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To cite this article: Beth Greenhough, Gail Davies & Sophie Bowlby (2022): Why ‘cultures of care’?, Social & Cultural Geography, DOI: 10.1080/14649365.2022.2105938

To link to this article: https://doi.org/10.1080/14649365.2022.2105938

EDITORIAL

Why ‘cultures of care’?

Academic discussions of care have stressed the complexity of the concept of care (Fisher & Tronto, 1990), and the difficulty of defining care ‘needs’ and ‘good care’ (Engster, 2007; Held, 2006; J. Tronto, 1987). Following the early work of feminists such as Noddings (2013) and Gilligan (1982), who argued for a revaluation of care work and skills, many have noted that care skills are widely seen as feminised. Studies have shown empirically that the social obligation to carry out caring tasks is strongly gendered and racialised (Fisher & Tronto, 1990; Yeandle et al., 2017), and noted that care work and care workers are socially undervalued in mutually reinforcing ways (Kearns & Reid-Henry, 2009). The work of J. Tronto (1987, 2005) has been a key influence, through its emphasis on care as dependent on particular affective skills and capacities, and through stressing that the objects of care include beings and entities beyond the human. Thus, in a much-cited definition Fisher and Tronto (1990, p. 40) suggest that care is ‘a species activity that includes everything that we do to maintain, continue and repair our world so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life-sustaining web’. This emphasis on the need to understand care as embedded within a richer context is one which resonates particularly well with geographical scholarship.

Care has long been a topic of interest for geographers, as a particular object of analysis in the form of the provision of health services and care labour (see for example, Milligan 2000, Dyck et al., 2005; Hall, 2011; Power & Bartlett, 2019); as an exploration of particular forms of care such as friendship (Bowlby, 2011) and of the experiences of those who receive care (Wiles, 2011); as requiring attention to the different sites, scales and times at which care takes place, ranging from the transnational (c.f. Raghuram, 2012); to the urban (E. R. Power & Williams, 2020) and rural (Parr et al., 2004); to the interplay between the demands and norms of the ‘private’ and ‘public’ (cf., Bowlby, 2012; Bowlby et al., 2010; Dyck et al., 2005); and as the basis for developing a more ethical geography (Kearns & Reid-Henry, 2009; Lawson, 2007; Popke, 2006; Raghuram et al., 2009; Smith, 2000). Recently work has expanded beyond the focus on humans as objects of care to consider, for example, entities such as soils (Puig de la Bellacasa, 2017) and nonhuman animals (Davies, 2012; Greenhough, 2011; Schuurmana & Franklin, 2018; Srinivasan, 2013), while Power (2019) and Power and Mee (2020) have suggested the ‘capacity to care’ is generated and shaped through the intertwining of architectures and systems of governance and discourse in sociomaterial ‘infrastructures of care’.

Despite the considerable body of work on care, geographers, along with other social scientists, have not generally discussed the concept of a ‘culture of care’1 in any depth, although Woods and Kong (2020) and Pearson and Watson (2018) have provided recent detailed empirical explorations of

changing ‘cultures of care’. Like care itself, the idea of a ‘culture of care’ is hard to pin down, even though when it is used it is usually taken for granted that the reader understands its meaning. The term is generally used to refer to norms of caring behaviour, practices of care and modes of relating which promote and enable effective care and implicate the display and exchange of what are seen as ‘appropriate’ affect and emotional responses for a particular institution or social group. It is used to refer to ‘cultures’ of institutions or groups at the very local scale (e.g., an individual laboratory or care home) up to the nation state or global scale (e.g., Singapore (Woods & Kong, 2020), Canada (Molinari & Pratt, 2021), South East Asia (Tan & Atkinson, 2019) or the Global South (Raghuram, 2016)). Implicit in the idea of a culture of care is the notion of continuing but shifting patterns of behaviour, that are characteristic of particular social groups in particular places and times. At a broad scale Raghuram (2016) has suggested the idea of a ‘geohistory’ of particular care practices: any ‘culture of care’ is emplaced, located, relational and dynamic, emerging from a particular socio-material context (Raghuram, 2016). Therefore, whilst many of the papers in this special issue draw attention to institutional cultures of care, they also demonstrate that it will be difficult to change an institutional culture without changing this broader socio-material context.

This special issue of *Social and Cultural Geography* explores what it means to talk about ‘cultures of care’ and to think of culture with care. It emerges from a 2018 session on *‘Situating cultures of care’* at the Royal Geographical Society (with IBG) Annual Conference. The session asked presenters to think about the ways in which cultures of care are defined and practiced, and how they vary across institutional care settings, across political contexts and countries, and across human and animal bodies, noting in the latter case how questions around ‘cultures of care’ are emerging in both human and animal care settings. We challenged presenters to think about the differences between institutionalised care and more informal practices; how care is regulated, resourced and accounted for or measured; and what critical perspectives from health, wellbeing, and medical geographies bring to a growing policy conversation around ‘culture’ as a concept that matters for care. In this short editorial we offer a few reflections on these issues as themes which cut across the interests of the different authors participating in this special issue, before turning to offer an overview of the different papers.

Institutional ‘cultures of care’

The view that institutional cultures can be harmful and require intervention is not new; for example, criticism of ‘defensive’ institutional cultures in government agencies and local authorities or racist or misogynistic cultures in the police, sport or workplaces have been made often over the last 20 years or so. In a variety of fields, culture is often pinpointed as both the cause of, and the solution to, care failings. The idea of creating and maintaining a good ‘culture of care’ is one of the latest additions to the list of such proposed cultural interventions. Various institutions have sought to actively create a good ‘culture of care’ for both human and nonhuman subjects within their organisation. Some date the emergence of this focus on organisational ‘cultures of care’ (or the lack thereof) to a series of prominent care failings, including those detailed in the Francis Report (Francis, 2013) on the Mid Staffordshire NHS Foundation Trust and the Brown Report (Brown, 2013) into animal research at Imperial College London (see for example, Gorman & Davies, 2020; Williams, 2021, this volume). Creating a good ‘culture of care’ is now a critical component of the local aims and external assessment of care practices across a wide range of institutional settings, including hospitals, care homes, schools, workplaces, and in animal research, while the geographical literature has seen critiques of institutional structures (notably the neoliberal university) which are marked by a failure to care (Askins & Blazek, 2017).

The idea of a successful institutional culture of care often emphasizes the importance of communication, connection, and empowering people to sustain care as well as specifying types of caring behaviour (Hochschild, 2003; Rafferty et al., 2015b, 2017). But highlighting culture as the problem can direct attention to individuals' responsibility to 'be caring' without considering how this capacity is shaped by power relations, inequality and the availability of resources. In other words, it can ignore the question of what enables people to 'be caring', whilst allowing others to ignore care demands. Thus, it can redistribute responsibilities for care from those with management positions to those individuals who are most precarious within institutions.

The delivery of a culture of care is arguably becoming increasingly formalised and monitored through specific mechanisms. As Fisher and Tronto (1990, p. 50) argue, '[b]ureaucracy, by its nature, distorts and fragments the caring process through its division of labour, through the hierarchy of authority and power, and through its need to reduce problems to a standard form'. In such situations care often becomes rapidly reconfigured as a demand for care workers to perform particular (measurable) forms of emotional labour (Hochschild, 2003). These developments reinforce concerns that firms may use policies which are, ostensibly, about 'caring' for workers as a means of their control. In the NHS, for example, the meaning and measurement of a 'culture of care' is closely associated with the NHS 'culture of care' barometer (Rafferty et al., 2015). Such mechanisms are arguably often at odds with more reflexive, empathetic and situated understandings of care which have become increasingly prominent in recent academic writing (see for example, Puig de la Bellacasa, 2012, 2017).

A key theme that cuts across much of the more recent geographical work on care has been the impact of the state's changing role in regulating, resourcing, and allocating responsibilities for care, and how this in turn shapes the capacity of both institutions and individuals to provide care (c.f. E. R. Power, 2019). Neo-liberal ideas and austerity following the 2008 financial crash have brought about restructuring, affecting an increasingly diverse range of settings, ranging from early education, care services and animal welfare, to research ethics. Cuts in care services and resources as a consequence of austerity, and new ideas of how care should be provided, have led to changes in regulation and financing. These developments have stimulated a variety of analyses of how practices and ideas about care adapt to changes in resources, as well as to shifts in ideas, beliefs and emotions surrounding care. These analyses have begun to show impacts such as altered capacities for selfcare, changes in the capacity to care for others or reductions in assistance for carers. In some cases these changes have stimulated new and creative ways of caring, and highlighted limitations in previous practices of care. In many cases they have led to increased difficulties for carers (Bonner-Thompson & McDowell, 2020; Hall, 2011; A. Power & Bartlett, 2019; A. Power & Hall, 2018).

The experiences of both formal and informal carers during the ongoing Covid −19 pandemic also shows evidence of the impact of major changes in resources and behavioural norms on capacities to care (e.g., Giebel et al., 2021; Hertz et al., 2021; A. Power & Herron, 2021; Primdahl et al., 2021; Women and Equalities Committee, 2021). The Covid 'lockdowns' impacted the informal 'cultures of care' within families and communities through significant reductions in, or withdrawal of, services providing care or benefits enabling care, for (amongst others) children, people with learning difficulties and people with physical disabilities, or who are frail. In contrast, some formal care services such as hospitals and care homes found their work dramatically increasing and 'cultures' changing (e.g., Marshall et al 2021). Although the papers in this special issue are about situations prior to the pandemic, some of their findings and analyses suggest that the concept of 'cultures of care' can offer new possibilities for future work on the impact of changes to care resources, care infrastructures and guiding norms on care practices.

The Papers

The papers in this special issue address some of the critical and comparative questions that arise from situating 'cultures of care' at the locus of relations between caring subjects, matters of care, care theory, and policy and regulation. Collectively they explore how national and local contexts, as well as institutional cultures, may shape assumptions around emotional labour, responsibility, and care, and how different cultures around care may emerge at the margins as institutions are stripped of responsibilities for care under austerity politics. At the same time the papers also highlight how the exploration of institutionalised cultures of care allows for interesting comparisons across sub-disciplinary fields of research – animal, health and social geographies – not often brought into conversation.

The first three papers take up the challenge of exploring how a concern for a 'culture of care' has emerged in the regulation and operation of animal research, providing an interesting counterpoint to the largely human focus of much of the work in geography to date. As we noted above, institutional approaches often place an emphasis on communication as being key to the development of a 'culture of care', and Nuyts and Friese (2021) add empirical evidence to assumptions that communication between scientists and animal technicians is important for creating a 'culture of care' in animal research facilities. They show how networks of communication are siloed by topic and status, tracing how conversations about operational issues and moral concerns are distributed between different groups, and thinking through the implications of this for developing a shared, collective 'culture of care'. They also flag the potential role of communication 'brokers' for navigating between different groups.

Staying within animal research institutions, Bella Williams (2021) looks at the wider networks within which a 'culture of care' is embedded. Williams' paper brings together her own experience of working in animal research, focus groups she conducted with people in different positions within institutional structures, and Tronto's four dimensions on 'good care' (taking responsibility, attentiveness to others' needs, competence to provide appropriate care, and responsiveness to the needs of the individual cared-for), in order to examine practices which support or limit care. While discussions of care within this sector often focus on the issue of animal welfare, Williams argues that an attention to human-human relations, and the support and care different individuals within an institution show for each other and each other's work, is central to understanding and developing more supportive cultures of care.

Returning to place more emphasis on human-animal relations, Roe and Greenhough (2021) draw on longitudinal in-depth interviews with junior animal technicians, to examine how care and harm co-exist in this sector. Their paper reflects on the harms experienced by both the animals used in research and the technicians involved in the process of both caring for and killing animals. In doing so they complicate existing discussions of the power relations and harms that can be inflicted through caring relationships. They show how both the cared-for subject(s) and the carer(s) can be in need of care and suffer harm, and demonstrate the role of personal history, emotions and affect, in shaping the experience of being an animal care provider.

Moving from the spaces of animal research to look at the juxtaposition of harm and care in a different setting, Jo Little (2021) looks at the relations between violence, love and care in the provision and allocation of safe housing. Her work demonstrates the need to understand care within organizational structures and the wider cultural attitudes, interests and motivations that shape those organizations. She shows how attitudes towards survivors of domestic abuse include strongly embedded notions about romantic love and personal agency, which may limit access to safe

housing, and to wider cultures of care and support, demonstrating how the cultures of institutions reflect and implement wider cultural assumptions. Also embedded in these institutional cultures were ideas about the responsibility for self-care, which often failed to recognise the impact of infrastructures of care on the 'capacity to care' for the self (E. R. Power, 2019).

Colebrooke et al. (2021) turn to the experience of those negotiating universal credit to write about how being 'on the edge' shapes cultures of care within third-sector organisations and housing associations. By "edgy-ness' they mean 'a sense of anticipatory unease emerging in relation to lived experiences of material conditions of austerity' (ibid. p. 2) and emphasise that this is an *emplaced* affect – in their case reflecting rural Cornwall's long history of economic marginality. They are interested in how this 'edgy-ness' means that practitioners who deliver care may value outcomes that differ from those of the project funder. This example resonates with broader discussions about the ways in which care is rendered measurable and accountable. They argue that one implication of this for practitioners in the organisations they studied was to prioritise not only 'hard outcomes' such as employment but also '*affective* competencies – such as self-confidence' (ibid. p. 14) which would allow people to cope with on-going precarity, in some cases through communal responses.

Retaining this focus on institutional cultures, but now turning to look at higher education, Gabrielle King (2021) uses her personal experiences of navigating institutional ethical review in fieldwork to explore what happens when procedures intended to protect research participants cause harm to both researchers and respondents. Examining how a culture of care in university research might change the operation of University Research Ethics Committees (URECs), she identifies the potential to move '*Towards a culture of care for ethical review'*. Through a discussion of a series of her own research encounters she explores how URECs might operate to provide a culture of care for researchers as well as research participants. She stresses the need to widen the responsibility for care-ful research beyond the individual researcher, and to work towards providing a culture of collaborative support rather than one of individualised responsibility, academic hierarchy, and competition.

The final paper works across institutions concerned with human and animal subjects. In 'W*hen "cultures of care" meet'*, Gorman and Davies (2020) look at what happens at the interface between two different cultures of care: the culture of caring for laboratory research animals and the culture of patient involvement. Examining what happens when patients tour animal research facilities, they explore how the distinctive cultures of care which have evolved with respect to animal welfare and patient engagement are brought together. More specifically, the paper looks at how moves to invest patient representatives with opportunities to shape care practices, including animal care practices, can be positive. But such opportunities can also generate anxiety if not accompanied by changes that empower patients to make meaningful contributions to the things they are being asked to care for. This observation re-emphasises the importance of paying attention to the different degrees of power, knowledge, and ability to effect change held by different participants in 'cultures of care' and (as Williams, 2021, this volume, also notes), the power of some players to control how interactions and communication are structured.

Conclusion

Returning to the work of Puig de la Bellacasa (2017, p. 166), we suggest that these articles help elaborate her suggestion that 'care is embedded in the practices that maintain webs of relationality and is always happening in between'. This is a special issue not about discrete 'cultures of care', which are easy to identify, measure, or compare. Instead, the articles demonstrate that each culture of care is a complex network through which care is expressed, extended, audited, and at times

undone. Many of the papers emphasise the significance of interactions with the wider context within which an institutional culture is embedded. As they show, this will affect the amount, type, and precarity of resources and attitudes to, for example, animals, romantic love, individual responsibility, or professional ethics. They also show how the capacity to care is a complex competency, which often exceeds the scope of institutionalised processes of training, monitoring, and evaluation. For all its complexity, or perhaps because of this, we continue to find the idea of a 'culture of care' productive. It provides a platform for discussing how the connections around care also involve assumptions about responsibilities and accountabilities. As Rafferty et al. (2017) propose in their reflections on the NHS Culture of Care barometer, the 'culture of care' has value as a concept for its performative functions and the belief that 'culture changes by talking about it'. We hope that further work will follow to help us all think and enact cultures with care.

Acknowledgments

We would like to thank all of the authors for their work in developing their conference papers into written articles and the supportive editorial team at Social and Cultural Geography. Particular thanks go to all of the paper reviewers who cared enough to give their time to help; making this careful, hidden labour of review more visible is in itself central to attempts to bring a 'culture of care' to academic publishing (Arjaliès et al., 2018).

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