspect of private life, care is usually associated with activities of the household. As a result, caring is greatly undervalued in our culture -in the assumption that caring is somehow "women's work" in perceptions of caring occupations, in the wages and salaries paid to workers engaged in provision of care, in the assumption that care is menial". (Tronto 1998).

At its simplest, care has a dual set of associations and meanings: it refers to both a disposition to be concerned, and also to the actual practices that follow from these concerns (Tronto 1993). There is a tendency in discussions of care to emphasise one of these dimensions over the other – to focus upon the emotional and intellectual capacities to be moved to care about other people or particular needs, or to focus on the actual work that goes into caring, and underplay the motivations that they are a response to in the first place. Fisher and Tronto (1990) argue that one can break caring down into four phases, each of which is associated with distinctive moral qualities and motivations:

> 1. Caring About: This involves becoming aware and paying attention to the needs of others. The key moral quality here is attentiveness, being able to acknowledge the needs in others as well as in oneself.
>
> 2. Caring For: This involves actually taking responsibility for meeting a need. This might involve organising, mobilising resources, paying for work, and so on. The key moral quality here is that assuming responsibility.
>
> 3. Caregiving: This refers to the actual practices of meeting needs. It requires the effective performance of various tasks. The key moral quality here, then, is competence. This is important, given that a great deal of caregiving is undertaken in institutionalised and professionalised contexts – by nurses, doctors, teachers, policemen, social workers and so on. It is important, then, not to assume that questions of professionalism, competence, and technical capability are somehow foreign to the values associated with care.
>
> 4. Care Receiving: This refers to the response of the person, thing, or group that receives caregiving. This requires moral quality of responsiveness. Responsiveness is not only about those who have received care, it also requires the attention of those doing caring work and those who have assumed responsibility. This, then, is the phase at which the process of caring generates further needs for care, further calls for attentiveness, and further demands to assume responsibility.

This might seem like a linear sequence, but as should be clear from the forth 'phase' in this list, there is in fact a constant interaction between each of these elements, so that care is better thought of as a negotiated process. It is important to keep in mind that integrating each of these aspects of care into any specific practice of caring is always likely to be a highly complex achievement. Above all, that there are likely to be all sorts

of moments of conflict embedded in this process of integration. Caring involves all sorts of practices - listening, feeding, giving advice, administering medicine – and it is hard work for all those involved, work which is both physical and emotional in character. The integration of these four phases implies the integration of different sorts of actors – family members, friends, professionals, and so on – and the integration of a series of different spaces of social life – the home, certainly, but also the routines of paid work, and the geographies of modern living spaces, with their characteristic separation of home, work, school, and so on.

   This four-phase model suggests that care is intimately related to questions of power. The relative power of a group is manifest in its ability to have other people to provide its own caregiving work. In turn, while some groups benefit from the care of others, it is also common for them to devalue care in general. The key to this devaluation of care, Tronto argues, is an unwillingness to acknowledge one's own vulnerability. This commonly leads to particular groups being defined as particularly vulnerable – young children, or the elderly - and therefore as particularly in need of being cared for. This maintains the sense that 'normal' adults are free from the needs and vulnerabilities that call for care – that they are fully independent, so that care becomes associated with dependence. Tronto argues, in contrast, that care, and the issues of vulnerability and need that it raises, affect everyone – the ability to act autonomously depends on the carework of other people, in both personal spaces of intimate family relations as well as more public spaces such as schools or hospitals. Care, then, is not merely a private matter, and nor is it only concerned with 'moral' dispositions to be nice to other people. It is, rather, a fully public issues of political significance, not least because our understandings of what counts as a public issue or a political issue is defined in part by understandings of how caring should be distributed.

   Tronto (1998) distinguishes between three possible relationships of care. Care can occur among equals, between friends for example. Or care can be provided by one set of people for others who could, in principle, provide this care for themselves. Thirdly, some care is based on asymmetries of competence that are quite fundamental to the need and provision of care concerned, because the caregiver has some ability, knowledge, or resource the care receiver does not. The most obvious example is the sorts of care that young children require. These are relationships of dependence, where the vulnerability to which care is a response is clear. In practice, of course, these three types of relationships are likely to be mixed up. So, for example, the needs arising out of the dependency of children on adults for care (the third sort of relationship above) can be distributed between parents and friends (a version of the first kind of relationship where care is provided amongst equals), but it also is likely to involve schoolteachers, doctors and various experts (that is, relationships of the second kind, where care is delegated), and in some cases, this can involve significant inequalities. In such cases, wealthy or privileged groups are able to take advantage of socio-economic inequalities to displace caregiving onto poor or disadvantaged groups.

'Carescapes'
The topic of care has become an increasingly important focus of research in human geography. This is particularly the case in areas of the discipline where care has always been an implicit concern, for example, in medical geography, or in geographies of

housing, or in more broadly in areas of research interested in changing patterns of welfare provision. In these sorts of fields, the set of relationships between caring about, caring for, caregiving, and care receiving are centrally important to understanding the history and contemporary transformation of, for example, mental health care provision, or changing patterns of housing tenure and housing need, or changing policies towards welfare entitlements of children, the unemployed, or the elderly.

In order to understand the ways in which relations of care are related to questions of time and space, McKie et al (2002) develop the notion of carescapes. If care involves the coordination of a complex variety of tasks undertaken by a range of different individual and collective actors, then the idea of carescapes adds to this an appreciation that care therefore involves the coordination of the different spaces and different times in and across which these tasks and actors are distributed. Taking the example of childcare as their example, these researchers point out that childcare in Western societies involves the combination of the spaces of the family home (where lots of informal and unpaid caring for children, especially young children, takes place), with the public spaces of paid work, schools, hospitals and nurseries. People therefore develop distinctive carescapes in order to combine these different spatial and temporal patterns, and this involves a complex negotiation and renegotiation of the schedules of everyday routines such as going to work, doing the shopping, picking kids up from school, and so on. The development of particular carescapes is neither just a simple matter of connecting the private sphere of the home to the public sphere of the workplace however, and nor is it just a matter of isolated parents juggling their responsibilities to their own children. Rather, the sequencing and coordination of work and care tasks takes place in a variety of spaces and often involves a range of actors, including "childminders, friend's homes, school, local shops, parks, doctors, regional shopping centres, leisure centres and so on" (McKie et al 2002, 912).

An important feature of the idea of carescapes is not just the emphasis on the geographies of caring, but on the connection between these routine everyday geographies and the complex times and temporalities of caring. They emphasise that the responsibilities of caring involve at least three different temporalities:

"the temporality of the human life course with its different and differing dependencies (childhood, pregnancy, illness, old age and interaction with family and friends); the temporality of paid work career paths (within the context of regional, national and global economies) and the temporality of the daily routines of the people and institutions with whom a person habitually interacts (education, welfare, health and training)" (McKie et al 2002, 905).

This emphasis on the longer-term temporality of the life course and of careers helps to underscore the complex task of developing and sustaining carescapes. This involves not only the establishment of everyday routines of coordination, but must also be able to adjust to various 'crisis' situations – sudden illness, cars which won't start, trips away from home – as well as shifts in the requirements of care as, for example, children grow up and move schools, or when parents lose jobs, change careers, split-up or divorce, and so on.

Summary

Care is far from a private matter, in either the sense that practices of care are contained only in spaces of the home and the family, or in the sense that they are not shaped by and impact upon public issues of employment, social policy, and welfare provision.

The ways in which care is organised is quite fundamental in shaping social understandings of what is a public issue, what is a private issue – that is, with defining the nature of needs and where the burdens for meeting them falls.

4). Care unbound

The Paradox of Care

The notion of carescapes pinpoints the importance of thinking through the different locations where care takes place. I want now to turn to the question of how the impulse or imperative to care is motivated – to the question of how caring about others arises in the first place. We have already seen that for Noddings, caring about was considered secondary and derivative of a more immediate, authentic form of caring for. It is dangerous and misleading to assume that authentic care is necessary partial – it is care for one's 'nearest and dearest' that is automatically expected and offered, and that it in turn is necessarily up-close-and-personal, based on relations of close proximity and familiarity. In turn, caring about would appear to be less authentic because it is assumed to be more passive, and in turn therefore implies a more distanced relationship. The implicit assumption in Noddings' distinction is that as care is extended to more people over greater distance, the degree of authenticity and involvement is steadily diluted.

The simplistic distinction between 'authentic' care and more diluted forms of care, and why the assumed association of these two with relations of proximity and of distance respectively, is problematic because it leads us to ignore the problems of coordination that the idea of carescapes highlights. It also that it makes it very difficult to think about the forms of care that might be expected to people one does not know or who might be a long way away as anything but pale imitations of proper forms of care. If one opposes caring for to caring about, then authentic care is assumed to be really about one's relations with people one is personally involved with in a quite intense fashion. This leaves the question of how to respond to the needs of strangers or to people who live somewhere else a difficult one to conceptualise.

The emphasis on the partiality of care is an important reminder that one cannot, in practice, actually care equally for everyone, not because of some moral deficit, but rather because care is the sort of value that is precisely tied to the value of partiality. There is a paradox at the heart of the value we ascribe to care – the moral concerns that motivate love or caring derive their value from very partial and personal situations, and yet these concerns also inform a felt sense of responsibility to people we do not know or have not met who are in need, but by definition, care is the sort of value that cannot simply be aggregated and extended to just anyone – its value lies in it being wrapped up in relations of recognition and attentiveness.

Some philosophers make a distinction between two kinds of caring: intimate caring, based on personal relations with people one knows very well, and humanitarian caring, extended towards others one only knows about. But this still seems to suggest that the model of care is naturally given in some way. The problem is whether it is possible to

maintain the sense of intense partiality and attentiveness that underwrites the value of care (as distinct, say from justice, whose value lies in impartiality), while combining it with an extension over larger areas of social and geographical space.

But the four-phase model of care suggests that caring for is never simply immediately forthcoming, that it always requires some form of attentiveness to the needs of others. Caring for and caring about are not necessarily opposed in the way often implied. Rather than assuming that caring for is an almost a natural disposition against which other forms of care should be judged, thinking about care as a combination of attentiveness, responsibility, acting, and responsiveness suggests that no form of care is just spontaneously given without first of all being called for. By putting caring about before caring for in the four-phase model, we see that an important element of the value of care is that it is a response of being called upon to care about, that it requires that a carer is attentive to the needs of other people. Without this element of attentiveness and responsiveness on the part of the carer, the value of care as a relationship would be undermined.

Once we have identified this fundamental aspect of care – that it is something that is called forward by the expression of needs by others – then we can begin to reassess the imaginary geographies that underlie the problem of caring for distant others. David Smith (2000, 97-106), the geographer who has written most widely about this problem, argues that extending the scope of care in a humanitarian fashion requires more than the forms of partiality that both feminist theorists of care and communitarian theorists value, which remain embedded in the personal sentiments that motivate care for one's nearest and dearest. This model maintains a sense that one needs to find some principle of identity or similarity before one can extend care. Geographers have argued that responsibilities to care at a distance in fact arise from other sources. For example, the complexity of causal relationships that connect people living in different places through market transactions, supply chains, displaced pollution effects, and the like, means that we are in fact bound up with and implicated in the lives of all sorts of people living in all sorts of different places. So, just as 'intimate care' is based on relations of mutuality and dependence, this would support the argument that we are morally obliged to care for distant others with whom we are likewise connected in relations of mutuality and dependence. If this sounds a little too intellectual – it makes it appears to suggest that one could calculate the extent and number of one's caring obligations by tracking all the lines of connection that intersect in one's everyday life – it is worth noting that campaign organisations and charities who have been successful in mobilising care at a distance through sophisticated media and marketing campaigns do so not by making epistemological arguments about causal connections, and more through mobilising the same range of sentiments – laughter, pity, shame, respect, and so on - that underwrite the attentiveness and responsiveness of 'intimate care' (Silk 1998).

Care Structures
So, we seem to have got to the point where we can see that any simple distinction between intimate care exercised in relations of spatial proximity and humanitarian care exercised in relations of distance, which tends to elevate the former over the latter as the more authentic model of care, needs to be unpicked. All forms of care are mediated in various ways, and stretched out over various spaces and times. Intimate care can be and is

exercised over long distances – through mobile phone calls between children and parents, mobile phone calls or emails between friends, the exchange of gifts between lovers, the sending of remittances from one family member who has migrated to those still living at home. The preceding discussion about the carescapes of childcare should already have alerted us to the fact that even this most personal and intimate form of care involves both face-to-face contact but also various forms of action mediated by other actors and institutions. So, while some forms of care provide that the carer and the cared-for be in physical proximity to one another, then it also quite normal that care can be provided at a distance in various ways:

"While much childcare requires face-to-face interactions and bodily contact, some parents are using mobile phones as a means of 'staying in touch' with and monitoring older children while spending longer at work, which much media alarm is voiced over the use of the TV as a babysitter. Car travel allows us to move children quickly from one context to another, to be close in time if not in miles" (McKie 2002, 911).

This reminds us that the experience and understanding of what counts as care and how well it is provided are shaped by and transformed both the social and technological organisation of relations of caring. The notion of carescapes is valuable is because it moves us away from thinking about particular spaces as uniquely spaces of care in contrast to others, and instead points out that care is always distributed across different times and spaces.

It is also worth remembering that we learn about how and what to care for in all sorts of mediated ways – it is difficult to imagine the experience of falling in (and out of) love without realising that while being a deeply personal one, it is also 'modular' in the sense that the rituals and practices that go to make up this type of experience are learnt and re-learnt and transformed by reading stories in books, watching soaps on television, listening to pop music on the radio, and by talking about all of these things and one's own life to other people. Caring for others is neither as immediate nor as direct as a simple distinction between caring for and caring about would seem to imply. Care requires an interactive context of deliberation in which people can decide what the appropriate response to expressions of needs should be, who is responsible, what sort of action should be taken and so on.

The implication of this argument is that the scope, content and form of our concern for others is shaped in important ways by cultural infrastructures, which work up and maintain even the most personal and intimate dispositions to care for others. There is no reason in principle that intense feelings of commonality or responsibility with others should be contained at the national scale. What is notable, for example, about the sorts of international humanitarian media events that have been developed in the past three or four decades is how they seem to be re-scaling feelings of care at a global level, leading perhaps to forms of 'global feeling'. Now, it is tempting to suppose that televisually mediated care is actually not really all that we would want genuine care to be – it can easily seem to conform to Noddings model of indifferent caring about. But this interpretation assumes that television is a medium that is impersonal and indifferent. The media theorist and historian Paddy Scannell (1995) argues quite the opposite. He argues that radio and television have a characteristic 'care-structure' which accounts for their ethical significance. Care refers, rather, to the very conditions of being concerned at all about he world around us:

"That things matter for us (no matter what), the ways in which they matter and the extent to which they do so, mark out the boundaries of our concerns. Concern is all such things as noticing, remarking upon, attending to, observing, picking out, foregrounding and bringing to bear a focused attentiveness upon phenomena (upon each other and our selves and circumstances) in such ways as to find and make the matter to hand significant and meaningful in some way or other." (Scannell 1995, 144).

The care-structures of modern mass media vastly expand the range of matters that one can be concerned about and care for, but also, and more importantly, they transform this range of publicly available material into the sorts of things that people feel involved with and competent to talk about and pass judgement over: "not just weighty matters as they appear in news, current affairs and social concern documentaries" but also "the goings on in soaps", and "fun things and odd things, and sporting 'moments' and last night's movie and a great deal else besides" (ibid., 163).

The range of public matters is thus extended, but in so doing, the way in which these matters are considered things to be concerned about and care for is also transformed, so that ordinary norms of sincerity, sociability, and authenticity become the terms through which matters of public importance are evaluated.

Summary

The scope and the practices of care are historically variable – they depend on policies, technologies, and above all, on the complexities of social relations and cultural meanings. There are different social and technological modalities of care, through which people learn how to be attentive and sensitive, how to listen, how to respond appropriately, and how to act in response to need – whether this means bearing witness to someone's suffering, giving them some form of material comfort, donating to an intermediary care organisation, or trying to do one's own caring work – paid or unpaid – more competently.

5). Conclusion: Who Cares?

Thinking about care geographically can be helped by decomposing care into four sets of activities: being attentive, being responsible, being competent, and being responsive. These four activities raise a range of analytical questions:

1. Attentiveness. What care is necessary? Are there basic human needs? What types of care now exist; how adequate are they? Who gets to articulate the nature of needs and to say what and how which problems should be cared about?

2. Responsibility. Who should be responsible for meeting the needs for care that do exist? How can and should such responsibility be fixed? Why?

3. Competence. Who actually are the caregivers? How well do they do their work? What conflicts exist between them and care receivers? What resources do caregivers need in order to care competently? Who pays attention to changes in care receivers' needs?

4. Responsiveness. How do care receivers respond to the care that they are given? How well does the care process, as it exists, meet their needs? If needs conflict with

one another, who resolves these conflicts?

Actual practices of care involves the complex integration of all four of these activities, and this in turn involves the co-ordination of activities over various spaces and diverse temporalities – leading to the development of distinctive 'carescapes'. The importance of Gilligan's work is that the activities of care – "being there, listening, the willingness to help, and the ability to understand" – all of which reflect injunctions "to pay attention and not to turn away from need", are all shaped by social practices that are crossed by power relationships (Gilligan 1986, 249). This implies that issues of care are not only matters of ethics and morality, but also about big public issues of deciding on what matters, what to care about, and distribution of burdens and benefits of care.

Further Reading

The best introduction to the ways in which issues of justice, care, and ethics are relevant to geography, and to the ways in which a geographical perspective makes a difference to how these things are thought about in the first place, is David M. Smith's Moral Geographies: Ethics in a World of Difference, Edinburgh University Press, 2000. The best introduction to the topic of care in moral philosophy and political theory is Joan Tronto's Moral Boundaries, Routledge, 1993.

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