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### Caring

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## CARING

*Annemarie Mol and Anita Hardon*

### **A fluid concept for adaptable engagements**

The English word *care* is both a verb – *to care* – and a noun – *care*. The latter tends to be used for social domains, say, *parental care*, *elderly care*, or *health care*. In this chapter, we tell quite a few stories that emerge from the domain of health care, but it is not our aim to describe that domain. Instead, we use what we have learned there to topicalize a particular *genre of activity*. This is why *caring*, the gerund form of the verb, features in our title. *Caring* is an activity, not a terrain. However, a further complication arises, as the verb *to care* draws together the emotional engagement of being concerned and the practical engagement of contributing to restoring, sustaining, or improving something. Our interest is with the latter. But even when practical, the activity of *caring* is not neutral: it is meant to culminate in something that counts locally as “good.” However, what *is* “good” in a particular setting, not just in the opinion of the *carer* but also from the perspective of the other people, creatures, and environments involved is not always obvious and only rarely unequivocal. Learning about and calibrating between diverse local “goods” is part of the activity of caring. And then, crucially, that people *try* to care does not mean that they succeed. Rather than providing control, caring efforts are explorative and adaptive. *Carers* respond to surprises and expect them to occur.

This, at least, is where we stand at present with regards to this word. In what follows, we will provide a sketch of how we got here. The genealogy we outline is meant to offer inspiration to scholars who, when researching practices, institutions, assemblages, or situations, wonder whether the term *caring* might serve their analyses. In the empirical settings in which you work, reader, the term *caring* may be current, used by some of those involved, or altogether absent. Whatever the situation may be, in mobilizing the term *caring* as an analytical tool, you are invited to enrich it, and to push and pull it in different directions. That is the idea. We are

curious where, from here on, our fluid concept of *caring* will move – shifting earlier insights and transforming itself along the way.

## Household words

Traditionally, *caring* has not garnered a lot of attention in academia. In the rivaling theoretical schemes that dominated the social sciences in the 1960s and 1970s, daily caring activities were deemed to be of secondary importance. For example, in Marxist social theory, the feeding, sleeping, and so on, with which people sustained themselves and each other, were subsumed under the category of *reproduction*. They required doing, but only the means of *production* were deserving of scrutiny, as only these were considered to shape social relations and to underly social conflicts. The injustices Marxists sought to combat were presumed to emerge from the fact that the ruling classes own of the means of production while workers have to sell their labor on the market. Liberal political theories, in their turn, situated daily caring activities in the *private* sphere, far removed from the *public* realm where political concerns were supposed to be democratically debated and resolved. Liberals wanted to stay clear of everybody's private life and only collectively discuss issues to do with politics.

In both cases, feminists shook up these distinctions and called for paying attention to what had too easily been discarded as irrelevant in the grand scheme of things. In relation to Marxism, they argued that the labor workers sell to the owners of the means of production is not the only hard work being done. The activities slotted under the term *reproduction* deserve to be recognized as “labor” in their own right: as *domestic labor* (Weeks 2011). Moreover, it was to be recognized as a separate, second injustice that women, not men, do most of this work, either in underpaid jobs or for no pay at all. This, after all, makes them either financially dependent upon their salaried husbands or forced to work a double shift (Hochschild 2012). In response to liberal political theories, feminists argued that the private sphere is not simply a cozy refuge from the political disputes that mark the public sphere. Instead, what happens in the private sphere, however personal, is political, too. For one, via taxes, housing conditions, childcare provisions (or a lack thereof), and so on, states influence how private lives are shaped. Second, relations in the private sphere are not just loving but also full of antagonisms – around loyalty, money, lifestyle. They have a politics of their own that includes disputes and may edge into physical violence (Honig 1994). (See also the chapter on *making home* in this volume).

At the same time, the feminist blurring of the distinction between domestic life and the organization of society was made to work the other way around. In this context, the proposition was that politics does not necessarily have to be shaped as a matter of clashing interests, handled in the form of disputes. Instead, the state could take inspiration from the ways in which, in private settings, people relate to others in caring mode (Tronto 2013).<sup>1</sup> This work took inspiration from care ethics, a feminist alternative to rule ethics. Rule ethics proclaims that what is *good to do* in specific cases can be deduced from general principles. There are however many

such principles and they do not always align. For example, the principle of the dignity of human life stipulates that one should save another person's life if at all possible, while the principle of ownership states that stealing is bad. Developmental psychologists told children a story about a man who could only save the life of his wife by stealing medicine. The idea was that their maturity would be revealed by their ability to play the two principles off against each other. However, some children, especially girls, proposed that perhaps the man could *talk* with the pharmacist about his wife's situation. This is the origin story of care ethics. It does not operate through weighing the relative value of general principles but by negotiating specific, situated concerns. Rather than argumentative, it is *caring* (Gilligan 1977; Tronto 2013).

In the earlier debates mentioned here, the term "care" was not particularly prominent, but that does not make these debates less relevant to our present concerns. In care ethics, in its turn, the term "care" implies something positive and that risks hiding crucial questions about what exactly counts as good. All in all, then, genealogical connectivity is not simply a matter of continuous *words*. There may be connections while terms shift and disconnections may hide behind a stable terminology. Similarities and differences to do with words are also relevant when translations are being made between so-called *languages* and the theoretical traditions expressed in those languages. It is, for instance, remarkable that English-language scholarly work on *care* shows significant traces of German discussions of *Sorge*. When, early in the twentieth century, Heidegger wrote about *Sorge* he was not at all concerned with *domestic labor* or other activities (disproportionally taken on board by women) that in English are marked as *caring for*. Instead, his concern was with being, that is to say with being a human, not seen from the outside, but experienced from within. Wrapped in *Sorge*, "the human" formed the center of his [sic] own concerns, worry, and distress. This resembles (at least to some extent) the English *caring about*.<sup>2</sup> Heidegger deplored that *Sorge* was under threat from modern technology, which in his eyes objectified people and instrumentalized their activities. A romantic longing for *Sorge* has lingered in academia for a long time: Heidegger was by no means the only scholar to express it. It also resonates in, for instance, Habermas's work, when he voices a concern that in modern societies the *system*, with its rules and regulations, squeezes the *life world*, and erodes its possibilities for person-to-person love and kindness (Habermas 2015[1981]).<sup>3</sup> (See also Chapter on *making home*).

The German *Sorge* has been employed in various ways to express an opposition between alienating and oppressive modern technologies and truly human, dedicated care. This is different for the Dutch term *zorgen*. While *zorgen* may sound like *Sorge*, it has a quite different theoretical genealogy in the social sciences. One of the relevant steps in its trajectory occurred when, in the late 1950s, the sociologist Hilda Verwey-Jonker proposed a Dutch translation for the English term *welfare state*. At the time, there was a widely shared conviction that in welfare states, the punitive *fatherly* role of the state was gradually complemented by supportive *motherly* arrangements. In this context, Verwey-Jonker suggested the term

*verzorgingsstaat* – caring state. The term caught on and was widely used in discussions about the *caring state's* pros and cons. Those who applauded social security payments emphasized that social life should not be competitive; rather all citizens deserved to share in the collectively earned new wealth. Opponents, by contrast, argued that the *caring state* unduly pampered people. Various understandings of what fathers and mothers are and should be lingered in the background of never-ending discussions about the problems of the *caring state*.<sup>4</sup>

A further relevant development in the genealogy of *zorgen* happened a little over two decades later when another Dutch sociologist, Abram de Swaan, published a collection of essays, *De mens is de mens een zorg*, a title that might clunkily be translated as: *The Human is Another Human's Object of Care* (De Swaan 1982). At a time when many sociologists investigated the economic aspects of human affairs, De Swaan, inspired by Elias, insisted that human life unfolds thanks to practical interdependence among members of a society (Elias 1978). For our collective survival, De Swaan argued, we all depend upon each other's *zorg* – care. In a household, the bread-winning husband “takes care” of his wife and children, while the housewife “takes care” of everyone's eating, drinking, clothing, cleaning, and what not. (This was the Netherlands. In the late 1970s to early 1980s, the percentage of married women working for a salary was, also comparatively, strikingly low.) But *zorgen* does not just occur within families, the whole of society is constituted by it. Teachers care for the intellectual and moral growth of their pupils. Bakers care for those who eat their bread, and when customers hand over money, this is their way of caring for the bakers. Even the police are caring – police officers, after all, protect people against each other's violent streaks and foster safety in public spaces. While calling such activities *work* foregrounds the efforts invested and questions of financial return, calling them *care* foregrounds interpersonal relations and mutual dependence.

The different approaches related above all inform what, today, might be understood as *caring*. They do not, however, coalesce neatly. Instead, they are in tension with each other. Marxist *reproduction* – even if it includes *domestic labor* – is quite different from the liberal *private sphere* – even if it is recognized that this is shot through with antagonism as well as love. The German *Sorge* – an allegedly “human” way of being – has little to do with the Dutch *zorgen* – which is not in conflict with technology, but instead makes use of it and reaches out to it. Smoothing out these frictions and tying all the loose ends together into a thick, intricate version of “caring” is not our aim. Instead, we want to acknowledge our ancestors and point out how these diverse trends loom, as sources of inspiration or as caveats, in the background of the investigations that we, together with a wide array of colleagues, conducted in the field of *health care*. There, we learned a great deal about the activity of *caring* that, give or take a few differences, is bound to be relevant to other sites. We hope to illustrate this in the sections that follow, in which each presents a lesson collectively learned. To facilitate writing up these lessons, most of our examples come from research in which we have been closely involved. Hence, what follows is a situated *herstory*, a trail, not an overview. We do not cover all possible variations

of *caring*; other stories might be told. Our open-ended list is not meant to be conclusive, but inspiring.

## Caring and working

Paradoxically, even in the societal domain of *health care*, for quite some time, *care* was not considered particularly important. Instead, pride of place was accorded to *cure*. Healing interventions were at the center of attention in medical research and hospital practices. The term *care* was mostly used for activities meant to provide people with basic sustenance (such as feeding and washing), as well as to the palliative care (such as heavy pain killers) provided to patients for whom there were no longer any life-saving treatments available. The *care/cure* distinction hid the fact that so-called *curing* interventions, from surgical cuts through to pharmaceutical pills and injections, do not work alone. They may be singled out as crucial, but in practice they depend upon a multitude of co-occurring activities, all too easily discarded as “merely care.” Social scientists who studied health care practices sought to foreground the relevance of the activities locally glossed as *caring* and to demonstrate that these were crucial to the potential for *curing*. In this way, the distinction between curing and caring activities gradually blurred. What counts as a “health care intervention” consequently expanded from a singularly physical cut or drug to an extensive social and material arrangement and engagement (Corbin and Strauss 1988; Herzlich and Pierret 1984).

Take contraceptive pills as an example. Clinical trials had shown that these *worked* for women who wanted to avoid pregnancy, while still having penetrative heterosexual encounters. Social scientists pointed out that it is not simply the pills by themselves that work. Yes, the hormones that these tablets contain are relevant, but their efficiency is not in the hormones alone. For a start, the women concerned have to do the swallowing – and not just once, but every day, preferably at more or less the same time. Doing this is not as easy as trials to study the pill’s effectiveness made it seem. For it depends on such things as a daily schedule of some regularity and the possibility for the woman in question to safely store her pills or to carry them with her. This makes things difficult for women who live in small spaces they share with many others, and even more so for women whose mothers-in-law, hoping for more grandchildren, observe all their doings from close by. Difficulties also arise for women who only engage in heterosexual activities irregularly and do not see the point of continuously ingesting “unnatural” hormones. Hence, the *working* of the pill depends on a lot of *work* – that is, on the efforts of the woman taking it and on the support, or opposition, she has from her surroundings (Both 2015; Hardon et al. 2019; Hardon 1997).

Something similar is the case for antiretroviral drugs. Medical research found that these were effective in keeping the human immunodeficiency virus (HIV) in check in the bodies of infected persons. But when these drugs were offered to HIV patients in the Busoga region of Uganda, many of them did not benefit as much as expected. So, what was going on? To answer this question, anthropologists spent

time with the HIV patients concerned and spoke with them enough to gain a sense of what was relevant in their lives. Thus, it became apparent that the patients were not just offered a pill that kept the HIV virus in check. They were also tasked with following a particular *care scenario* and it was impossible for most of them to fit this scenario into their lives. Patients were supposed to come to the hospital to pick up their drugs once a month. Waiting times meant that this took hours and many of them could not afford to lose a day's work. They often lived far away and were too poor to afford the necessary bus fare to travel to the hospital. Hence, the drug failed because the care scenario was inappropriate. In Busoga, at least, and only after some time, the proposal that it was not pills that do or do not work, but the wider practice of which they are a part, was accepted. And indeed, when patients were provided with enough medication to last them three months and their bus fares were reimbursed, health outcomes improved (Hardon et al. 2007; Hardon and Dilger 2011).

Interestingly, the scholarly research that studies like these are most closely entangled with does not even contain terms like *care* or *caring*. Instead, it reports on *technology transfer*. When researchers in the budding field of science and technology studies followed technologies like cars or water pumps, they also concluded that the *working* of these “things” is not contained within them. The efficiency of a piece of technology, they proposed, is instead spread out across a network (Akrich 1992). Take, for example, the cars that marathon runners won and then took to their small villages in Northern Kenya where at the time there were hardly any roads. Once these cars were rolled off from the truck that carried them, they might still function as an icon of success or as a classy tool to carry the dead to their graves. But in order for a car to work as a mode of transport, a lot has to be in place – roads, a supply of gasoline, money to pay for that gasoline, driving skills, mechanics able to maintain a car, spare parts, and so on. In the absence of a sustaining network, cars fail. Or take the water pumps designed to be pumped by large, muscular men, many of which were scattered throughout rural areas across the global South and then left to rust. They simply did not *work* in villages where fetching water was a chore for children and young women who were too small to handle them (Rathgeber 1996).

But if work on *technology transfer* inspired research into practices to do with *caring*, the inspiration also traveled in the other way direction. Hence, the *term* “caring” came to circulate beyond health care and entered settings where it had not previously been readily used. Take the solid-looking *Zimbabwe Bush Pump type B*. This water pump was designed attentively, carefully, one might say, to provide villagers in rural Zimbabwe with clean water. It was not particularly heavy and, what is more, painted a in beautiful blue, looked attractive. But, like any piece of technology, it only worked if it was provided with care. Why not call it *care*? In order for the pump to provide clean water, people in the village had to avoid contaminating its source with excrement. They had to install the pump with a concrete slab surrounding it and to maintain a certain distance between the pump and their latrines. They also had to use their own muscular power to pump. If a bolt came loose, they had to tighten it. If the bolt somehow disappeared, villagers might insert a wooden stick in its place. In one way or another, this pump, however shiny, only worked if its

particular needs were met by its users – who would only consider doing so if, once working, the pump would meet some of their needs (De Laet and Mol 2000).

Previously, we saw that in contexts where the term *care* inherits the baggage of *Sorge*, technology and care are in opposition to each other. However, in the examples just presented, be they about pills or pumps, technological tools and caring activities intertwine. Jointly, they make it possible to reach local goals such as not getting pregnant, not dying from HIV, and accessing clean water. In these contexts, discarding all modern technologies to make space for *Sorge* sounds not just romantic, but frivolous (Pols 2012). The *caring* at stake resonates instead with the pragmatically oriented Dutch *zorgen*. And while anthropological studies of medical interventions revealed that pills, if they work, only work thanks to well attuned broader care arrangements, the case of the bush pump illustrated that technological tools themselves require care.

### Who cares for whom?

As caring is performed across networks, it is not always easy to say *who* or *what* does the caring and *who* or *what* is being cared for. Take contraception once again. When a woman is on the pill, *who/what* is doing the caring: the doctor prescribing it, the pill itself, the cleverly designed strip that specifies the days of the month to take it, the bathroom cabinet or the purse that holds it, or the user who remembers to take it? That the action is spread out means that the effectiveness of the network does not depend upon the size of any of its nodes. Take the situation of people with atherosclerosis in their leg vessels. A sizeable team equipped with a good operation theater and a lot of surgical tools may open up their stenosis so that the affected leg no longer hurts when the patients walk. This scenario requires some activity by the patients: they have to go to the doctor, articulate their complaints, submit to all kinds of tests, entrust themselves to the operation team, and do their very best to recover. Despite all this activity, the success of the intervention is only granted to the surgical team. This is different with walking therapy. When people whose legs hurt due to atherosclerosis walk a lot, faithfully, twice a day, for months on end, their complaints significantly diminish. As it is not easy to sustain such an effort, most people only do so when they get proper support from a professional. Interestingly, one of the social techniques the professionals deploy to encourage patients is to hide their own efforts. In this case, then, the patient gets all the credit: “Wonderful, you have less pain! You can be proud of that. Nobody did this for you. *You* have done it, all by yourself” (Mol 2002b).

If it is not always straightforward who is the *subject* of care, neither is it necessarily clear who is its *object*. In the Philippines, if mothers care for their children who are coughing, they care, at the same time, for their husbands. They provide their children with cough syrup because their husbands feel embarrassed when their child coughs a lot. The husbands are concerned that others will assume their child’s coughing is a symptom of tuberculosis, which is locally stigmatized as a disease of poverty. They are men: they do not want to appear too poor to see to the needs of



their families (Whyte, van der Geest, and Hardon 2002). We could, if we wanted, draw upon cases like this to interfere with the divide between *structure* and *agency*. Again and again, social scientists have asked whether what people *do* should be understood as resulting from structures that determine it, or as rooted in their own agency. However, in the practices of care alluded to here, action is shared. It is spread out across all those involved in a network or, if you prefer that term, assemblage (see chapter on *assemblage*). Like subjects and objects of care, everyone and everything involved in a network or an assemblage may compel, facilitate, limit, and hinder all other parties to it. They may also labor, suffer, profit, enjoy, or engage in some of these activities, in different combinations, at the same time. In the process, they help to give shape and substance to each other (Akrich and Pasveer 2000; Moser 2005).

This makes it sometimes difficult, or even outright impossible, to clearly distinguish subjects and objects of care from each other. Take a caring practice far beyond the confines of health care – bicycle riding. In a city like Amsterdam, there are so many cyclists that avoiding accidents depends upon their continuously and attentively caring for themselves, their bicycles, and everyone and everything else around. Experienced bicycle riders do this almost by stealth. They yield to cyclists coming from the right, avoid potholes, brake when children appear out of nowhere, and slow down when they approach a crossing. They look other cyclists in the eye when approaching them and coordinate their movements. Less adept riders, such as tourists on rental bikes, have less mastery of these caring techniques, which leads to irritation among the locals and unfortunate accidents, as well. Friction is likewise introduced when electric bikes, moving at higher speeds than traditional ones, make it harder to anticipate imminent choreographies. Hence, bicycle riding depends on the propensities of technological tools, from roads and traffic lights through to bicycles, pedals, brakes, and electrical motors. Equally relevant are the particulars of riders, including their skills or lack thereof. Unless all the elements adapt to all the others, caringly, across their potential tensions, accidents occur (Kuipers 2012).

## Tinkering

The Heideggerian investment in *Sorge* was informed by a generalized suspicion of all things modern. Technologies were prominent among modern things but so, too, were techniques. Relating to other people in a trained, professional way, informed by scholarly knowledge, was considered an anathema to “true care,” which was supposed to be authentic and heartfelt. Like love, care could neither be learned nor developed. This suspicion of training may help to explain why Heideggerian *Sorge* was never particularly welcomed in health care (Pols and Moser 2009). There, after all, *caring* for other people, in their role of *patients*, was shaped as a professional endeavor. Acquiring the relevant skills depended upon serious training. Take the task of washing a patient who is bedridden. It is obviously germane to go about this task in a kind way, but kindness is not enough to get it done thoroughly, soothingly, and without hurting the patient. Proper and helpful washing depends on professional *techniques* for washing (Pols 2006; Moser 2010). Engaging

in a conversation, likewise, can be done with greater or less trained savviness. It helps to nod while another person talks and repeating her words may also signal listening. That such conversational techniques can be acquired does not make using them any less caring – or even less kind. Social science research into conversations between professionals and patients shows that astute use of appropriate conversational techniques makes exchanges of information more efficient while, at the same time, providing more space for patients' emotional responses (Bensing 1991; Heritage and Maynard 2006).<sup>5</sup>

Once again, the theoretical lessons point in two directions. For attentive analysis of health care practices not only suggests that *caring* may involve the use of techniques but also that conventional understandings of *techniques* deserved to be amended in the light of lessons learned from caring. Thus far, we have alluded to one element of this: practices in health care undermined the Heideggerian contrast between *Sorge*, as an authentic and affective way of being in the world, and *techne*, the attempt to acquire an instrumental grasp on the world with the aid of technologies and/or techniques. Now, we take a further step. For there were also different versions of what “acquiring a grasp” – pursuing a *techne* – might entail. A particularly influential contrast was proposed in the early 1960s by the anthropologist Lévi-Strauss (1962). Primitive people, or so Lévi-Strauss contended, try to accomplish things by tinkering, by *bricolage*. They use materials that are available in their surroundings and put these to work as tools in creative, open, and iterative ways. There is no straight line that leads from where they are to what they hope to achieve. Even their goals may transform along the way. Modern technologies, by contrast, are designed to be linear and progress from A to B. They are a means to an end. To allow for such linear progression, the network upon which technological tools depend has to remain invariable. Remember the example of the car: it only works as a transportation device, if it is part of a network that includes such things as level roads, gasoline, and people who know how to drive.

Health care appeared to include not only a plurality of similarly linear techniques but also others, which were far less rigid. Their use seemed to be marked by *bricolage*: it involved a lot of tinkering. Take the diagnosis of anemia. This may be done in a “modern” laboratory mode, by measuring the level of hemoglobin (Hb) in a person's blood. If the level of Hb is below a certain threshold, the person has anemia. The laboratory techniques upon which Hb measurement depends form a tight network, which includes a Hb measuring device (large or small, but in either case not useful when it is inaccurate), calibration fluids (to test if the device is still accurate, but quickly depleted and difficult to come by in resource-poor settings), clean needles to prick fingers without transmitting infections (relatively expensive and potentially scarce), and educated nurses or technicians (who may have more urgent tasks to accomplish). A demanding network like this may easily fall apart. So-called clinical diagnostic techniques allow for significantly more variation. When diagnosing anemia clinically, one may ask patients about their complaints. But if there is no time for that, or if doctor and patient have no shared language, it is not obligatory. Observation may be enough. Lower an eyelid or examine the

bedding of a patient's fingernails: if these give the impression of being too pale, the person has anemia. The threshold is not exact; clinical diagnosis is not straightforward. However, since, time and again, there are opportunities to adapt one's readings, it is fairly robust. The lesson for now is that health care, in which laboratory and clinical techniques are combined, straddles the bricolage/engineering divide and thus undermines its salience (Mol and Law 1994).

What is more, it is not only diagnosis that may be a matter of tinkering but treatment as well. Especially in the case of chronic diseases, where there is no endpoint, no *cure*, patient trajectories are rarely linear. Take as an example life with type 1 diabetes. Since the pancreases of people with this disease do not produce insulin, their cells cannot absorb the sugars that circulate in their blood – sugar needs insulin to move across cell walls. Once this was established in the 1920s, industrial production of insulin took off. People with type 1 diabetes who can afford it, or whose insurance pays for it, now survive thanks to the insulin that they inject into their bodies from the outside. If that sounds like simple *engineering*, in practice it involves a lot of *bricolage*. The quantities of carbohydrates one ingests increase one's blood sugar – but how fast? Engaging in exercise lowers one's blood sugar – but to what extent? Emotional turmoil also interferes in blood sugar levels – but in which direction? In practice, linearity is an illusion and the precise doses of insulin to inject, the amounts of foods to eat, the number of walks to go on, and so on, have to be adjusted, again and again, with respect to one another. As attaining previously set goals is all but impossible, the self-care of people with type 1 diabetes is a matter of persistent tinkering. The professionals tasked with providing support had better be attentive, versatile, and adaptive, too (Mol and Law 2004; Mol 2008).

What or who to blame for the fact that, in health care, modern technologies do not offer the control expected of them but instead require *bricolage*? Maybe the problem is with the bodies with chronic diseases, which harbor a great many, not quite predictable “variables.” But maybe it is with the unruly lives of the patients, who, quite like other people, acquire and lose jobs, partners, houses, and friends – and face other trials and tribulations. Or the technologies themselves are to blame, if only because every innovation again requires (often unexpected) adaptations. Take as an example the introduction of miniature blood sugar meters, which allowed patients to measure their own blood sugar levels. If previously measurements could only be performed in a laboratory and infrequently, now, or such was the idea, it would become easier for patients to maintain good glucose levels. However, with the opportunity to measure oneself, the target shifted. The cutoff points for normal and high glucose levels significantly lowered (Mol 2000). This illustrates that it is not just bodies and lives that come with surprises but technologies as well. This is likewise the case with non-health care technologies. These, too, are unruly, whimsical, and non-linear. And if in health care we call adaptive ways of working *caring*, perhaps this term is helpful in other domains, too. It might fit situations in which, while control is out of reach, aiming for improvement is nonetheless worthwhile. These are situations in which modern technologies require adaptable, iterative *bricolage*, and creative, non-linear *tinkering* (Latour 1996; Law 2002).<sup>6</sup>

## Juxtapositions

*Caring* blurs the divide between problem-solving styles that are *primitive* and *developed* as it may simultaneously involve high-brow technologies and adaptable tinkering. And then there is another, related divided, that *caring* straddles: that between *traditional* and *modern* resources. Take once again the conundrum of living with HIV (Hardon and Moyer 2014). Thanks to a set of high-tech pills, it has become possible to survive the virus's onslaughts. The pills, however, cause side effects, including skin rashes. In the early 2000s, anthropological inquiries into HIV care in a rural clinic in Uganda revealed that quite a few of the nurses administering care there had HIV themselves. This motivated them in their work and helped them better understand their patients. The nurses were concerned that the pills they took to keep their HIV in check affected their skin. This was a problem, both because the itching was irritating and because the rashes were visible and risked giving away their HIV-positive status. From their patients, the nurses learned about traditional healers in the area, who were treating *their* skin reactions with local herbs. The guidelines from the Uganda Ministry of Health stipulated that modern medicine should not be mixed with traditional healing. However, the nurses were curious. They tried the herbs and were pleasantly surprised that they indeed soothed the itching. Hence, caringly, in a tinkering mode, they shifted the guidelines to one side. Together with the traditional healers, they developed a cream containing the relevant herbs. This cream assuaged the troubles of all those involved and also helped the nurses keep their HIV status a secret: no longer did a visible skin disorder give them away (Kyakuwa and Hardon 2012; Hardon and Posel 2012).

Caring, then, is not about purity but about improving difficult situations. Nurses who care deftly combine globally used HIV inhibitors and locally crafted creams made from traditional herbs. The blurring of the boundaries between tradition and modernity also works the other way around. These days, traditional herbs are often packaged and marketed as if they were modern medicines (Hardon et al. 2008). An intriguing example of this is *Power Magic*, a popular neotraditional product in Indonesia, which emulates herbal leaves formerly used for penis enhancement. In *Power Magic*, the leaves are replaced by a wet tissue to which a concoction of chemicals has been added. Before having sex, men use this tissue to clean their genitals, which they hope will prevent infection and, at least as importantly, prolong their erections. An anesthetic has been added to the solution in which the tissues are soaked so as to have just that effect. The men who use *Power Magic* think that being a good partner means delaying ejaculation. The women with whom they have sex reported other preferences – more on that in what follows. For now, our point is this: *Power Magic* is an imbroglio. It pastes together traditional goals (long-lasting erections), new fears (of infection), modern drugs (anesthetics), and shiny, biomedical-looking packaging (Hardon and Idrus 2015).

Health care practices in the global North are eclectic as well. In pain treatment in the Netherlands, patients may receive both painkillers and acupuncture; they may be offered counseling as well as yoga (De Langen 2018). And it is not just tradition

and modernity that are mixed. Modern medicine itself is, despite rationalist dreams of coherence, an amalgam of different styles, approaches, understandings, and ways of doing things. Take the treatment for atherosclerosis in leg vessels mentioned previously. An operation opens up the clogged artery or grafts a bypass, so that blood can flow again and this increases blood pressure in the afflicted person's extremities. Walking therapy does not cause these changes – but it *does* alleviate the pain that patients feel when walking. Thus, these two treatments do not affect the same object, do not reach the same target. Nevertheless, they are juxtaposed in clinical settings (Mol 2002a). Or, in another example: advanced cancer treatments juxtapose operations that disrupt anatomical structures and remove a tumor from a person's body, with radiation therapy that kills tumor cells but leaves them in the body, with chemotherapy that kills cells in the process of dividing, with immunotherapy that works by fortifying a patient's own immunological defenses (Heldal 2010). Theoretical differences about what cancer "is" are pushed to one side and different approaches are combined in practice.

This brings to mind the contrast between the grand theories and pragmatic social science approaches at stake in the present volume. Health care practices are not hooked to principled ways of reasoning but orient themselves on the basis of "what works." This is something from which pragmatist social scientists might take inspiration. *Care ethics* is certainly marked by it: the book in which Tronto first outlined this alternative to rule ethics contains many examples taken from nursing (Tronto 1993). There is, however, a caveat. Pragmatism may indeed be a matter of putting principles on a back burner so as to combine insights and resources that "work." But what are the criteria for "working?" Take those patients with atherosclerosis in their leg vessels. If an operation "works" to improve the blood flow and to increase the blood pressure in a patient's ankle (relative to that in their arm), while walking therapy "works" to get people to walk without pain – then which of them "works" best? They work in different ways, help to achieve different goals, against different costs, for different people. Rather than one of them being effective and the other not, they have different effects. This is a problem for the kind of pragmatism that assumes that "working" equals attaining a goal that is obvious and goes without saying.<sup>7</sup> In practice, goals are rarely self-evident. It is a part of *caring* to figure out along the way what might be good to do and to attune to that. And if there are various "goods" at stake simultaneously, as usually there are, caring involves mediating between these. And if things change, if they go better or worse, new adaptations are needed, again and again (Lettinga and Mol 1999; Struhkamp, Mol, and Swierstra 2009).

### What counts as good locally

*Caring* may entail working toward what locally counts as good, but "what locally counts as good" is neither obvious, nor invariable. In the context of health care, this was, at one point, difficult to articulate. The stakes seemed clear: *life* had to be defended against *death* and *health* was preferable to *disease*. However, in final

decades of the twentieth century, questions about what is *good* became highly relevant to health care. For instance, in the context of cancer treatments, nurses started to point out that a few extra days, weeks, or even months are not always beneficial to patients. For if the extra life time comes at the cost of demanding treatments, there is a lot to say for accepting an earlier, quieter, more dignified death (Klinkenberg et al. 2004). *Health*, in turn, may well be a great good, but with which parameters of health to reckon? Laboratory parameters may seem best because they are easy to handle, while clinical ones are not numerical and may therefore be deemed to be too vague. But take once again the situation of people with atherosclerosis in their leg. They themselves may be interested first and foremost in the treatment goal of “no more pain when walking.” However, pain cannot be measured from the outside, only patients themselves have direct access to it. This is why in clinical trials other parameters, such as the blood pressure in the ankle (compared to that in the arm), were given precedence. This means that for quite some time, clinical trials established that walking therapy did not “work.” It only came out as effective in settings where patients’ self-reporting of their pain was sufficiently trusted (Mol 2002b).

Locally, then, different things may count as *good* and different *goods* may suggest different activities. If one of them is prioritized over the others, this may suit all those involved, but it may also give rise to contestation. Hence, engaging in *caring* does not serve an unequivocal, common good. To think that it does is yet another romantic dream (Puig de la Bellacasa 2017). Caring practices, like other practices, are rife with tensions. Take electric bicycles: these may well be wonderful for people who have to cover long distances, or whose muscle power has waned, but they make the urban choreography of cycling considerably more difficult for everyone else. Such tensions are not always readily recognized by all those who share a practice. Some *goods* all too easily disappear into the background. For instance, in interviews with patients treated for breast cancer, social science researchers found that many of them were truly concerned about the alienation that comes with the loss of all their hair. They told their doctors, but the doctors took no notice. Since the doctors were focused on issues of life and death, they could not quite believe that hair loss was a serious problem for their patients (Pols 2013). And while the men in Indonesia who use *Power Magic* hope that postponing ejaculation increases their female partners’ pleasure, their partners revealed in interviews that they felt that such prolonged intercourse lasts too long and becomes far too tiring (Hardon and Idrus 2015).

Sometimes, different goods are voiced by different people, but *people* do not always make the difference.<sup>8</sup> *Circumstances* may do so, too. For instance, diagnosing anemia in clinically, by observing eyelids and fingernails, is hard to do if the deviations from the norm are only slight. It is most successful in resource-poor settings where people suffer from severe anemia and where, consequently, the clinical signs are more pronounced. It also helps that overdiagnosis of anemia is no drama: iron pills are cheap and have few side effects. Laboratory diagnosis, by contrast, may be *good* in that it offers greater precision, but in resource-poor settings, this

good is easily outweighed by the risk of passing on malaria or HIV through unclean needles (Mol and Law 1994). This indicates that different goods may be tied to different possible *courses of action*. Likewise, one good may be impeded by another. For instance, if one is a nurse working in Uganda, keeping one's HIV status a secret is a good in that it helps with being accepted as a professional nurse and avoid stigmatization. At the same time it is a bad, in that it impedes sharing experiences with one's HIV patients and in this way gain their trust (Kyakuwa and Hardon 2012). Additionally, what stands out as a *good* tends to change over the *course of time*. In the 1990s, the Zimbabwean state donated bush pumps with two goals: to provide villages with clean drinking water and to strengthen state power. Two decades later, things had changed. While for villagers clean water was still a good, it was no longer a public concern. It had been privatized and clean water was now on offer via marketable, patented products meant for individual use, such as the LifeStraw® (Redfield 2016).

Investigating what locally counts as *good* in care practices has intellectual links with another social science conversation: that concerning qualification, valuation, or valuing (Kuipers and Franssen, this volume). Researchers in this field ask how it is that situations or entities come to be classified as either *good* or *bad* as a part of complex social and material practices. The ensuing research has a lot to offer to studies of health care practices, but lessons may also travel in the other direction. For example, the lesson that verbal judgments may be supplemented, or replaced, with silently enacted appreciations (Pols 2005). Or that other one, that instead of passing judgments, active attempts at improvement may count for most (Mol 2006). In the Netherlands, the prioritization of intervening over knowing was strikingly apparent when a treatment for HIV was not yet available. While in many other countries, the task of not spreading HIV was imposed upon those who were infected, in the Netherlands everyone was warned to protect themselves. The virus was taken to be a threat to manage as a collective. Even those who were "at risk" were not advised to get themselves tested. What, after all, was the relevance of knowing one's HIV status if there was no treatment, nothing one could do? Seeking a diagnosis was only encouraged once HIV inhibitors entered the scene (Duyvendak 1995).<sup>9</sup> This indicates that performing good/bad divisions is not quite the same as passing judgment. Instead, good/bad divisions may also be enacted by intervening, by acting against a particular *bad* and promoting an esteemed *good*. By *caring*.

This has consequences for researchers interested in valuing. It means that to find out "what locally counts as good" asking people about their values, goals, and appreciations may not be the best way to go. Instead, local valuations may as well speak from what people do. It is by taking the pill that women enact their hope to avoid too many pregnancies. It is by crafting a soothing herbal cream that nurses perform an itching skin as obnoxious. It is by taking on board all the effort involved in calibrating doses of insulin, quantities of food eaten, and exercise that people with diabetes show that achieving "a stable blood sugar level" is worthwhile. Similar valuing practices take place beyond health care. It is by being attentive that bicycle riders perform avoiding accidents as important. It is by building long distance roads



that governments show their reverence of transportation by car. It is by shopping, chopping, and cooking that cooks underscore the marvels of a fine meal. Urban cleaners, whatever their personal preferences, confirm clean as a good as they take rubbish out of bicycle racks and swipe streets. Likewise, it is by writing texts that social scientists celebrate extensive reflection and attentive tinkering with words.

## To conclude

Concepts are meant to be tools. They should not impose themselves on the analyst but serve the analysis. Here, we have taken you through various iterations of the concept *caring* with which we have worked for decades, finding it ever more inspiring. Although most of our examples came from research into health care, our concern is not simply with this societal domain. It is rather with *caring*: a particular way of engaging with self, others, and surroundings that has been fostered within that domain, but is equally relevant elsewhere. Even in settings where so far the term “caring” is rarely used, it may well serve your analysis – give it a try. The version of *caring* that we offer here, emerging from research in which we happen to have been engaged, is not a focused intervention, performed in a single moment. Instead, it takes a processual shape. This may follow a fairly rigid scenario, or rather be adapted again and again, turning *caring* into an iterative process of tinkering. The techniques and the knowledges, in the plural, which allow for *caring* are heterogeneous and, while meant to be transformative, they are also transforming. The activity of *caring* is not taken on board by isolated individuals but spread out over a wide range of people, tools, and infrastructures. Such *caring* does not oppose technology but includes it. The technology involved does not offer control but needs to be handled with care – while, in its turn, it is bound to only work as long as it is being cared for.

*Caring*, we suggested, is not rule driven, it is not invested in principles. Instead, it draws on varied resources that may all work, even if in different ways. The diverse bits and pieces that in *caring* are juxtaposed, do not form a friction-free and harmonious *whole*. That *caring* is full of tensions is not an impediment but helps to keep contrasting approaches alive. When diversity is not smothered by uniform standards, a welcome reservoir of alternative possibilities is available when adaptations are required. In this context, foregrounding ways of working that tend to remain hidden is not criticism so much as a contribution. It is its own kind of care, since it constitutes an attempt at improvement. It invites into the situation an adjustment or an alternative, something that might work to foster this or that good.

But which good? What *is* good – here, now? Attempts to put the various goods pertinent to *caring* practices into words tend to reveal that they diverge. More tensions. Added to that, *caring* activities are rarely *just* good. Effects tend to be accompanied with side effects, upsides with downsides. Good results may have tragic edges. But while many problems are chronic and do not go away, one way of living with them is often preferable to another. Added to that, even if improvements do not materialize, it may be worthwhile to keep trying. Again. And again (Dányi 2020). All of which means that the pragmatic celebration of “what works,”



while preferable to fixed laws and rigid principles, only goes so far. What works for whom, in what way, under what circumstances, in which respect – there is invariably much to detail and explore. This cannot simply be done once and for all, for what is hoped for is not necessarily achieved and what is achieved is likely to include unpleasant surprises. What is, and what is not, good or bad, or both, never achieves stillness. Such is *caring*.

That is to say: this is where we are now with this term. We are curious to see where it may take you, and where you may take it, if you run with this fluid concept, and, by putting it to work in your own research, enrich it.

## Notes

- 1 Tronto, working in the US, suggests that the state would do well to take inspiration from “domestic” kinds of care. However, in the Dutch setting, where the state actually uses caring tropes as a policy instrument, this invites the criticism that the caring state is subtly disciplining (De Wilde and Duyvendak 2016).
- 2 The particular way in which the English word “care” combines *taking care of* and *caring about* is detailed in Fisher and Tronto (1990), among others. By contrast, the French term *soin* translates *caring for* but not *caring about*. French feminists who appreciate the polyvalent English *care* have thus imported “*care*,” untranslated, into their otherwise French texts. See Paperman (2013), Brugère (2017).
- 3 For another striking case of such nostalgia and the concomitant ideas about where *caring* is located, see also Peter Sloterdijk’s *Spheres* trilogy (2011).
- 4 See also De Swaan (1988). In the 1980s, one of us reconstructed Dutch debates about the *verzorgingsstaat* and the failings of mothers: there were striking parallels – from concerns in the 1950s about over-caring mothers whose sons remain weaklings and never grow up into adults, through to concerns in the 1970s about mothers who discipline their offspring with hardly visible, but all the more vicious, soft power (Mol 1987).
- 5 This stretches out into relational techniques that are not quite conversational but that, even if wordless, non-verbal, may be trained and are far from pre-cultural. See Mol, Moser, and Pols (2010).
- 6 Since technological artifacts designed to allow for *bricolage* are more adaptable, they manage to reach places that differ from those in which and for which they were developed. See again De Laet and Mol (2000) and also Benouniche, Zwarteveen, and Kuper (2014).
- 7 There is a marked difference here between the English language tradition of pragmatism that historically emerged in relation to fairly obvious problem/solution pairs and the French language pragmatist sociology that, from its start, grappled with the coexistence of different *worlds* or *economies of worth*. See Boltanski and Thévenot (2006), Dodier (1993).
- 8 There are also difficult “trade offs” – or rather tragedies – in animal care – where potentially infected individuals are sometimes killed in the hope of thus saving larger herds. See Law 2010.
- 9 For the French situation, see Dodier (2015). The issue of how health care practices differ between countries, or regions, or modes of insurance, and so on, is an intriguing one in its own right. For a good example of how this may be analyzed, see Pasveer and Akrich (2001).

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