Practising Caring –
A Diffractive Inquiry

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requirements for the degree of Doctor of Philosophy

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This thesis is the result of the author’s original research. It has been composed by the author and has not been previously submitted for examination which has led to the award of a degree.

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Abstract

My doctoral thesis is a speculative, personal, and affective inquiry into practising caring in organisations and organising. Caring – as a verb or doing – is an under-explored phenomenon within organisation studies. I investigate how caring is experienced and theorised processually, by exploring the dynamic effects of difference in a health and social care context during a period of unprecedented change to healthcare strategy, leadership, and delivery.

My study is oriented around two interrelated curiosities – how might I travel with diffractive inquiry as a research logic, and what might be discerned differently about practising and theorising caring from an ontologically processual stance?

As I move beyond methods and methodology, my research logic is informed by an understanding of classical pragmatism as a philosophy of experience, and feminist technoscience expressions of diffraction as ethical practising of mattering. What is novel is fidelity to experience as a stimulus for learning and consequential action, and the always ethical nature of our entanglements as we become with.

Drawing on feminist technoscience, classical pragmatism, care ethics, and caring theory, I explore how an ethos of caring as response-able practising – attuning, inquiring, and coattending to the entangled flourishing of ourselves, others, and our worldings – is experienced in everyday encounters. My argument is that in theorising and practising caring, we need different vocabulary and language: generative, performative, and rooted in everyday experience as it is experienced.

My contributions comprise an invitation to look more closely at how caring – as a social dynamic – is continuously unfolding in the day-to-day of organisational life. Secondly, I propose a vocabulary of caring, which conveys the ongoingness of care in practice. My third contribution is to suggest that ‘ethos’ – rather than ‘ethics’ – conveys how caring unfolds in practice. A further contribution is in showing how ontological inquiries may generate insights that epistemological studies miss or discount; as well as foregrounding entangled and co-creative relations between researcher, participants, ideas, and situations, and the ethical mattering of crafting doctoral output. A final contribution is experimentation with diffraction as inquiry logic, as a way of surfacing seemingly inconsequential and yet catalytic differences in day-to-day organising, relating, and doing.

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“It matters what matters we use to think other matters with; it matters what stories we tell to tell other stories with; it matters what knots knot knots, what thoughts think thoughts, what descriptions describe descriptions, what ties tie ties. It matters what stories make worlds, what worlds make stories.”

Donna Haraway
Staying with the Trouble
(2016b: 12)

Glossary of Significant Terms

Affect	Being open to the world, active in it, and patient for its responses. It is the cutting edge of change, through intensities of feeling, where one always affects and is affected in encounters (Massumi, 2015: vii–xi).
Care	All we do to maintain, continue, and repair our world so we live in it as well as possible. Includes our bodies, ourselves, and environment in a life-sustaining web (Fisher and Tronto, 1990: 40).
Caring	An ongoing process of learning, relating, and responding, involving mutual development and growth, where the specific other(s) may be a person, a non-human other, an idea, or a community (Mayeroff, 1971).
Diffraction	A dynamic mapping of interference. A diffraction pattern does not map where differences appear, but rather maps where the effects of differences appear (Haraway, 1992: 300).
Dualism	An agential move to reduce the entire spectrum of experience to one or other of two opposites, forcing hard epistemological distinctions (Simpson and Hond, 2022).
Entanglement	To be entangled is not simply to be intertwined with another, as in the joining of separate entities, but to lack an independent, self-contained existence (Barad, 2007: ix).
Ethic(s)	Deals with issues of practical decision making. Its major concerns include the nature of ultimate value and the standards by which human actions can be judged morally right or wrong (Singer, 2022).
Ethos	The broad characteristics of an ethical culture that influence a group’s customs and practices, rather than a self-sufficient and independent foundation for ethics, which competes with other moral theories (Bowden, 2000: 39).
Experience	An active process, transforming perceptions, relationships, and actions, acknowledging how experiencing and knowing are social, temporal, and historically contingent processes (Seigfried, 1996).

Intra-action	Reworking of causality, things-in-phenomena. Boundaries between here-now and there-then, self and other, are not definite. We are in a continuous process of co-creating and experiencing (Barad, 2003, 2011b, 2014).
Performativity	Agential sociomaterial processes producing ontological effects, bringing into being certain kinds of realities, performed through language, gesture, and other corporeal actions (Barad, 2003; Butler, 1988, 2010).
Process	There is neither a beginning nor an end to process; rather it is a perpetual becoming that makes and re-makes knowings as we continuously re-compose our world(s) (Massumi, 2013).
Response-ability	A praxis of care and response, of collective knowing and doing, as an ecology of practices, with differences in ecologies, economies, species, and lives, as we make worlds (Haraway, 2016b).
Social	De-centres human agency as the source of action and moving to entanglement of humans, materialities, and any other relevant element in situated activities (Gherardi, 2019a).
Theorising	Ideas, insights, or unfinalised narratives that are resonant and open to re-interpreting and re-theorising by others according to their own lives and circumstances (Cunliffe, 2022: 22).

Table of Contents

Table of Figures

Chapter 1 – introduction

Introduction

The emphasis we place on care/caring has more urgency at domestic, community, organisational, and planetary levels – whether that is care as paid/unpaid work or living/working in caring relations with human and non-human others. Care, and its ethical dimension, has been defined as a disposition, moral sentiment, altruism, moral theory, rules and principles, a feminine ethic, a feminist ethic, work / service / maintenance, a process, an organising principle, a political theory, an aesthetic, and a product. These definitions typically focus on the *what* of care – what is it – and the *who* – who does it and who do we care for/about (our family, friends, people we are paid to care for, and proximate others); although some also focus on the *why* – cui bono. Care, it seems, refers simultaneously to *"complex sets of practices, motivations, ideals, dispositions, occupations, burdens, duties, expectations, emotions, ends, and more"* (Sander-Staudt, 2006: 29).

Of particular significance for my study is the conception of care as a social practice, rather than moral principles or work, given the nomenclature 'care ethics' or 'ethic(s) of care'. Its focus is as a practical, situational, and relational ethic**.** I explore what 'as practice' means *in practice*. Rather than focussing on the actors and the activities (or practices) of care, the theories that prescribe what good care *should* be like, I look to the unfolding process of caring (as a verb) as it is experienced. Exploring *how* caring is practiced develops the idea of 'caring as a process', articulated by Milton Mayeroff decades before the term 'ethics of care' was coined.

Much of the literature on care arises from feminist scholarship, political theory, psychological sciences, education, nursing, and other caregiving professions (Bowden, 2000; Gilligan, 1993b; Held, 2006; Kroth and Keeler, 2009; Noddings, 1984; Tronto, 1993; Woods, 2011). My study on practising caring in organisations and organising is informed by classical pragmatism, feminist technoscience, care ethics, and caring theory. I explore how is caring experienced and how it may be tentatively theorised from a processual perspective, not in dualistic opposition to the ethics of care but to answer a different question, rooted in lived and speculatively retold experience.

In the chapters that follow I notice how response-ability, an ethical capacity of *"cultivating collective knowing and doing"* (Haraway, 2016b: 34), in the flow of everyday activities, is experienced through my entanglement within these situations. Entanglements, Karen Barad (2011b: 150) says, are not an alternative name for the interconnectedness of all beings as one but are ethical relations, of being agentically bound with others in the actions we take.

This chapter introduces what follows and why. What is distinctive about my study is how I go about it: from an ontological rather than epistemological orientation. This is less about the pursuit of hard facts and theories, but to inquire within flows and dynamic reconfigurations of social agency. My understanding of process is not as some*thing* to study, but as a way of moving with and through inquiry, as a becoming. This guides not only how I engage with empirical experiences, diverse literatures and ideas, and being moved affectively to theorise, but also in my own development as a researcher. These mutually informing processes are diffractive, involving sensitivity to consequentiality in noticing and theorising differently, as well as to making a difference. I shall now explain something of that journey.

Becoming a processual researcher

Even before the outbreak of COVID-19 in 2020, the National Health Service (NHS) in Scotland was undergoing major change, shifting towards more community and home-based care, in response to fiscal, workforce, and public health challenges;

and guided by a strategic aim of 'compassionate and kind care'.[1] My fieldwork was undertaken from late 2019 to early 2020 within Glasgow City's Health and Social Care Partnership (GCHSCP)[2]. GCHSCP has a statutory responsibility to provide community health (called Primary Care) and social care services for children, adults and older people, homelessness, and criminal justice services.

I travelled with Primary Care staff within GCHSCP to learn how collaborative public leadership is done, in practice and from practice during a multiyear programme of strategic transformations. I was informed by an understanding of collaborative leadership as 'co-productive practices of dialogue, improvisation, and daring' (Simpson and Buchan, 2018). Practice comprised a *"social process of constructing meaning about, and acting within, our world"* (Buchan and Simpson, 2018: 4).

My field work ended abruptly, less than halfway through its planned duration, which necessitated a fundamental rethink about the purpose, focus, and approach of my study. Perhaps without the pandemic, my original inquiry might have continued largely untroubled by the deeper questions lockdown gave me time to ponder. What emerged, and what is still unfolding, is a more profound engagement with processual inquiring as an ethical practice of 'mattering' (Savransky, 2016), a way of being as well as a way of doing, still informed by classical pragmatism, now in conversation with moral philosophy, and feminist technoscience.

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[1] https://www.gov.scot/publications/national-monitoring-evaluation-strategy-primary-care-scotland/pages/2/

[2] The National Health Service was established in 1948 (as three institutions: NHS England and Wales, NHS Scotland, and NHS Northern Ireland) as a comprehensive publicly funded healthcare system, funded through general taxation, and free at the point of delivery. Following Scottish devolution in 1999, NHS Scotland became accountable to the Scottish Government. NHS Scotland is divided into 14 health boards, one of these is NHS Greater Glasgow and Clyde (NHSGGC). As the largest health board in the whole of the UK, serving around 1.2 million people, NHSGGC is subdivided into seven Health and Social Care Partnerships (HSCPs), in collaboration with the relevant local authority. HSCPs manage community health services and create closer partnerships between health, social care, and hospital-based services. Glasgow City HSCP (GCHSCP), the location of my study, is subdivided into three localities – North West, North East and South – providing primary health and care services from approximately 145 GP surgeries, as well as health and care centres, community pharmacies and dental practices. These community-based services are collectively called Primary Care.

These ‘queering’ – differing from convention in some way, as well as scholarship representing alternative genders and sexualities[3] – ways of seeing/being are at the margins of organisation studies as I bring them into conversation now, looking beyond methods and methodology, to retrospectively make sense of the whole research logic/experience, including participating-with, analysing, theorising, and writing as world-making.

In becoming a processual researcher, I am learning that this invites fidelity to experience. Prevailing methods and paradigmatic categories within functionalist Social Sciences research would arrest the experimentation, intensity, and movement alive within my inquiry (St. Pierre, 2011, 2018, 2021). No methods led me here. No coding could help me make sense of what unfolds. No generalisable theories will emerge from my findings.

I take inspiration, however, from John Dewey’s logic of inquiry (1939), John Shotter’s withness thinking (Cunliffe, 2002; Cunliffe and Scaratti, 2017; Katz and Shotter, 1996; Shotter, 2010b; Shotter and Katz, 1996); Donna Haraway’s concept of response-ability (2016b), Karen Barad’s concepts of intra-action (2011b) and diffraction (2007), and Jane Addams’ social ethics (1902), to acknowledge my entangled participation in unfolding social processes. Worldmaking processes that have agency. These are big ideas, which I explore in the chapters that follow.

A ‘provocative and troublesome’ lockdown

My participants – ranging from Primary Care practitioners at doctors’ surgeries to members of a senior leadership team – were mobilised in late February / early March 2020 to respond to the public health emergency as COVID-19 took hold in Scotland[4]. Being in the same physical space as my participants became a potential

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[3] https://www.merriam-webster.com/dictionary/queer#dictionary-entry-1

[4] https://data.gov.scot/coronavirus-covid-19/

transmission risk, for them and for me. At the same time, my primary (and at the time, sole) supervisor began an extended period of sickness absence. Without supervisory guidance, or access to my organisational participants, and with a perceived paucity of 'relevant' empirical data, a crisis ensued. Life, and my inquiry, came to a standstill. As I reviewed my field notes and reflected on my experiences and where my attention had been, I realised that I did not have usable material to continue with the planned line of inquiry. Nor did it seem likely that I could go back to the organisation once 'normality' resumed.

It was around this time that I read the *Logic of Care* (Mol, 2008), prompted by a conversation with my supervisor several weeks before. The book focusses on the process of diagnosing, informing, injecting, and encouraging in the giving of medical care, where the patient is not only the object but a principal actor. I could see the relevance for my participants in implementing Scotland's National Clinical Strategy (NCS). One of the NCS goals – 'realistic medicine' – seeks to place the care receiver at the centre of decisions made about their needs to facilitate shared decision making, guided by the vision of 'careful and kind care' (Calderwood, 2018).

Annemarie Mol offered me a way back into my research that was empirically grounded, not just in terms of field work, but to inquire more closely into a dilemma in health care that touched the people involved in a way that my original study might not. It was already in my field notes, although I had not seen it while my attention was on collaborative leadership and organisational learning. My notes contained comments about care: being cared for, not caring, caring too much, caring for patients, caring for colleagues, self-care, and its absence. These are all experiences, temporally connected in 'vertical time' (Helin, 2023), non-linear and speculative. Vertical time invites going deeper into oneself to discern what matters, to inform what and how we write. From my concurrent experiences as a patient, I also understood that I was as much a research site, situation, participant, and world-maker, as the health and social care practitioners. My experiences with doctors, medication, and consultants heightened sensitivities – to ageing, for example – that had been previously muted. This awareness gave my inquiring a sense of legitimacy.

I noticed the embodied and social enactments of caring amongst the everyday tasks of organising: care for a colleague's wellbeing, care that a tacit process be followed, care within the prosaic minutiae of printing, care about appropriate resources for care giving, the need to set boundaries for self-care. Mol and her colleagues (Mol, Moser and Pols, 2010b; Mol, Moser, Piras, et al., 2010) suggest that care is a matter of '*tinkering'*, where knowing is fluid and people and technologies interact in uncertain, adapting, practices. I started to see more processual dimensions of caring, its affect and effect, as distinct from the normative practice(s) of care. These ideas are developed in the empirical vignettes in chapters 4, 5, and 6.

Much scholarship explores the similarities and differences between affect, feeling, and emotion – as well as compassion, sympathy, and empathy – favouring one term over another, with its nuanced meanings in a given discipline (Deigh, 2010; Gherardi, 2017a; Goetz et al., 2010; Haaparanta, 2018; Massumi, 2015). In this study I am referring to *feelings* as a felt sense of situated and emergent difference that 'troubles' (Haraway, 2016b) or 'perplexes' (Addams, 1902) our awareness in some way, although I draw on some of these other literatures. Following Gerhard Thonhauser (2019), I understand feelings to be more than corporeal or cognitive, as a dualism, but rather involving our mind and body (embodied) and more, with potential to be evaluative, relational, and processual. My attention to feelings in caring runs counter to the prevailing theories of care ethics which, while recognising the emotional dimensions and vulnerability of caring, seem not to develop their ethical potency (Brugère, 2014a). When we respond, these affects tell us something about what we value and how we might respond to others (Barnes, 2012: 15). In this context, caring means participating in relationships involving affective, material, and temporal dynamics (Hamington, 2004). I could see these feelings and relationships were data, aspects of a problematic situation, beyond classification.

Care, caring, the ethic or ethics of care, and care ethics comprise terms used by different authors; and sometimes more than one is used by the same author. Tony Monchinski (2010) argues that these terms are compatible if not interchangeable, given their shared commitment to praxis. I suggest that their philosophical assumptions are divergent, even if ontologically relational, such that the meaning and practising of these words do differ. For my study, it is caring – as a verb and rooted in a processual ontology – as a social dynamic that I develop and theorise.

As I meditated on my experiences with my participants, and the way that I felt the presence of caring as something distinct from the care work they did, it seemed to me that – according to the care ethics literatures – what I experienced did not count as ‘care’. I went back to Mol, and her concept of tinkering, sociomaterial practising. Exploring *how* caring is practised *ongoingly* revisits the idea of caring as a process (Mayeroff, 1965, 1971), a second wave feminist theory of caring (Fisher and Tronto, 1990); and caring as a ‘grand theory’ – covering a broad area of concern – in nursing philosophy (Roach, 2002; Watson, 1997). I see a caring ethos in the collaborative philosophical activism of Jane Addams (Lake, 2021), a contemporary of better known (and male) classical pragmatists such as John Dewey and William James.

Acting out an ontology of becoming

The way ‘science’ establishes its validity is by developing congruence between its ontology, epistemology, and praxis. It presumes a more-or-less stable world that can be accurately represented by objective observers using stable and repeatable constructs. One of the earliest decisions I made – even before lockdown – was to undertake my research *processually*, although what that means to me in practice continues to evolve. What makes a processual approach distinctive is that it invites ways of thinking/acting with, rather than a specific theory, to see our world as constantly in the making, and with a multiplicity of possibilities, participants, and perspectives (Helin et al., 2014; Jackson et al., 2022).

In those months of lockdown, Barad and Haraway prompted me to consider what world I might create through my research, and what a commitment to the 'rupture of indifference' (Barad, 2012: 216) might mean in practice. As I reflected on Elizabeth Adams St. Pierre's (2011, 2018, 2021) challenge to consider *how* one might undertake emergent research, and what conventions that close off thinking and action might need to be let go of in the process, the more deeply I understood her call to *live* the theories and philosophies that were now informing my inquiry.

St. Pierre's voice complemented Andrew Pickering's (2008) invitation to 'act out an ontology of becoming', where we might experiment with different ways of conducting ourselves in the world, to *"imaginatively and critically explore the open-ended spaces of the world's possibility"* (Pickering, 2008: 12). This acting out is not solely about responding in the midst of problematic 'situations' (Dewey, 1939), but also in quiet dimensions of experience (Mayeroff, 1963: 147), and a deepening awareness of what is rather than what should be. I was being called to trust the process, in all its multiplicity and confusion.

These voices brought me back to classical pragmatism, to appreciate its distinctive potency as a 'philosophy of experience': firstly, through an ontological commitment to process and emergence, secondly a naturalistic theory of knowing, and thirdly an orientation towards future-directed action (Simpson and Hond, 2022). Dewey's concepts of 'inquiry' and 'situation', and Addams' social ethics, with their commitment to the complexities and fullness of social experience – embodied, participatory, and restorative – were in harmony with more contemporary voices in feminist technoscience.

What is shared is a commitment to contextual, consequential experimentation, and experience, particularly as it is experienced in the everyday (Seigfried, 1996). James (1912) called this ‘radical empiricism’. For my inquiry this means making visible the affects of my entanglement – with Primary Care practitioners and the situations we shared – not as a form of autoethnography, but as a practice of ‘speculative fabulation’ (crafting transdisciplinary fables) for caring is *“emotional, messy, and demanding of the best thinking one has ever done”* (Haraway, 2011: 102).

My ongoing development as a researcher involves moving from understanding process as epistemology to process as ontology. This is problematic because, as Barbara Simpson and Frank den Hond (2022: 6) note, there is *“little guidance for empirical researchers who wish to step out on a ‘strong’ process pathway”.* Pragmatism is not grounded in a conception of knowledge as absolute truth (Simpson, 2018), and there is a recognition that various methods of inquiry can lead to different understandings (Hamington, 2004). Knowledge is neither static nor monolithic, rather comprising experience – emotional, aesthetic, situational, and relational (Dewey, 1934). What this means for me in practice is a performative rather than a representational approach to understanding ordinary everyday actions (St. Pierre, 2018: 604), where knowing – rather than knowledge – is fallible, mutable, and informed by practice and (working) hypotheses (a form of theorising).

This acting out Pickering invited has become more than travelling with empirical experience as it is experienced, but also influencing my development as a researcher, and their interplay. This means ongoingly becoming more alert to incongruences – such as perpetuating dualisms when I am seeking generativity in nuance and difference – while also realising this is probably a lifelong and non-linear process. Refinements in my logic have been an attempt to let go of the constrictions of method and methodological thinking to more dynamic inquiring, as well as not clinging onto appealing ideas, mindful of the need for a coherent logic I can explain and defend.

As Line Revsbæk and Simpson (2022: 4) note, from a processual perspective, the *“practice of doing empirical process research is inseparable from the scholarly processes of reading and writing”.* Rather than writing this chapter and the entire thesis from where I have got to (at this time of writing as I now bring the chapters together) as if it and I were fully formed and predetermined, showing my confusions and workings out I hope conveys the dynamism, uncertainty, and emergence in my study, as its form and direction becomes revealed.

My research logic comprises a ‘thinking without method’ (St. Pierre, 2018) – a creative conversation between classical pragmatism and feminist technoscience – that I call diffractive inquiring (DI) (Augustine, 2022). DI offers possibilities for different experiences of knowing, where everything is moving, and in the making; and where data is beyond categorisation. DI – in its fidelity to experience – has resonance in inquiries where organisations and organising are understood as emergent, dynamic, and fluid; and where data is ‘transgressive’ (St. Pierre, 1997), and beyond categorisation in most qualitative research.

Writing differently

As I have explained above, there is no methodology or methods per se, but a logic rooted in practices of inquiry and diffraction.

In writing differently, as a practice of analysing/writing (Richardson and St. Pierre, 2017; St. Pierre, 2018), I am departing from some of the conventions of typical doctoral theses. For example, there is no ‘literature review’ chapter (nor are there ‘findings’ or ‘conclusions’ in any normative sense). There are two reasons for this. Firstly, care ethics is only now being introduced into organisational literature, and from a critical stance, while caring theories are dispersed within nursing philosophy and moral philosophy. My intent with the diverse literatures I draw on is diffractive rather than incremental, I am not extending extant theories. Secondly, to separate theory and practice – rather than how they are mutually informing – would be to perpetuate a dualism and at odds with the logic of my inquiry. Instead, I engage with literatures in several chapters – firstly to introduce the concepts of care (in chapter 3), and then how they inform empirical experience as I move to analysing (chapters 4, 5, and 6).

I write, intimately in the first person, drawing on empirical experiences, and my concurrent journey through the menopause, as well as memories, resonances, and evocations. My varied use of pronouns and tenses reflects the temporal fluidity of the study – of past, present, and imagined future in the here and now as I write. This entangled participatory stance challenges notions of an objective researcher as an outsider (Berger, 2015; Cunliffe and Karunanayake, 2013), by virtue of not being part of the organisation under study, or with shared experiences or social position.

In writing this way I am influenced by recent moves by organisational scholars to do process research differently (Simpson and Revsbæk, 2022), post qualitative inquiry (Richardson and St. Pierre, 2017; St. Pierre, 2018), transdisciplinarity (questioning the boundaries put around disciplines and bodies of knowledge, bringing ideas together to see how they interact) (Braidotti, 2014; Miller, 2016; Rigolot, 2020), and a 'writing differently' movement within organisation studies (Helin, 2019). It proposes an alternative way of academic writing so that it might be possible to *"touch vulnerable flesh and invoke new ethical practices",* even disrupting the 'masculine order' in scientific writing (Gilmore et al., 2019: 3; Stewart, 2011).

Some feminist scholars suggest that how we write is a form of care – even love, as an action rather than a feeling (Kiriakos and Tienari, 2018) – in practice, in our pursuit of knowledge-making (Martin et al., 2015; Puig de la Bellacasa, 2012). My writing style is affective yet scholarly, not academic in a traditional sense, but crafted with love and care – as modes of attention – foregrounding what can be known differently through how we write, as well as what we choose to write about.

I understand the risks in embodied, sensuous, emotional, social, and identity-related inquiring (Kiriakos and Tienari, 2018): that my words are less intellectual, authoritative. However, I regard writing as an ethical practice, taking responsibility for the transformative impacts my words, actions, and gaze may have. The quote from Haraway on page iii of my thesis has served as provocation and reminder to choose and use my words carefully. Sheena Vachhani (2015) describes such writing as a practice of 'feminine poetics', in contrast with the academic demand for theory and 'authorisation'. Vachhani (2015) continues, a feminine stance is more a critique of discounting the unnameable in how we might see organisations and organising.

Until my PhD, I had few direct encounters with the NHS in my adult life. The occasional visits to the doctor, even rarer trips to an emergency department. Over the last four years, there has been an intertwining of personal need and research interest, as my own health and research exposed me to the frontline, and behind the scenes of this frontline world, of Primary and Secondary Care. I was experiencing chronic and long-term effects of the perimenopause. After months of deliberation, I started using hormone replacement therapy (HRT) in late 2019, only to wish I had done years sooner. In early 2020 I underwent tests for ovarian cancer (all clear). In mid 2021, after 48 hours of unceasing abdominal pain, I was admitted to hospital for an emergency total hysterectomy with bilateral salpingo-oophorectomy and signed off sick for two months. I was now in surgical menopause. In 2022, like for many thousands of menopausal people in the UK, the prolonged national shortage of transdermal HRT (Breen, 2022) was a source of panic and distress. Later in 2022, more abdominal pain, another consultant…

My experiences as a 50-something / mixed heritage / cisgender / post-menopausal woman are material, as they inform how I notice and theorise from my empirical and resonant experiences. My inquiry is ‘confessional’ (van Maanen, 1988) and ‘transgressive’ (St. Pierre, 1997), not to reify my position and perspective but because thinking and writing this way highlights aspects of what is under investigation that may not otherwise have been noticed. I am an agentic and intimate participant in every encounter (Barad, 2007; Mazzei and Jackson, 2017).

Those parallel dynamics were present when I sat shadowing a group of administrators, for example, wondering which of them were also going through the menopause, noticing when one of them had a hot flush; in 1:1 conversations with participants being told of times when one of them walked around the grounds of a hospital unable to find the right building where a meeting was taking place, despite having been there many times before but feeling confused and overwhelmed; when a participant told me about their partner’s infidelity and the existential crisis they underwent about their own judgement, identity, and value.

Structure of this thesis

I investigate how caring is experienced and theorised processually. My thesis is oriented around two interrelated curiosities – how might I travel with inquiry as an emerging and diffractive process, including in its writing up, and what might be discerned about practising and theorising caring from a processual stance?

In chapter 2, I outline the developing logic of my inquiry from a methodology informed by classical pragmatism and social poetics, and with a focus on collaborative action methods as I researched collaborative public leadership, to a more speculative and diffractive inquiring, as my understanding of process deepened, and I immersed myself in caring practice. My main point is that when undertaking research processually, methods and methodologies can impede travelling with mobility and emergence in the process of inquiring. However, a working logic is still required to provide coherence in the developing argument.

In chapter 3, I situate the empirical and conceptual contexts of care, outlining my research sites and healthcare participants, and the scope of the original study. I discuss care as work, and care as practice, and the ethics of care, and the limitations of these literatures from a process perspective. Caring as doing is arguably a more processual and performative way of thinking about care in practice. For this reason, I depart from the language and theories of care ethics, and a relational ontology.

In chapters 4, 5, and 6, I interweave empirical experiences, how care ethics literatures might interpret them, and how diffracting through pragmatism, nursing theory, moral philosophy, and feminist technoscience offer a more processual and generative way of following caring in practice.

Chapter 4 introduces attuning as noticing and being moved by perplexing feelings in each situation. All our feelings have ethical potency, in that they alert us to difference. Practising caring invites ongoing attention to how we find ourselves troubled in social encounters. Chapter 5 discusses inquiring as being mobilised by our perplexities (brought into awareness through attuning). It is pluralistic and future oriented, which is less about expertise and practices. Chapter 6 explores coattending as a collaborative process of participating in consequential action. It changes the immediate situation and can have world-making affects / resonances.

In chapter 7, I move to theorise an ‘ethos of caring’ as response-able practising: attuning, inquiring, and coattending to the entangled flourishing of ourselves, others, and our worldings. My argument is that in theorising and practising caring, we need different language and vocabulary: generative, performative, and rooted in everyday experience as it is experienced. I discuss the implications and contributions of my ‘findings’ for theorising and practising.

In chapter 8, I suggest possibilities for future inquiries, inviting caring practice into wider discussion with organisational scholarship, and revisit my ongoing processual development and how I am becoming differently.

Whereas conventional doctoral theses are evaluated for reliability, generalisability, and contribution to knowledge, I imagine three alternative criteria: congruence to processual logic, fidelity to a multiplicity of unfolding experiences, and generativity as a stimulus for action and ongoing discussion.

There are necessary expediencies in writing a doctoral thesis for examination, as well as opportunities for knowing differently. Committing a processual inquiry to words and a familiar(ish) presentation with given meanings/interpretations comes with the possibility of not fully encapsulating temporal, conceptual, and experiential vitality and potency that eludes description, but not experiencing.

In the next chapter I introduce the logic of my inquiry and how it responds to the expected rigours of methodology, including ethics, data, and methods.

Chapter 2 – logic without method(ology)

Introduction

This chapter outlines the evolving processual logic of my study. It traces my travelling from a collaborative action inquiry into leadership practice, and 'familiar epistemological process research' (Simpson and Hond, 2022) to an 'ontological realm of inquiry' (Shotter, 2015) and 'thinking without method' (Jackson, 2017), and its implications for my study. My pre-COVID-19 methodology was informed by classical pragmatist philosophy, social poetics (Katz and Shotter, 1996), and participatory methods, in a design I named 'conversive encounters'. This logic – and its associated fidelity to experience – informs the orientation for everything that follows, including my subsequent argument (elaborated on in chapter 7) about an alternative language and vocabulary of caring.

As I outlined in chapter 1, my leadership study was no longer viable due to the early cessation of my fieldwork. This had consequences for my entire doctoral research plan, calling me to question whether it was possible to continue and in what form.

During the first lockdown in 2020, I was reading, thinking, and living with Mol, Addams, Dewey, Shotter, Simpson, Barad, Pickering, and Haraway. These voices – along with the reimagined encounters with my organisational participants – encouraged me to move away from the language and practices of methods and methodologies, which *"minimise, quantify, and aggregate, and devalue alternative approaches that expose the complexities and contradictions of organising as well as living and relating with others"* (Gao et al., 2022). By that I mean that my study seemed no longer viable if I were to persist with defined methods to interrogate what 'little' leadership data I had. Rather than a methods-led approach, I realised I needed to focus first on experience, finding alternative approaches and ways of seeing what comprised data.

This led me to an appreciation of inquiring beyond method/methodology, as an ethical process of 'mattering' (Barad, 2007), rather than a more instrumental, methods and methodology-led project. I call this process 'diffractive inquiring' (DI), and it is a logic informed by classical pragmatism and feminist technoscience.

I start by discussing conversive encounters, which brought together pragmatism and social poetics to investigate the practice of collaborative public leadership. Dewey's logic of inquiry was a core principle of my original design, and so I explore how my understanding and use of inquiry evolved in response to the emerging situation I found myself in. This deepening understanding – alongside coming to understand process as ontology rather than epistemology for my study – had implications for my research logic, methods, data, ethics, and theorising. I outline how these all changed as my focus moved from leadership to practising caring. I then introduce diffraction which, alongside inquiry, now informs the logic of my study, in a stance I called diffractive inquiring.

Conversive encounters

This section outlines my original research method – conversive encounters – and the ideas that informed its design. It shows my early understanding and application of research logic, to then discuss how I developed to complete this study. This is important because my inquiry logic is now inseparable from analysing/theorising.

Despite an acknowledgment in qualitative research there may be limited knowledge about a phenomenon, research is often framed in the context of uncovering constructs, variables and relationships to generate testable theories (Johnson and Harris, 2002). Even if the question is loose, it must still be geared towards definitive knowledge. I knew my inquiry was intended to study collaborative leadership in practice and from practice. While there are gaps in the literature, not least the partial theorisation of Leadership-as-practice (L-a-p, which comprised the theoretical context of my initial research) (Collinson, 2018a, 2018b), and few empirical studies to substantiate L-a-p’s claims (Kempster et al., 2016; Raelin, 2018), I felt constrained by the prospect of entering the field with a pre-determined question. I believed it might stifle spontaneity and co-creation with my participants, as well as looking for specific things at the expense of other phenomena. In addition, as an experienced organisational (process) consultant, it ran counter to how I was used to working.

There have been challenges to this paradigmatic way of thinking, with calls for a return to philosophically-informed inquiries that call into question constructed discourses (St. Pierre, 2011), and scholars proposing a ‘third way’ methodological orientation for organisational research (Chia, 2002; Elkjaer, 2004; Martela, 2015; Morgan, 2014). Classical pragmatism has been offered by some as one such third way. However, this categorisation still appears to be an attempt to define it as a research paradigm and situate it in the context of other research paradigms; perpetuating a dualism that pits one (desirable) approach in opposition to others.

There are so many troubling dualisms, Haraway (2004: 35) reminds me: self/other, mind/body, culture/nature, male/female, civilised/primitive, reality/appearance, good/bad, whole/part, agent/resource, maker/made, active/passive, right/wrong, truth/illusion, and total/partial. Can I possibly spot and challenge them all? What other dualisms might I create? All these approaches set boundaries around theoretically-informed knowledge claims, whereas pragmatism is guided by lived experience rather than theory (James, 1912). And yet boundaries still exist within pragmatism, even within the totality of a situation. Barad reminds me that my work here is creating a semantic boundary, which is less about words and more about the worlds I create. It is a performative act.

If one accepts that paradigms are epistemological strategies that emphasise different representations (therefore creating dualisms), reifying one particular methodological discourse (Shepherd and Challenger, 2013), I wondered what might be possible if a researcher chose to step away from this rhetoric by reimagining the research endeavour as polyvocal (Bakhtin, 1981; Belova et al., 2008; Paulson, 2020; Sergi and Hallin, 2011), future-forming (Gergen, 2015; Nayak and Chia, 2011; Paulson and Strainchamps, 2019) empiricism that integrates ontological, epistemological, and axiological concerns with its own 'scientific' logic? Insofar as I understood what process meant, I decided to undertake a process study.

What makes a processual ontology distinctive is that it offers a way of experiencing, rather than a specific theory, inviting us to see us and our world as entangled and continuously in the making; and with a multiplicity of possibilities, participants and perspectives (Helin et al., 2014), which positivist (or realist) critics might argue is at odds with scientific inquiry. At the heart of a becoming (processual) ontology is the notion that change is ongoing. People and things (such as organisations and social entities) have emergent and temporal dimensions. This does not mean that stability is non-existent, but rather phenomena are continuously created, maintained, and sustained so that we can experience (and change) them. A point of interest for the processual scholar is *how* these creations emerge and change, rather than what they are.

To achieve this, I constructed a methodology informed by pragmatism and its concern for *"…the flow of experience and processes of mutual transformation ... ontologically processual, and epistemologically conversational and relational"* (Simpson and Lorino, 2016: 66). In this context, classical pragmatism, bringing together practice and theory in mutually informing and creative interplay, offered a more generative way of inquiring beyond the 'constricting influences' of paradigms (Bernstein, 1971: 170). The guiding principle is experience: *"to try to interpret each notion by tracing its respective practical consequences"* (James, 1907a: 45) where:

"we cannot in any way reach perfect certitude nor exactitude. We never can be absolutely sure of anything" (Peirce, 1994: 1.147).

I was informed by concepts of inquiry (Dewey, 1939), abduction (Brinkmann, 2014; Fann, 1970; Locke et al., 2008; Peirce, 1878), conversational trans-action (Lorino, 2018; Simpson and Lorino, 2016), the situation (Brown, 2019; Dewey, 1939; Mackay, 1942), community of inquiry (Shields, 2003), practical knowing (Dewey, 1929; Dewey and Bentley, 1950); and concepts of social poetics, arresting moments and withness thinking within conversational realities (Cunliffe, 2002; Katz and Shotter, 1996; Shotter, 2006, 2010b, 2012, 2015; Shotter and Katz, 1996).

I was interested in using, or developing, a method that followed every day talk as it happened in workplaces rather than special designed 'events' such as workshops. I knew it was unlikely that my participants would have the time to commit to anything other than allowing me into their workplaces as they went about their tasks or attended meetings. Influenced by Patricia Shaw's idea of 'working live' (2002) that focusses on people's capacity for participating in the conversational activity that constitutes life in organisations, and Deidre Boden's (1994) proposition that organisations are 'run through talk', I sought a method that paid attention to the generative conversational dynamics of organising as they happened. That is to say, the conversational flow brings into existence some form of change: in understanding, relationship, and praxis. To that end, the pragmatist idea of 'trans-action' (Dewey and Bentley, 1950), later stated as conversational trans-action (Simpson and Lorino, 2016) offered a theoretical basis to explain my endeavour.

Such an empirical attitude may only yield 'limited, partial and situated results' but could be of far greater practical use (Shotter, 2017: 83). I believed my inquiry should yield intellectually robust and practical assertions, even if I diverged from concepts of 'theory' and definitive 'knowledge'. The study also built on writing as a dialogical engagement (Gergen, 2009b; Helin, 2016), where my thesis would become part of a wider conversation about collaborative leadership. Central to this idea was the suggestion that data generating and analysing are in ongoing dialogical interplay as knowing emerges and develops performatively and intersubjectively.

Conversive[5] is an adjective with two meanings: 1. capable of being changed and 2. ready to converse. The design – the conversive encounter – involved shadowing (Czarniawska, 2014b; McDonald and Simpson, 2014) and an adaptation of co-operative inquiry (Heron and Reason, 2001, 2011). It recognised the interplay of generating and analysing 'data' ongoingly in changeful situations, with a particular focus on 'arresting moments' (Cunliffe and Scaratti, 2017; Shotter and Katz, 1996) as signifiers of new learning in action, to be assembled processually in an interwoven account.

Introducing inquiry

In this section I introduce the pragmatist concept of inquiry[6]. It is a foundational idea for this study – along with diffraction, which I discuss later in this chapter – informing not only my original research design, but also the logic of the entire thesis and theorising of empirical experiences.

What I saw was people responding to uncertainty: a process did not work as planned, a task was performed in a way that a colleague thought inappropriate, someone wondered what expertise and insight was absent from a meeting, a group co-creating a new process using the knowledge and resources of who was in the room, disagreement about what resources were needed and who should get a share of them, people talking over each other in a meeting shutting out the quieter attendees. Uncertainty alongside the need to take the next step. Tensions between

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[5] https://www.webster-dictionary.org/definition/Conversive

[6] I favour the US English spelling of 'inquiry' in this thesis, rather than British English 'enquiry', noteworthy as my thesis is written in British English. The main reason is due to Dewey's Logic of Inquiry, a foundational concept in my study. I considered using inquiry when I was referring to the Deweyan process, and enquiry for more informal 'investigations'. However, in US English inquiry can be both formal and informal.

those who wanted to act first and rationalise later, and those who wanted to plan for every eventuality before taking any action. I was on this journey alongside them, also uncertain about my next steps as well as theirs, my identity as a researcher as some participants questioned who they were in this healthcare transformation, a tension between going with the flow of whatever happened versus a more instrumental planned approach to what I might do when I arrived on site.

These encounters might be thought of in theoretical terms as problematic situations: beliefs or ways of working that are becoming problematic may be examined and resolved through action. This 'indeterminate' situation is central to Dewey's logic of Inquiry (1939): *"the transformation of an indeterminate situation into one that is so determinate in its constituent distinctions and relations as to convert the elements of the original situation into a unified whole"* (Dewey, 1939: 167). Inquiry is a dynamic, dialogic (James, 1907b) and self-correcting (Bernstein, 1971: 177) social process of transformation to ongoingly change conditions within a given situation.

Facts and ideas are judged according to their instrumental usefulness in bringing about change, not only their coherence with one another, or the reliability with which they are produced, but their adequacy in resolving uncertainty. The aim of inquiry in everyday life is the emergence of tentative yet actionable, future-forming possibilities. There is no inquiry that does not involve the making of *some* change in conditions (Dewey, 1939: 34).

The potential to initiate and enact change does not rest solely with those in positions of authority or seniority but can be taken up by those who collectively respond to the need for a situation (such as a task, ways of working, or shared beliefs) to alter in some way. Arguably, those with lived experiences of what is problematic about a situation have a perspective on what needs to be done that others may not (Addams, 1902). But there are no spectators in inquiry – all participants are active experimenters in a dialogic and creative process.

The collaborative dimensions of inquiry were of particular relevance for my study; in part to acknowledge the intersubjective dynamics as my participants co-created their futures, but also my relationally-responsive participation (even as a researcher) in the co-creation of the change. While it may not have always been deliberately instrumental, by virtue of being in the room I was aware that sometimes the conversations and reflections, while perhaps a performance for me, were also future forming for the participants. A further idea I drew upon from the canon of pragmatist concepts for the articulation of conversive encounters was the ‘community of inquiry’.

The concept of community of inquiry has been distilled from the writings of Dewey and Addams (Shields, 2003) an organising principle that Patricia Shields applies to diverse public administration contexts. Common to all communities of inquiry are a problematic situation, scientific attitude, participatory democracy, spirit of critical optimism, open-ended quality, and a role for facilitation. My field study consisted of a few small projects. Some of the groups were organisational teams who worked together on a day-to-day basis, others were programme-level teams where the participants came together in meetings to progress the aims of the transformation programme they were implementing. I suggest that by agreeing to become participants in my study, there was an openness to scientific attitude and participation such as that each project might be thought of as its own community of inquiry: inquiring within its own related dynamics of change and transformation.

Dewey developed the ideas of Charles Sanders Peirce, who saw an individual’s doubt as the basis of inquiry to develop practical ways of coping (Elkjaer and Simpson, 2011; Locke et al., 2008; Lorino, 2018). The problematic situation – an interweaving (Follett, 1924) ‘contextual whole’ of multiple connected objects, circumstances, and events (as forms of data) through which we can make sense of the whole (Brown, 2012: 269, 2019) – is the starting point for critical thinking. Dewey's concept of situation is central to his logic of Inquiry although what that has been taken to mean in use is the subject of some debate (Brown, 2019), from conceptions of the whole universe to a stream of situations.

In terms of my own research, although there was an overarching strategic context there was no 'whole' that can be made sense of in a health care system comprising small businesses and independent contractors, public bodies and third sector organisations, informed by public policy and legislation, as well as the care giving orientation to patients with individual needs and circumstances. Nor was my intent 'sensemaking' in terms of the development of knowledge: generalisable theories or truths about organisational learning or change. My research inquiry comprised multiple interrelated encounters: sites of activity and inquiry where transformation was happening, which I planned to analyse as fluid conversive encounters. To that end, my study considered the research endeavour as one situation, albeit responding to changing health and legislative circumstances in different ways.

John Brown (2019: 14) highlights that while Dewey's references to a 'unified whole' may infer some kind of normative success, Dewey (1939) reminds me of Peirce's maxim: the fallibility of an experimental attitude. Instead of knowledge, Dewey (1939) wrote of 'warranted assertions', the outcomes of using a belief in practice, in which knowing cannot be separated from doing. In this context, the knower and the known are inseparable, bound together in a process of inquiry, with a simultaneous reliance on both belief and action (Dewey and Bentley, 1950).

Inquiry is scientific as it has systematic attitude (Brown, 2012, 2019; Dewey, 1939; Elkjaer and Simpson, 2011; Lorino, 2018; Morgan, 2014; Shields, 2003) and coherence to its own norms (Bernstein, 1971), ideas becoming true through experience rather than having inherent truth (James, 1907b: 142); with inquirers working through non-linear phases of problematising, hypothesis building, reasoning, experimenting, and analysing experience (Vo and Kelemen, 2015). Brown (2012: 285) highlights that elsewhere in Dewey's writings there is an emphasis on observation as the first step to determine the facts of the case, which then set the terms of the problem.

In developing his logic of Inquiry, Dewey also built on Peirce's proposition (Fann, 1970; Lorino, 2018) that an inquiry grounded in experience uses an abductive explanatory, or 'working hypothesis' logic of discovery, for *"deduction proves that something must be; induction shows that something actually is operative; abduction merely suggests that something may be"* (Peirce, 1994: 5.171).

Dewey's logic of Inquiry engages abductive, deductive, and inductive logics as an integrated experimental (scientific) method, which may be experienced as groups move through stages of uncertainty to action. Following Frank Martela (2015) and Svend Brinkmann (2014), I understood my logic in the field might be more abductive, to hold on to a stance of 'what if' thinking. In addition to this empirical grounding, abductive logic offers creative potential (Locke et al., 2008; Simpson and Lorino, 2016), by working to find new ways of seeing and acting. It calls upon me to challenge previously held assumptions (Locke et al., 2008).

Logic, without method(ology)

By 'logic' I follow Dewey's (1939) assertion that it comprises inquiry conditions which are progressive (using the best 'methods' available and not solely what has come before), operational (combining concepts and practice), postulative (capable of leading to tentative but sufficiently stable beliefs), naturalistic (emerging from lived experience), and social (situated within a context and culture). I use Dewey's logical theory to construct a logic for this study, informed by theory and prior logics, but not a facsimile of other methodologies and their associated methods. By logic I mean a set of principles that inform the coherence, rigour, and claims of my inquiry.

This section highlights how my methodological understanding evolved, and how this impacted my understanding and practice of aspects of inquiry. I take inspiration from scholars who posit that thinking without method relieves *“qualitative inquiry from the twin forms of epistemological imperatives of knowledge production and a conventional dependency on procedural method”* (Jackson, 2017: 666). Alecia Jackson continues that the starting place for thinking without method is always in the middle of the unexpected. As I explain, this is where I found myself, starting my research *in media res*. Sub sections cover developments in my understanding and practice of logic, methods, data, ethics, and theorising. These are all typical components of ‘methodology’, and I show how I depart from more conventional applications, and why, in my processual logic.

Abduction, empiricism, and diffraction (logic)

Pragmatism as a ‘philosophy of practice’ is *“…concerned primarily with the flow of experience and processes of mutual transformation ... ontologically processual, and epistemologically conversational and relational”* (Simpson and Lorino, 2016: 66).

This articulation summarised my understanding of Pragmatism for the development of my study. I discerned three leitmotifs within Simpson’s and Philippe Lorino’s definition – performativity, intersubjectivity, and processuality – that I adopted to ensure congruence in my own research logic, from design to analysis. A leitmotif is a dominant recurring theme associated with a particular idea, person, or place. The term was popularised in Wagnerian opera but is now used more widely *“to bind a work together into a coherent whole, and to relate a story without the use of words, or to add an extra level to an already present story”*[7].

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[7] https://www.merriam-webster.com/dictionary/leitmotif

By performativity I sought to emphasise the potential for language and gestures to be agentic, where making an utterance is the performing of an action (Austin, 1962: 6), which goes beyond talking about action, and future forming in its concern for the future consequences of the actions and choices that are taken in the present (Simpson and Hond, 2022). In developing John Austin's idea, and with particular reference to intersubjectivity: *"Lone utterances begin to acquire meaning when another (or others) coordinate themselves to the utterance, that is, when they add some form of supplementary action (whether linguistic or otherwise) …we see that meaning resides within neither individual, but only in relationship"* (Gergen, 2009a: 4). I saw performativity as a collaborative process, as two or more people engaged in conversation and subsequent action.

Intersubjectivity, as I understood it, emphasised two aspects: a 'withness' orientation that saw the researcher as a co-creator of the conversational reality; and that the performative interplay of practical knowing and doing happens across the spaces-in-between, where we are *"selves in relation to others and so all of our experiences are social"* (Cunliffe, 2008: 208). This intersubjectivity can be thought of in pragmatist terms as trans-action.

Finally, processuality suggested that organising (distinct from organisation) is a continuous state of becoming (Nayak and Chia, 2011; Tsoukas and Chia, 2002) as sites of human action in which, through the ongoing agency of its members, organising emerges. Change, not stability, is the ongoing 'state' of our world (Cabantous and Sergi, 2018: 1238). I now see how the use of 'state' is problematic from a processual perspective, implying stability and structure. It brings home to me again the difficulty in expressing the ongoing fluidity and emergence that a processual ontology affords, and how this dynamism can be stifled through language. It has also been a source of vexation when there is a seeming conflation of entitative and processual thinking. How can I become clear?

As elegant as I thought these ideas were, they needed a rethink post lockdown and the emerging situation I found myself in. I also realised that my logic was incongruent in its pursuit of analysable ‘data’ that could be interrogated for themes. These were ‘representational epistemologies’ (Simpson and Hond, 2022: 138), intended to uncover ‘facts’ from the rubble of dialogue, conversation, and talk.

I still understood that I needed to analyse what data I had so that my research could continue, but what I had did not seem to be the stuff of static or objective analysis. My notes, and remembrances of my time in the field, included the ‘ordinary affects’ of everyday organisational experience (Stewart, 2007) – meetings, lunchbreaks, answering the phone, making cups of tea, and printing payslips etc – in all its transgressive multiplicity and the ‘troubling subjectivity’ (St. Pierre, 1997, 2011) of sensory experience. Following Silvia Gherardi (2017b), I wondered about the ‘atmospheric’ potency in these affects, what worlds – what caring dynamics – were these quotidian aspects calling me to notice that went beyond talk.

Given the centrality of verbal communication in original inquiry, prior to lockdown, I had considered four approaches to analysing my material: dialogical sensemaking (Cunliffe and Scaratti, 2017), conversational analysis (Garfinkel, 1967; Heritage, 2011; Samra-Fredericks, 2004; Wilkinson and Kitzinger, 2017), narrative inquiry (Boje, 2000; Czarniawska, 2007; Hunter, 2010) and frames/framing (Carroll and Simpson, 2012). None of these were suitable in this emerging situation – my data did not contain dialogical or conversational exchanges. I had planned to audio record sites visits once my participants and I felt more comfortable around each other, however due to lockdown we never reached the point where I recorded.

I explored the critical incident technique (CIT) (Chell, 2004, 2015). The perceived ‘critical incident’ comprises ‘intangible phenomena’ such as an emotional event in the life of a person or an organisation. They are ‘critical’ in the sense that they are indicative of underlying trends, motives, and structures that have a more general meaning and indicate something of importance in a wider context. CIT strengths were its explorative and theory building potential, its flexibility, and its practical applications. Its limitations were its search for patterns in the incident, and its outsider stance.

Months after my formal fieldwork ended, my curiosity was about how caring was/is unfolding as a social process. What changed about the encounters is how I re-experienced them, now and ongoingly, and how I used field notes and my recollections to think, read and write. My intention was not to categorise them into something coherent and definitively knowable but to enliven entanglements (dynamic configurations), and to leave space for future resonances and memories of caring. Conventional research methods minimise, quantify, and aggregate, and devalue alternative approaches that expose the complexities and contradictions of organising as well as living and relating with others (Gao et al., 2022). I then stumbled across diffraction (which I discuss in the following section).

Through diffraction, I saw the potential to explore how empirical experiences might be understood through the effects created by difference (caring), from my position as entangled and embodied observant participant and research instrument. How is caring the difference that makes a difference here? How are these differences connected and co-constituted? This made me ponder whether these ordinary affects that had held my attention in the field had the potential to tell me something about caring, as a social process, rather than seeing care only in the content/practice(s) of what was being done.

Diffraction's animating principles of *generativity* and *emergence* are sympatico with Pragmatist concepts of 'inquiry', 'fallibility', 'mutability' and 'situation' (Dewey, 1939), 'abduction' (Fann, 1970; Locke et al., 2008), 'stumbling' (Brinkmann, 2014), its questioning of dualisms/binaries and reimagining of space and time (Simpson, 2009, 2018; Simpson and Hond, 2022), as well as ‘withness thinking’ (Shotter, 2006), concepts I am experimenting with that call upon us to notice differently.

Diffraction enabled me to relive my empirical encounters as historic events, to create speculative fables as temporally unfolding situations for, as Barad (2014: 168) writes, in diffraction there is no absolute boundary between here-now and there-then. I think of this as fidelity to experience, inspired by James’ (1912) idea of ‘radical empiricism’, by which he meant *“empiricism must neither admit into its constructions any element that is not directly experienced, nor exclude from them any element that is directly experienced”* (1912: 42). A process ontology affords me the potential to see diffraction as more than an alternative analytic approach to coding and other interpretive analytic practices that seek out, group and valorise sameness in the quest for order and stability, essentialising human (and only human) experience in the process of representation (Jackson, 2013; Mazzei, 2014).

For organisational scholars, consultants and practitioners, a diffractive way of noticing, situated within a processual ontology, means shifting our attention from discrete *things* like ‘leaders’ and ‘organisations’ to agentic processes *“emerging within material intra-actions occurring within the flow of activities occurring out in the world at large”* (Shotter, 2015: 75).

What this means to me in practice is that diffraction exemplifies an abductive logic (Simpson and Hond, 2022), re-tuning sensitivities towards previously unnoticed, but generative, aspects in situations. Diffraction enables us to become speculative and experimental, including our own involvement in a situation, even as an ‘observer’.

Karen Locke, Karen Golden-Biddle and Martha Feldman describe abduction as the *“search for possible explanations to an experienced anomaly”* (2008: 908), where the ‘situation’ is characterised by feelings of doubt and uncertainty. It is enacted through spontaneity and ‘what-if’ thinking in response to the continuous unfolding of unanticipated events, taking me to ‘new places’ (Agar, 2006: 60), and to different knowing (Simpson and Lorino, 2016).

Dewey’s logic of inquiry is rooted in experience, or the world of practice, so too is abduction. A logic of abductive (plausible hypothesis), deductive (testable proposition), and inductive (empirical protocol) reasoning (Simpson and Hond, 2022; Simpson and Lorino, 2016) brings together uncertainty, collective action and experimentation to restore comprehension (practical knowing) such that the task can continue (until the next uncertainty). Warranted assertions are interpretive outcomes of inquiry that we might act upon, yet remain always open to be changed in the future (Martela, 2015). However, this logic is not straightforward or linear, and apparent blind alleys are part of the process of discovery.

It could be suggested that the Inquiry principles I outline above have some similarity to forms of Grounded Theory (Charmaz, 2006, 2008; Locke, 2010), with its *“systematic, yet flexible guidelines for collecting and analysing qualitative data to construct theories 'grounded' in the data themselves”* (Charmaz, 2006: 2). Citing its Pragmatist influences, Virpi Timonen, Geraldine Foley, and Catherine Conlon (2018) outline the shared core of (1) remaining open to new unanticipated findings by staying grounded, (2) capturing and explaining context-related social processes, (3) pursuing theory through engagement with data, where engagement with data is itself another form of data; and (4) while fully-fledged theory might not emerge there still needs to be a commitment to surfacing real truths.

Grounded Theory is systematic (*inductively* so) in leading to substantive theories generated from data that have conceptual density and durability over time (Charmaz, 2006). This positivist stance (*what* questions) has been challenged, including by Kathy Charmaz (2008), who proposed an approach to answering *why* questions that reify the voices and concerns of the participants. She summarises this approach to Grounded Theory as (2008: 403): treating the research process as a social construction; scrutinising research decisions and directions; improvising methodological and analytic strategies throughout the research process; and collecting sufficient data to discern and document how research participants construct their lives and worlds. More iterative approaches to Grounded Theory attempt to capture the realities of processual research (Orton, 1997), although they still move between inductive and deductive logics in a ‘loosely coupled system’ of techniques to generate theoretical claims.

At first there appears to be some congruence between Charmaz’ position and my own goals. I note that Martela (2012), a pragmatist scholar, used Grounded Theory for his doctoral research. However, the words in italics in the paragraph above – inductive, what and why – signify a fundamental divergence between the intention of using Deweyan-informed Inquiry and the dominant approaches to Grounded Theory. While Deweyan Inquiry works with abductive, deductive, and inductive logics to generate ‘warranted assertions’ to inform tentative action, my primary logic was *abduction*: being guided by the effect and affect of ‘difference’, and ‘what if’ thinking. Grounded Theory generates theories.

Fidelity to experience (methods)

Throughout my career I have always maintained an interest in lived experience, and the meaning we make from experience, and at the same time I have ‘act hunger’ (Moreno, 1978), a drive for action; a by-product of 30 years’ work experience as well as a personal motivation to be a catalyst for change. These two ‘pulls’ – towards understanding and towards action – led me to explore including Complex Responsive Processes (Griffin, 2002; Stacey, 2001), practice-based studies (Gherardi, 2012; Nicolini, 2012; Nicolini et al., 2003), Science and Technology Studies (Czarniawska, 2008; Latour, 2005; Law, 2004); and Social Constructionism (Cunliffe, 2008; Madsen et al., 2018; Shotter and Katz, 1996) for suitable research methods. They are related insofar as they call upon the researcher to situate their gaze on experiences as they happen between people. However, their ontological foundations differ, as do their methods, researcher-participant relationships, and subsequent knowledge claims.

Pragmatism is not a single doctrine or even a set of tenets but a living tradition of thought with multiple, often conflicting, theorisations (Bacon, 2012; James, 1907a; Lovejoy, 1908a, 1908b; Rescher, 2000; Simpson and Hond, 2022). What these diverse understandings share is a commitment to social progress through participative action and empiricism. I situated my inquiry within Simpson's (2018) definition of pragmatism as a 'philosophy of practice', with its focus on action and change, placing participation and learning at the foundation of that change. Meaning and action are the basis of experience; a different perspective from the scientific separation of knowledge from action that Dewey suggests has hindered social progress (1929).

My original design comprised an exploratory project with focus on participatory, change-oriented research design, used to explore experience, meaning and perspective, from the standpoint of the participants. It brought together shadowing and collaborative inquiry, informed by the principles of Action Research (Bradbury and Reason, 2003; Heron and Reason, 2001; Kagan et al., 2010), namely its collaborative nature, egalitarian approach to power and learning in the research process, and emphasis on taking action on an issue: *"…an approach to human inquiry concerned with developing practical knowing through participatory, democratic processes in the pursuit of worthwhile human purposes, drawing on many ways of knowing in an emergent, developmental fashion"* (Bradbury and Reason, 2003: 108). This interplay of learning and action is central to pragmatism as an 'empirical attitude' that requires language and gestures as forms of mediation between people. Action Research was also familiar in health and care (Waterman et al., 2001), and this was another important design principle for me so that my participants might feel more comfortable.

Shadowing is a highly contextual way of studying the work and life of people who move often and quickly from place to place. It differs from traditional ethnography, which assumes a more static environment (Czarniawska, 2014a: 92). It offers the means to triangulate not only what subjects say they do, but to be present as actions / interactions play out (Sutherland, 2018). Even the word 'triangulate' highlights the burden of proof in making valid claims.

In 1966, John Berger – cultural thinker, art critic and author – spent six weeks shadowing his GP. In *A Fortunate Man* (Berger and Mohr, 1967), Berger recounts his observations of 'Dr Sassall' in rural England practising medicine to heal rather than medicate his patients. Healing was of the whole person, as a member of a community with shared memories and experiences, culturally and economically deprived, where the doctor strove to *become* his patients so that he could better understand them and how they might each find comfort.

Berger's study was focussed on the GP, perhaps creating (or reinforcing) a romantic image of the lone (male) maverick and shamanic healer; both part of and clearly differentiated from the community. There is no reference, beyond a cursory acknowledgement, of Sassall's family, and no mention of his surgery colleagues and other health professionals. Perhaps this narrow focus was of its time, despite Berger's socially progressive views. My intent was to widen the focus to all involved in the planning and delivery of Primary Care: not just other health professionals, but administrators, receptionists, and practice managers.

The structure of the collaborative inquiry would build on the ideas of Shotter, Kenneth Gergen, Peter Senge and Otto Scharmer, John Heron, and Peter Reason, the dialogical action research ideas of Ann Cunliffe and others, as well as Heron's writing on facilitation. Its purpose would be generative, to support the participants' sensemaking about collaborative leadership and to create actionable insights that might be of value for the entire Health and Social Care Partnership. I acknowledged my own need to be ‘useful’ in some way to the organisation under study, as well as their hope to gain something from the research.

Simpson now articulates pragmatism as a ‘philosophy of experience’ (Simpson and Hond, 2022), characterised by a commitment to process and emergence, an experimental approach to knowing, and an awareness that the meaning of actions are shaped by anticipated consequences. This shift in emphasis was significant for me as it widened my epistemological understanding. Pragmatism could help me make sense not only of practice(s) but the breadth of social experience in the totality of a situation, including feelings, relationships, embodiment, non-human participation, as well as the quotidian.

Such inquiring develops sensitivities towards previously unnoticed aspects of circumstances that are there to be seen. This realm of inquiry, Shotter says (2015), enables us to turn from ‘words of meaning’ to ‘worlds of meaning’, to the situation as a whole. Barad (2007: 149) gave me a similar perspective, that *“meaning is not a property of individual words or groups of words but an ongoing performance of the world in its differential dance”.*

Two Deweyan concepts took on new significance during lockdown: situation and inquiry. I had previously imagined that situations might be crisis points that stalled progress, and where all participants saw the ‘problem’ and knew something needed to change. In this context, the situation – and inquiry – was a dialogic process. The situation, according to Dewey (1939), is the contextual whole. It is not just isolated effects, objects, and actors in each context, but more than the sum of these parts. Inquiry for Dewey is a collaborative process of transforming an ‘indeterminate’ situation. This deepened understanding also had implications for what might constitute ‘data’, beyond observable practices and activities.

Generativity in troubling situations (data)

Social Poetics (Cunliffe, 2002; Cunliffe and Scaratti, 2017; Katz and Shotter, 1996; Shotter, 2010b; Shotter and Katz, 1996) draws attention to taken-for-granted ways of talking. It emphasises the responsiveness of talk as it happens between people and the performativity of talk, where meaning is fluid and contextual. Of relevance for my study was the idea of 'arresting moments' (Katz and Shotter, 1996), where, in the conversational interplay, we are struck, re-oriented or moved to respond in a different way (Cunliffe, 2002), perhaps by something hitherto unnoticed. Another significant concept was 'withness thinking' (Shotter, 1993, 2005, 2006, 2009, 2012, 2014), where one functions as a participant within the very phenomena one is inquiring into.

Social Poetics and the wider body of work on conversational realities, or 'knowing from within' (Shotter, 1993, 2006, 2012) seemed to offer me an approach to focus on the conversational dynamics of inquiry, and as a way of making sense of the interplay (for later analysis for example). My field notes contained very little conversational data, however, as I have explained.

My deepening understanding of the totality of a situation was helpful because it enabled me to widen my understanding of data beyond the dialogic or discursive – a focus for interpretivist scholars – to include the 'ordinary affects' of relations, scenes, contingencies, and emergences (Stewart, 2007) in all its transgressive multiplicity and the troubling subjectivity of dreams, emotions, and sensory experience (St. Pierre, 1997, 2011). These everyday relational and situational dynamics unfolding within prosaic tasks, activities, and preoccupations are overlooked by many organisational scholars. For me, they were vivid and potent remembrances that I did not want to dismiss.

Following Dewey and Bentley (1950), I now understand these experiences as generative and participatory *knowing* – mutable, fallible, divergent, and discerned through entanglement within the situation. I am discerning how caring unfolds among my participants through felt a/effects. As social inquiries are predominantly interactive, our emotional responses with participants are also data about the relational dynamics in a situation (Copp, 2008). Shotter (2017) describes these as ‘before-the-fact’ or ‘action-guided’ feelings, signs that we may ignore or resist of possible change ahead (Locke et al., 2008). This has ethical implications.

A potential question is why – given my interest in experience as it is experienced, including its embodied dimensions – I do not draw on phenomenology in my study, especially when pragmatism and phenomenology share an interest in discerning meaning. Indeed, as someone who has known James since my undergraduate days, I could have made use of his perspective on phenomenology. My understanding of the totality of the situation – in a Deweyan (1939) sense – is that it is a ‘contextual whole’ comprising environment, conversation, social relations, events, pre-cognitive and felt uncertainty, and more. To that end, pragmatism offers me a philosophical basis for situated, mutable and fallible meaning making in determining how to act.

Ethics committed to the ‘rupture of indifference’ (ethics)

The question of ethics cannot be separated from the fabric of this inquiry. However, the word ‘ethics’ has multiple meanings and applications, including within this study. One definition, by Peter Singer (2022), used in the glossary, states that ethics deals with issues of practical decision making, and the standards by which human actions can be judged morally right or wrong. It is certainly a way of viewing ethics that underpins care ethics but is a position I progressively depart from in this thesis, making the point for a different understanding of ethics – as ethos, and grounded in an understanding of pragmatist inquiry as always ethical in practice – in chapter 7.

There was an instrumental focus on research ethics, such as ensuring compliance with the NHS and University's standards for researching human beings, and the demonstration of a responsible design. However, I also understood that ethics was not something to be 'done' prior to entering the field. My participatory design had implications for the me as well as my participants, but the exact nature of these considerations could not be known and mitigated at the outset (Ryen, 2011). To this end, I knew ethics would be an ongoing response to my inquiry as it unfolded.

In his study of healthcare CEOs in Canada, Bart Johnson (2014) suggested dividing the ethics into two phases: those addressed by the university ethics committees (procedural ethics) and those that reveal themselves while in the field (ethics in practice). These relate to sampling, informed consent, researcher roles, objectivity, participant discomforts, the impact of research on participants (and potentially non-participants), confidentiality, and anonymity. This distinction made sense to me.

One of the reasons why ethics would remain 'live' was my choice of methods. Action research necessitates a much deeper, longitudinal, and relational working relationship between the researcher and the participant group. Conversation, dynamics, and emotions were intended as the primary source of learning and research; how collaborative leadership groups negotiate their collective task, make sense of roles, conflicts, and boundaries, and take action. These pose ethical considerations as they can be sensitive: involving power dynamics (such as status, role, gender, ethnicity, and organisational allegiance), challenging what may be institutionalised ways of seeing, diverse perspectives, and ways of using language; confidentiality and sharing of what has happened out with the participant group as well as within the data gathered (Päivi et al., 2004; Tee and Lathlean, 2004).

My commitment to involve participants as co-researchers, and to advance shared goals through collaborative research, could be seen as a form of 'advocacy'. This also posed ethical and political considerations, which critics might suggest compromises the credibility of the inquiry. My ethical orientation was grounded in the pragmatist assertion that scientific research, and indeed all inquiry, is ethical and values laden (Simpson and Hond, 2022: 140) in its future oriented and collaborative focus.

As I immersed myself in care literatures and feminist technoscience – as well as thinking more deeply about pragmatism – so my understanding of ethics developed in several ways. I knew from Cunliffe (2018) that the choices we make as researchers are not solely intellectual, but interwoven with who we are, as well as being consequential. Simpson (Simpson et al., 2021) writes that from a pragmatist perspective, ethics comprise a participatory and experimental process of transformation in situations. Johnson's ethics in the field, which I discussed above, did not go far enough in capturing how ethics unfolds in practice, as a way of being and seeing and responding, rather than favouring my ethical judgement as the researcher, essentialising experience, and objectifying my participants.

In addition to the above, it was in coming to learn more about feminist ethics, that I saw a transformational potential. Ariana Markowtiz (2022) states that practising feminist ethics involves committing to care, where care is interdependence and practising of caring for yourself, caring for others, and caring for the world around you, recognising that one's own liberation and healing is bound to others. I saw the work of Jane Addams in a new light. While Addams' life and work precedes the second wave women's movements of the mid 20th century and beyond (although she was a champion of women's suffrage, as well as working for justice for/with minoritised people[8]), it has been argued that in her focus on social justice, equality, and participatory practice, she was engaged in a form of 'feminist pragmatism' (Seigfried, 1996; Shields, 2006; Whipps, 2004). I was moved to bring Addams, Haraway, and Barad into conversation in my exploration of care and ethics, offering an alternative feminist voice from those who inform the care ethics movement.

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[8] https://sites.uw.edu/twomn347/2019/06/03/jane-addams/

When Barad (2012: 216) writes of an ethics committed to rupturing indifference, I take them to mean being moved to care, and taking responsibility for our actions and their consequences. More than appropriate conduct with my human participants and appropriate strategies for securing data, Barad was calling me to consider what kind of worlding my research might bring into being, not just for my participants, but societal and beyond human resonances. Their idea of 'ethico-onto-epistemology' – the intertwining of ethics, knowing, and being (Barad, 2007: 185) – of experiencing beyond method/methodology, is an ethical process of 'mattering'. Rather than the more conventional 'front loading' of ontology, epistemology – and for the really committed, axiology – in research design processes, Barad was inviting these principles to be performed, and adapted, ongoingly.

For Kathrin Thiele (2014), diffraction is more than finding better differences in our inquiries, it is also about changing our engagement with difference. For Thiele, it is an 'ethos'. The Merriam-Webster[9] dictionary defines ethos as practices or values that distinguish one person, organisation, or society from others. They are not abstract, but dynamic, lived, and potentially change-full. In my theorising (in chapter 7), I use the term 'ethos' instead of 'ethic(s)' because caring is performatively ethical: we are making choices and taking actions that affect and effect the choices and actions of others. Because we make an impact. Because how we respond to the enactments of others alters the course of what happens next. Because this is social and political. This calls for a different kind of theorising. I return to this in chapter 7.

Speculative fabulation (theorising)

My research journey has been – and continues to be – an experiment in (progressive) departures. This is more than a presentational departure.

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[9] https://www.merriam-webster.com/dictionary/ethos

My original study built on the idea of writing as a dialogical engagement (Gergen, 2009b; Helin, 2016), where my thesis would be part of a conversation, a response in anticipation of the next utterance; rather than solely a retrospective writing up. To that end my plan was always to write, subjectively, in the first person, integrating present, past and future tense as we might do in everyday talk. An experiment in temporality and re-presenting what had been uncovered in collaborative research.

During lockdown, the distinctions between data gathering, analysis, and writing up were replaced by the idea that writing is a method of inquiry (Richardson and St. Pierre, 2017; St. Pierre, 2018), where writing itself contributes to research and theory (Gilmore et al., 2019: 5; Weatherall, 2019). This was a practical decision, in how to repurpose my data while simultaneously analysing it, knowing that I was unlikely to regain access to empirical sites (as well as the finite nature of a doctoral studentship – I had to keep moving, somehow).

My plan was to adopt the writing style of a ‘layered account’ (Ronai, 1992, 1995), which Carol Ronai describes as a *“…narrative form designed to loosely represent to, as well as produce for, the reader, a continuous dialectic of experience … making accessible to the reader as many ways of knowing as possible”* (1995: 396–7).

I found Ronai’s work moving and profound, combining harrowing personal experience with scholarly insight. With time I also saw that her style was somewhat problematic for my inquiry – inferring discrete categorisations that could be separated out for individual inspection. It did not seem to fit where I was going: one voice – mine – with agency, speaking because of many different knowings that moved across time, place, experience, and discipline, where my knowing was tentative and evolving; and where those who engage with my work bring their knowings, in a continuous process.

Autoethnography is described as a strategy for representing lived experience, where the researcher conducts investigations and writes about their own experience (Lincoln and Denzin, 2003). I now realise as well as being an instrument of the inquiry, I was co-creating social dynamics with my participants. My voice became entangled with other voices, and in becoming inseparable enacted agency (Mazzei and Jackson, 2017). Unlike autoethnographic approaches that *reflexively* explore a researcher's experiences and their possibilities for theorisation (Broussine et al., 2008), entangled agency – a form of intra-active ethnography, where the *"story as enactment becomes something more than a recording of past events"* (Holman Jones and Harris, 2021: 6) – is not a property of any one participant to be exercised but is a 'dynamism of forces' (Barad, 2007: 141). These are 'charged atmospheres' (Stewart, 2011) of potent situations exchanging and diffracting, influencing and enacting.

Is my study a form of 'affective ethnography' which Gherardi defines as a *"process that draws on a researcher's capacity to affect and be affected in order to produce interpretations that may transform the things that they interpret"* (2019b: 742)? Its potency – where *"in the intra-acting of affect/be(coming) affected and in using embodied knowing as a resource, we may learn to resonate as a collective body"* (2019b: 748) – certainly appeals. Affective ethnography – as a deliberate, intentional 'style' (rather than method) *during* my fieldwork – would have added much nuance to my experiences of shadowing, and perhaps even the collaborative inquiry. However, its principles of becoming with participants, fidelity to place, and a capacity to make do in the field, is not a style I can retrospectively apply.

Haraway taught me that storytelling is care-full thinking (Terranova, 2016), philosophical praxis. And so I arrived at 'speculative fabulation' (Haraway, 2011, 2016a). They are *"fables rich with possibility, a mode of attention, a theory of history, as well as a practice of worlding"* (Haraway, 2016a). I understand this to comprise a narrative form that emphasises what can be made possible, and perhaps already is. Speculative fabulation creates realities through a practice of storytelling. Such an approach seemed to lend itself to a fidelity to experience, beyond its chronological happening. My field notes bear testimony to the fact that these encounters took place, as well as the lists of meeting dates in chapter 3, and that my participants are real, but the unfolding of situations draws on field notes, literatures, and other 'affects'. Following Gherardi (2017b), by affects I mean noticing and engaging with generative sociomaterialities within a phenomenon that may otherwise pass unnoticed. I take inspiration from Addams' generative and multi-voiced social inquiry (Rosiek and Pratt, 2013). The question for me was, how to theorise speculatively. Diffractive inquiry is my way of performing speculative fabulation, as I explain below.

Introducing diffraction

This section introduces diffraction – another foundational idea in this study. While diffraction has its origins in physics, the idea – more as a metaphor – is becoming used in social sciences (and other areas) to inquire into difference.

A fundamental theoretical shift in my inquiry logic was a move away from social poetics towards feminist technoscience, whilst maintaining a commitment to classical pragmatism, and with that a shift from reflexivity to diffraction. Feminist technoscience helps me know (and theorise) care differently – as I develop in chapters 3, 4, 5, 6 and 7 – as well as realising research as an ethical practice.

What is important for me in thinking with feminist technoscience is the attention given to care not only as a subject of inquiry, but also the politics and practices of knowledge-making. This is less about definitive claims, and more about questioning, opening, and attuning (Atkinson-Graham et al., 2015; Martin et al., 2015; Puig de la Bellacasa, 2017). In this context, I take feminist technoscience to foreground a situated empirical stance within scientific inquiry, beyond discrete disciplinary siloes, as a human and beyond human endeavour, and where epistemological claims about what might be known favour subordinate viewpoints, and with a shared pursuit of liberation (Åsberg and Lykke, 2010; Law, 2004: 159; Weber, 2006).

Feminist technoscience *is* critical – of capitalism, colonialism, race, class, ability, and gender (Martin et al., 2015) – in challenging who gets to make knowledge claims. Haraway (2016b) writes of 'staying with the trouble', which I take to be an invitation for care-full response to the power and perplexities in our changing and more than human worlds. I see these ideas as in harmony with the socially progressive and transformational potential of pragmatist inquiry, as exemplified in the work of Addams, Mary Parker Follett, and Dewey (who I think with in subsequent chapters). I understand classical pragmatism and feminist technoscience to not only challenge epistemological claims, which are ethical in their consequentiality, but also to invite a different ontological position – of situations, relations, and worlds that are entangled and always becoming.

Diffraction as a metaphor for inquiry involves attending to difference, to patterns of interference, and the effects of difference-making practices (Hill, 2017: 2). It was first articulated by Haraway (1992, 1997), as a mode of critical consciousness, a *"narrative, graphic, psychological, spiritual, and political technology for making consequential meanings"* (1997: 273), later expanded by Barad (2003, 2007, 2012, 2014) to become an ethical, material practice *"not merely about differences, and certainly not differences in any absolute sense, but about the entangled nature of differences that matter"* (2007: 381). To acknowledge our interdependency and agency in making and disrupting our worlds, as a boundary-crossing, trans/disciplinary queering (in all senses of the word) theory/practice of connecting and committing rather than separating or othering (Murris and Bozalek, 2019). Both acknowledge the influence of Trinh T. Min-ha (1989) in challenging them to think differently about difference, as something *non-binary* (and non-dualistic). It is a provocation to *how* we gaze as much as where and what.

There are many ways that diffraction is defined and used in research. Diffraction as logic draws attention to ontological aspects of research (Bozalek and Zembylas, 2017a). It does not set up one approach/text/discipline against another – in binary opposition – but leads to more generative provocations through detailed, attentive and careful reading ideas through others (Bozalek and Zembylas, 2017a: 115). For Barad (2011a), it is a means by which researchers can make visible entanglements and differences. Maria Udén (2018) opines that Haraway's motivation was bettering the way in which knowledge is produced, as a moral / ethical concern.

This resonates with my understanding of Haraway's (1988: 583) call for 'partiality' as a feminist practice challenging dualisms of mind/body and subject/object so that we can become answerable for the knowledge claims we make. Haraway asks us to be explicit about the situatedness of what we see and come to know. What this means to me is that in Haraway's use of diffraction, I am invited not only to disclose my partiality, to be transparent, but to actively – and ethically – involve it in my theory-practice worlding. What I see, feel, and subsequently theorise is inseparable from my societal position and lived experience.

In Barad's (2007: 237) agential realist account, an apparatus is understood as an entangled juxtaposition of the observer and that which is observed, of the way these two interact, and of the knowledge produced. Therefore, the apparatus is constituted by the method, the apparatus produces the method, and the apparatus is the method. This highlights to me its potential as a way of inquiring and engaging with the processes of researching, and not solely for data analysing.

Diffraction inquires into the relational nature and material effects of *difference* through embodied and affective engagement with the materiality of inquiring. While it is not a method in any normative sense, some use diffraction as a *critical* analytic practice (Sayal-Bennett, 2018). Diffractive analysis explores *how* processes can be understood through the effects created by their difference (Sayal-Bennett, 2018), and how they are connected and co-constituted (Bozalek and McMillan, 2017), rather than solely noticing these differences.

Diffraction departs from the 'optic metaphors' of reflective, and even reflexive practice (Barad, 2007; Haraway, 1997; Mazzei, 2014), which are familiar to interpretive organisational scholars. Reflexivity, predicated on a relational ontology (Cunliffe, 2011), is a practice that influenced my earlier study focus. For Barad (2007), a relational ontology takes as reality that the world is made up of individuals and things with inherent boundaries and properties which relate or interact with each other. Cunliffe and Matthew Eriksen (2011: 1430) characterise this as a way of being-in-relation-to-others. A relational ontology suggests that the origin of our experience is intersubjective rather than individual and cognitive. While Cunliffe situates reflexivity within a relational ontology (2011), scholars whose ontological orientations are rooted in immanence argue that reflexivity perpetuates a dualistic notion of separateness (Keevers and Treleaven, 2011), as well as reifying discursive – and human – practices over different ways of knowing, where everything is 'in the making' (James, 1909), data is 'transgressive' (St. Pierre, 1997), and beyond categorisation in most qualitative research. By contrast, in entanglement, Thiele (2014: 206) suggests, the very ontology of entities emerges through relationality – we do not pre-exist our involvement with others.

Reflexivity questions the taken for granted as we turn the gaze in on ourselves to our own practice as well as how we co-create organisational realities (Cunliffe, 2020). However, critics of these optic metaphors suggest that reflexivity perpetuates anthropocentrism, representationalism, and a reification of dialogue in the quest for meaning making, as well as being founded on an ontology of separateness (Barad, 2007; Keevers and Treleaven, 2011; Shotter, 2010a) – of inter-subjectivity or 'aboutness' (entities existing independently prior to connection) rather than performative intra-action or 'withness' (how we become, entangled, within this specific situation) and messier, more entangled and unpredictable ways of experiencing and knowing.

Reflexivity had been an important concept for me at the beginning of my doctoral studies as I understood it as an ethical and developmental practice. I saw intersubjectivity as relational and co-creative. However, as I thought more with Barad and others, so I came to understand how problematic a relational ontology could be, in its presupposition of separateness and what lies 'between' entities, as discussed above. This seemed at odds with an understanding of process, as social (human and beyond human), continuous, and interconnected growth (Simpson and Hond, 2022: 131).

Scholars have invoked diffraction as a 'difference-driven analytic' (Lather, 2016: 126) to inquire about workplace pedagogic practices (Doyle, 2016), performativity in posthumanist multi-species qualitative research (Jenkins et al., 2020), the role of embodied ways of knowing in becoming together (Cozza, Gherardi, et al., 2021; Katila, 2019), understanding resistance in senior managers (Harding et al., 2017), as well as by post qualitative educationalists seeking to engage differently with written texts (Murris and Bozalek, 2019). In the case of Nancy Harding and colleagues, for example, this involved multiple analyses of each theme in their data, reading each of those analyses through each other. For Davide Nicolini and Bridget Roe (2014), diffraction is a tool for illuminating divergence in professional knowledge-abilities and identities.

What these scholars do with diffraction varies, as does the extent to which they explain their understandings and use of diffraction beyond an attention to difference. What is common is how some pursue more generative and nuanced insights – albeit outcomes and effects – by reading ideas through each other.

This quest for outcomes and effects is challenged by Laura Visser and Olivia Davies, who notice inseparable flows within ‘processes of performativity’, where *“diffraction is not just a tool to see differences, but to explore the processes through which they are enacted, allowing us to see how differences matter”* (2021: 5). What this means to me in practice is that diffraction exemplifies an abductive logic (Simpson and Hond, 2022), re-tuning our sensitivities towards previously unnoticed generativity in situations. This offers richer possibilities in our engagements and theorisations, for novelty and practical relevance.

Diffraction is more than about finding better differences in our inquiries but is rather changing our engagement with difference (Thiele, 2014). Crucially for my inquiry, diffraction *“attends to the relational nature of difference”* (Barad, 2007: 92), illuminating differences as they emerge rather than as pre-defined subjects or objects within an inquiry.

This now comprises a fundamental principle of my inquiry process, although it means in practice will be a process of discovery through analysing and writing, which I return to in chapters 7 and 8. However, I also use diffraction as an analytic practice in chapters 4, 5, and 6, where “*diffraction is not a set pattern, but rather an iterative (re)configuring of patterns of differentiating-entangling*” (Barad, 2014: 168). It is a nascent practice in post qualitative inquiries (Lather, 2016; Mazzei, 2014). Data in this context comprises the totality of the situation, as experienced and as re-imagined, and its ephemeral effects.

Diffractive Inquiring

This section explains how the foundational ideas of inquiry and diffraction – outlined above – now comprise the logic of this inquiry, with its sensitivity to difference. This sensitivity informs how I recount and analyse empirical experiences, how I move to theorise an ethos of caring, and my own becoming as a researcher.

For Jackson and Lisa Mazzei (2017), a thinking with theory process ‘methodology’ is entirely ontological: not a thing but a doing (Barad, 2007). It does not follow a particular method, but invites a willingness to invent, borrow, and reconfigure concepts and approaches, to create new ways of thinking and acting.

My inquiry has taken me to many places since my departure from conversive encounters when it became clear this approach would not meet the needs of my study. The souvenirs I carry – diffraction, abduction, speculation, experience, situation, entanglement, inquiry, and ethos – seem to make more sense to me as a logic of inquiry motivated by difference.

What differences might matter? Thiele (2014) suggests that diffraction helps us work on how to live together a world of ongoing difference(s), in such ways that new senses of commonality and kinship are enacted. In thinking about Haraway’s and Barad’s invitations to make a difference – and informed by Dewey’s concept of instrumentalism and Shotter’s later ontological work – I see a shared concern for *consequential actions within the realm of everyday experience*.

I call this ongoing process ‘diffractive inquiring’ (DI), within ‘indeterminate situations’ (Dewey, 1939). It is an experimental, difference-oriented noticing of affect and effect in empirical encounters, performed in the concurrent and interwoven processes of analysing and writing my doctoral thesis. Central to DI is abductive logic, ethical practising, and fidelity to experience. Brian Massumi (2015: 207) describes abductions as ‘living hypotheses’. I understand DI to comprise entangled participation in processes of knowing, where everything is moving, and in the making, and where ‘data’ comprises the totality of a situation (across time and place) and is beyond categorisation.

DI calls upon me to acknowledge the ethical consequences in my instrumentality, as my agentic noticing and 'what if' questioning and 'perplexities' (re)makes worlds. As researchers, we make choices about what we see in the field, analyse, and then theorise. We are world-making, for abduction is a 'consequential process' (Locke et al., 2008: 913). This is an ethical matter, involving the entangled past and the future in emerging presents.

My organisational participants were not temporally involved in this diffractive inquiry, but these caring encounters emerge from our interactions. I speak because of them, but not for them. I am making what Barad calls an 'agential cut' (2007, 2014), creating a semantic boundary around a phenomenon, as well as what Haraway (2016b) describes as 'speculative fabulation' – a mode of attention, a theory of history and a practice of worlding.

DI extends the concepts of inquiry and social poetics that shaped my unfolding research. Its logic invites me to 'live without bodily boundaries' in my researching, such as transcending human experience and noticing non-human subjects, place, and technologies, an invitation that is familiar with STS. More importantly for my inquiry, in becoming aware of the ethical choices I make ongoingly (Murris and Bozalek, 2019: 1509–10), and in noticing how caring is ongoingly and response-ably co-created through my entanglement with troubling situations.

One aspect of diffraction as analytic practice within DI is my use of vignettes (Jenkins et al., 2020) (which I call 'situations' in chapters 4, 5, and 6, because in a Deweyan sense each vignette can be thought of as problematic in some way). Phil Langer describes them as a *"mediating position between conventional and experimental forms of writing"* (2016: 735). Vignettes are less about authentic or trustworthy representations of the phenomena under study (Barad, 2007), but synthetic, encapsulating*" complex and dynamic relationships of meaning, action and intra-corporeal transformation that we as researchers, and agents of* *observation, become entangled with"* (Jenkins et al., 2020: 10), through which we might discern consequential processes of intra-action. They are speculative, as I have discussed before. As a literary form, vignettes can facilitate attention to subtle atmospheres within the mundane, and in doing so amplify more sensuous qualities within the encounters recounted (Atkinson-Graham et al., 2015: 739). I use vignettes to cut together empirical experience, resonances, and theory. Vignettes have potency as they invite a focus on performativity rather than results. The development of vivid, performative vignettes offered a means for retelling my experiences in a way that was visceral and vicarious, as well as being speculative.

I will return to this discussion of logic in chapters 7 and 8, to discuss how it informed my analysing and theorising in practice.

Chapter summary

This chapter has explained the evolving logic of my inquiry, and why I have moved away from the language and concepts of method and methodology. This move was partly shaped by a deepening understanding of process, moving from seeing process in epistemological terms to coming to know process as ontology, and more importantly learning the difference. This change was also a practical necessity, without further access to my participants, my inquiry in its original design was no longer viable. The data I had was insufficient to continue with the same topic. As I engaged with feminist technoscience ideas and thought more about what empiricism meant in practice – from a pragmatist perspective – I realised that my inquiry was still unfolding, albeit taking on new focus and direction(s).

In bringing together classical pragmatism and feminist technoscience in media res, and their interplays, I thought of diffractive inquiring as a logic more than a style of researching. Central to this logic was writing – as a concurrent performing of re-experiencing my empirical experiences, analysing them for 'what if' they were telling me about care, and how these learnings moved me to theorise. This thesis is performative then, in showing diffractive inquiry in practice, as well as generative in the discerning of different insights. As I move from and between chapter to chapter, I follow my perplexities in how to move, guided by the principle of fidelity to experience as it is experienced.

In the next chapter I introduce the empirical and conceptual context of this inquiry. I outline the work and transformation taking place within the NHS in Scotland and GCHSCP. I explain how lockdown caused me to reconsider my inquiry, when its focus on leadership was no longer viable. As I discovered care literatures at the same time as my understanding of process was deepening, so I came to notice the limitations of seeing and theorising care in practice from extant care ethics and a relational ontology. It was this quest for an alternative – more processual – way of experiencing and talking about caring that led to my refocussed inquiry, and in particular the caring dynamics that I investigate in chapters 4, 5, and 6.

Chapter 3 – care in practice and as practice

Introduction

In chapter 1, I stated that rather than creating a divide between concepts and practice, they are in mutual interplay within several chapters. In the previous chapter I outlined the logic of diffractive inquiry (DI). Central to DI is a commitment to empiricism. In this chapter I introduce the empirical and conceptual context of the inquiry to illustrate how immersion in care literatures moved my understanding from care as work in a healthcare context to a more expansive understanding of care practices, and then to the possibilities of practising caring. I also outline how I came to focus – in chapters 4, 5, and 6 – on three caring dynamics. Although in my reading of the care literatures it seemed my experiences did not qualify as 'care', from a processual perspective and in diffractively engaging with caring theory, feminist, and moral philosophies, I became curious about caring as a process. My field data was gathered prior to developing the inquiry logic that now informs my study, as I explained in chapter 2. What this means in practice is that logic, conceptual focus, and empirical analysing are in mutually informing interplay.

The health and social care organisation where the research inquiry was undertaken – Glasgow City Health and Social Care Partnership (GCHSCP) – co-funded my doctoral studies; and it is with my participants' consent that I name the actual organisation (although participants' names and specific research sites have been anonymised). It mattered to my participants that they be an exemplar in adapting to the vicissitudes of learning in practice. The original scope of my fieldwork was to understand how collaborative leadership emerged in practice and from practice during a period of strategic transformation in Primary Care. However, during lockdown my focus shifted as I began to engage with care from a more sociotechnical perspective.

While an ‘ethic of care’ is now being extended by leadership and critical organisational scholars, finding literatures that exemplify a processual perspective of caring takes me elsewhere. Many of these critical literatures emerge from – explicitly or otherwise – a relational ontology. I look then to caring theory and moral philosophy, in addition to more recent feminist and sociomaterial organisational readings of care ethics. I am not seeking to reinforce dualisms by critiquing critical or relational perspectives. However, I would suggest that thinking about care from feminist technoscience, pragmatist, and caring philosophies invites not only possibility for being mobilised by our feelings and other affects, but also a perspective on taking action that *is* situated in socio-political contexts by asking *how* we can act collaboratively and consequentially in *this* specific situation. I introduce these literatures here, to engage with them more deeply in chapters 4, 5, and 6. What becomes material is how we talk/write about caring in practice, as I develop in chapter 7.

Primary Care in Glasgow City’s Health and Social Care Partnership

This section situates the empirical context of my inquiry, and the original research aims, prior to the first lockdown in 2020. I explain the structure of the National Health Service in Scotland, with a particular emphasis on Primary Care, and how transformation in health care strategy, leadership and delivery informed the landscape of my field work, even before COVID-19. This background situates the vignettes that follow in chapters 4, 5, and 6. However, there is a distinction between care work – which is the strategic and operational focus of the organisation under study – and a wider focus on care as practice and in practice in organisations and organising. It is this latter understanding of care that forms the basis of my inquiring and theorising.

The National Health Service (NHS) is the UK’s healthcare system, publicly funded through taxation. It is universal and free at the point of delivery. The NHS in

Scotland is undergoing major reform – even without the impacts of COVID-19 – shifting towards more community and home-based care. The strategic aims of the National Clinical Strategy for Scotland[10] – which are not without criticism, not least that the strategy will not achieve its intended aims (Temple and Pontin, 2017) – have consequences for the roles and capacities of GPs (family doctors), clinical and health and social care resources within enhanced multidisciplinary teams (MDTs); the increased use of 'social prescribing', a non-medical approach to support self-management, particularly for wellbeing and mental health; and an emphasis on person-centred care, placing the patient at the centre of decision-making about their health and wellbeing[11].

What is Primary Care?

NHS Scotland is divided into regional health boards that have localised responsibility for planning and delivery of health services – the largest is NHS Greater Glasgow and Clyde (NHSGGC). NHSGGC is subdivided into six health and social care partnerships (HSCPs), which are partnerships between the health board (NHSGGC) and the local authority (Glasgow City Council, for my study). While HSCPs have statutory responsibility for Primary Care services, they are typically delivered by NHS staff or sub-contractors on a day-to-day basis.

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[10] https://www.gov.scot/publications/national-clinical-strategy-scotland/

[11] https://www.gov.scot/publications/person-centred-care-non-executive-members/

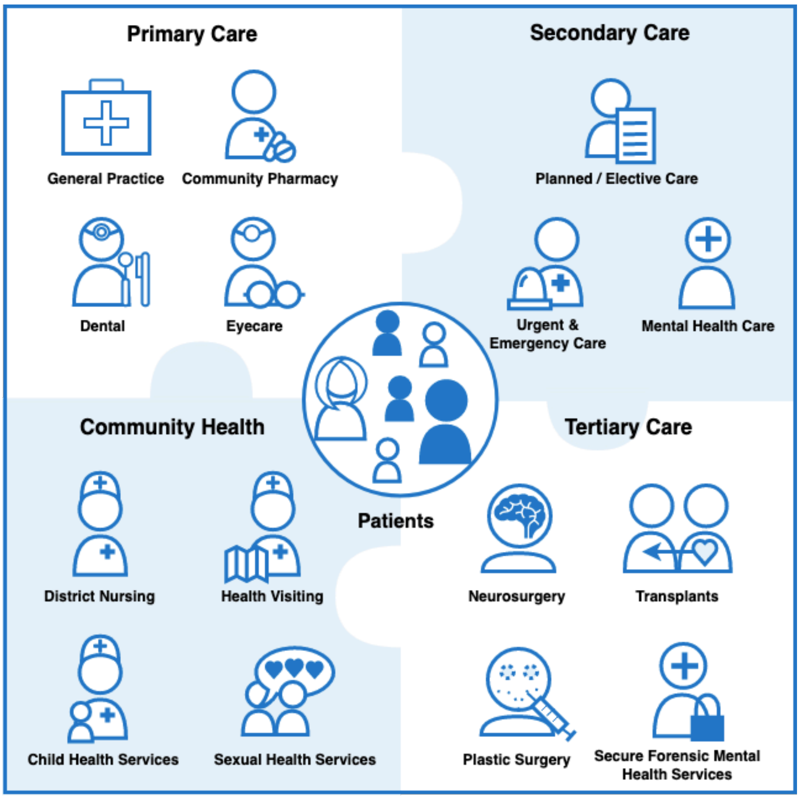

Figure 1 The healthcare ecosystem[12]

The figure above summarises the structure of the NHS. My fieldwork was undertaken within Glasgow City's Primary Care ecosystem (top left of the diagram). Primary Care is where most people in Scotland experience the NHS; with at least 90% of all health contacts taking place in GP surgeries[13], dental practices, and pharmacies. Primary and Community Care (the left-hand side of the figure above) is the statutory responsibility of the relevant HSCP, although delivery is complex, integrating public, private and third sector organisations with the shared mandate to deliver on Scotland's Health and Wellbeing outcomes[14]. For example, GPs are independent (this has been the case since the NHS was founded), and operate as partners in a GP surgery, or directly employed by a surgery, or work as 'locums' (via agencies or freelance). They are not employees of the health board, although one of

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[12] https://digital.nhs.uk/developer/guides-and-documentation/introduction-to-healthcare-technology/the-healthcare-ecosystem

[13] A GP surgery is one of a few terms used within the NHS to denote where community health services are provided. GP Surgeries are also called 'GP surgeries, 'general practices' and 'doctors' surgeries'd.

[14] https://www.gov.scot/publications/national-health-wellbeing-outcomes-framework/pages/5/

the – many – strategic changes underway within the NHS in Scotland is to move to a salaried model where GPs work for the heath board under an employment contract rather than a services contract.

I have explained this because the consequences of these new GP contracts and their implications for Primary Care transformation informed much of the context, focus, and dynamics of my original study. One of the goals of the Primary Care Improvement Plan was for some of the tasks carried out by GPs to be undertaken by other members of an enhanced multi-disciplinary team[15], where it was 'safe, appropriate and improves patient care'[16]. Another aim was rather than surgeries 'competing' with each other for patients, they were now asked to collaborate as local 'clusters' (around 5-8 surgeries in a neighbourhood) and to share resources – such as allied health professionals – where it is more cost effective for a physiotherapist, for example, to see patients from several surgeries in a week rather than being allocated to one surgery where there may not be sufficient demand. A further aim was that cluster leads – typically one partner-level GP from each of the surgeries in the cluster – work together on care quality and leading change in their locality.

The changing landscape of Primary Care in Glasgow

Glasgow is a city with well documented social and economic disparities, and their attendant impacts on health and wellbeing[17]. Nearly half of Glasgow's residents reside in some of the most deprived neighbourhoods[18]. What this means from a

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[15] The enhanced MDT, intended to come into effect in Scotland in 2021, would see elevated responsibilities for surgery-based nurses, surgery / practice managers and receptionists; as well as new services such as pharmacotherapy, vaccinations, mental health and community treatment delivered in doctors' surgeries and health centres (sometimes via third sector organisations) but without the default involvement of the GP in referring or overseeing the care intervention.

[16] https://glasgowcity.hscp.scot/primary-care

[17] https://www.gcph.co.uk/assets/0000/0801/GCPH_Briefing_Paper_25_for_web.pdf

[18] https://www.understandingglasgow.com/indicators/poverty/deprivation#:~:text=Deprivation%20in%20Glasgow&text=Just%20over%20185%2C000%20Glaswegians%20%2D%2029,most%20deprived%2020%25%20of%20areas.

health and wellbeing perspective is reduced life expectancy, unemployment, poor mental health, physical inactivity, addictions, child poverty, food insecurity, fuel poverty, gender inequality, and racial inequality[19]. A further aspect of health and inequality is multimorbidity, the presence of two or more long term health conditions in a person, which are exacerbated by deprivation[20]. What this meant for my study is that much work in Primary Care is focussed on managing and mitigating the complexities of day-to-day living, rather than health improvement per se.

According to the Glasgow Indicators Project[21], health can be thought of and measured in many ways, as positive or negative well-being/mental health, length of life, absence of disease, freedom from disability, mortality and in terms of lifestyle and behaviour. Their infographic below highlights some of the inequalities in Glasgow. They further suggest that improvements in healthcare in the city have been impacted by a range of factors including COVID-19, austerity, and the healthcare system itself.

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[19] https://www.understandingglasgow.com/indicators/poverty/deprivation#:~:text=Deprivation%20in%20Glasgow&text=Just%20over%20185%2C000%20Glaswegians%20%2D%2029,most%20deprived%2020%25%20of%20areas.

[20] https://www.gla.ac.uk/research/beacons/inequalities/multimorbidity/

[21] https://www.understandingglasgow.com/indicators/health/overview

LIFE EXPECTANCY AND HEALTH IN GLASGOW

Health can be measured in many different ways and life expectancy is a good way to measure health across a population

In Glasgow, women are estimated to live in good health for 57.6 years

And for men: 54.6 years

Comparatively the city has one of the poorest health profiles of any Scottish or UK city

Life expectancy for Glaswegian men at birth is 3.6 years less than the Scottish average and 2.8 years less for women

This is in part because improvements in health have lagged behind other comparable cities in the UK

There are also wide health inequalities within Glasgow itself...

Men in the richest areas of the city can expect to live up to 15.4 years longer than those in the poorest neighbourhoods

Check out further information on this topic, as well as lots more on Glasgow's population health here: www.understandingglasgow.com

Figure 2 Glasgow remains the most deprived city in Scotland[22]

While my study does not focus on the *what* of my research sites, nor do I take a critical stance as to *why* inequalities persist, the socioeconomic context is material. Some of my research sites were in these most deprived areas, some of my participants were from these communities, and much of the transformation work underway was to facilitate a more patient-centred approach rather than medicalising inequality. As I move to theorise in subsequent chapters – particularly in chapters 6 and 7 – I argue that caring in practice has resonances beyond the immediate situation, to wider questions of societal (and ecological) flourishing.

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[22] https://www.understandingglasgow.com/indicators/health/overview

Rising costs of social care, people living longer and with increased co-morbidities, austerity and cost efficiencies, staff shortages in the NHS, a looming workforce crisis with much of the workforce due for retirement in the next few years, the impacts of Brexit on staffing and retention, and now COVID-19, were driving the modernisation of the Primary Care in line with the National Clinical Strategy to achieve the: *"'triple aim' of better care, better health and better value."*[23]

From March 2020, Primary Care responded to unparalleled hospital referrals, minimal direct patient contact, spiralling infections, social distancing, containing the virus, protecting the most vulnerable, and mitigating the impact on health and care staff. Two months later, leadership groups were having different conversations, questioning the very strategy of the transformation programme. Not only did COVID-19 cause an existential shock to health and social care, and Primary Care as my focus, but it necessitated a fundamental re-think about my study.

The delivery of healthcare *is* inextricably tied to questions of politics, power, and equity (Tronto, 2010); as well as social justice, participation, and democracy. As I now inquire from a pragmatist and feminist technoscience perspective, I am mindful of emancipatory potential in everyday experiences and sensitivity to collective action (Haraway, 1997). Indeed, as Barad reminds me, practices of knowing, such as research *"are specific material engagements that participate in (re)configuring the world"* (2007: 91). While my attention was on how my participants went about their day-to-day, in their attending to colleagues, patients, and the administration of transformation, I was witnessing world-making. This makes me wonder to what extent I was also agential in that world-making, for example when an administrator shows me a document she must work on, or I listen in on a conversation, or in my offer for a co-created inquiry that while not taken up might have prompted a different perspective on the doing of leadership in practice.

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[23] https://www.gov.scot/publications/national-monitoring-evaluation-strategy-primary-care-scotland/pages/2/

Primary Care Improvement in GCHSCP

Each HSCP has a strategy for Primary Care transformation, outlined in a Primary Care Improvement Plan (PICP), which every HSCP must have and should have been in the process of implementing. The PCIP for Glasgow City was a multi-year programme (2018-21), at the end of which there must be an effective enhanced multidisciplinary team model at surgery and cluster level[24] so that the new GP contract can come into effect. Two changes that informed my study were:

1) **Multidisciplinary team working in GP surgeries:** the role and capacity of GPs as 'expert medical generalists' with its consequences for surgery management, nursing, the clinical and health and social care resources within an enhanced multidisciplinary team; and partnership working with the third sector and others in the delivery of social prescribing, particularly for mental health and wellbeing; and

2) **Integrating GP surgeries into the wider system via Care Quality:** through the formation of clusters, a professional grouping of 5-8 surgeries, to provide a mechanism whereby GPs can engage in peer-led quality improvement activity within and across surgeries and contribute to the oversight and development of care within the wider healthcare system and their locality.

A simplified organogram of Glasgow's Primary Care Transformation (as of summer 2019) is below:

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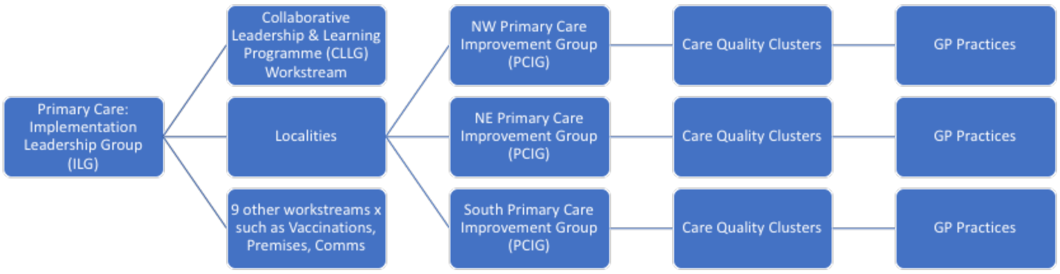
[24] https://www.nhsggc.org.uk/media/250803/item-12-primary-care-improvement-plans-18-49.pdf



The Primary Care Improvement Plan (PCIP) has 10 cross-cutting programme workstreams as well as the localities. These groups, the PCIP programme manager, and others as invited, all attend the Primary Care Implementation Leadership Group (ILG); which reports to the Primary Care Programme Board (PCPB) and the Primary Care Strategy Group (PCSG). The PCPB reports to the Glasgow City Integration Joint Board (IJB), which holds the statutory responsibility to deliver health and social care.

Glasgow's primary care is divided into 3 localities. Each PCIG meets every 3 months to discuss strategic, programme issues that are relevant for their locality. Membership comprises CQLs (approx. 7), Clinical Director, Primary Care Development Officer, representatives from Pharmacotherapy, Optometry, Dentistry, Links Workers and other Allied Health Professionals.

Each PQL participates in cluster quality activities, which means meeting at least twice per month, as well as other local responsibilities. Their remit is to oversee quality improvement in their cluster. Each cluster has a quality lead (CQL).

GP practices are formed into local clusters of 5-8 practices that are being asked to share best practice and resources, such as pharmacists etc. Each practice has a quality lead (PQL), who is always a GP.

Figure 3 My simplification of the Primary Care Transformation Programme in Glasgow City

The original scope of my fieldwork, developed in collaboration with GCHSCP, was to understand how collaborative leadership was emerging in practice and through practice during the implementation of the PCIP. I intended to build on an earlier study (Simpson and Buchan, 2018) that demonstrated practising collaborative public leadership was most effective when learning by doing involved participation across all levels of organisation, was focussed on a specific task, and where there was sufficient time and commitment to build relationships based on trust.

My original research focus

The transformations taking place in healthcare even before COVID-19 required changes to ways of organising, ways of working, and ways of relating. From an organising perspective, new management and governance structures were being implemented to deliver the 'triple aim' of better care, better health, and better value.[25] Ways of working included new models of leadership and collaboration, including the formation of GP surgeries into local clusters to encourage a focus on

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[25] https://www.gov.scot/publications/national-monitoring-evaluation-strategy-primary-care-scotland/pages/2/

quality and improvement through the sharing of resources and best practice. Ways of relating referred not only to GPs looking outside of their own surgery boundaries as members of clusters and the new cluster leadership groups, but new ways of working inside the surgery, such as enhanced multidisciplinary teamworking and increased responsibilities for administrative staff.

At senior management level, Health (via the NHS Health Board), Social Care (via the local authority) and GCHSCP staff were coming together to oversee and direct the implementation of the Primary Care Improvement Plan (PCIP); as members of the Implementation Leadership Group, the Primary Care Strategy Group, or locality-based Primary Care Improvement Groups. Learning about and enacting these changes had to be undertaken ‘in flight’ alongside the business-as-usual statutory delivery of health and care.

Building on the insights from Simpson’s and Buchan’s report, two projects were designed and approved. They were intended to run from October 2019 to June 2020, progressively ramping up in activity as the inquiry gained momentum:

- Project 1 – shadowing a) a GP surgery implementing workflow optimisation b) one area’s Primary Care Improvement Group meetings, and c) programme-level meetings
- Project 2 – a co-created and multidisciplinary collaborative leadership inquiry at cluster level.

As I mentioned, fieldwork ended when COVID-19 necessitated the first lockdown, less than halfway through planned duration:

- Project 1 had progressed to varying degrees
- Project 2 never started, despite senior support and some local interest.

I was hearing frustration among many GPs: that the promised resources (additional specialist staff, equipment, new premises etc) were not arriving, or they were being distributed unevenly (to surgeries and clusters that already had a ‘lot of resources’) or that the wrong resources were on offer (despite GPs telling the programme organisers what they needed (more mental health specialists, pharmacists etc). At a town hall meeting for Primary Care staff, there seemed to be a lack of goodwill, and annoyance that attendees were being asked the same questions (what do you need? what’s important?) but with no apparent impact of providing feedback.

One of the first questions I was asked every time I visited a new site, even if the participants had signed the consent form, was why I was there. While for one or two their question came from an acknowledged suspicion that I had been sent to spy on them, for many (I found out later, anecdotally) they were genuinely and pleasantly surprised that I thought them interesting enough to study. I soon learned that explaining I was there to research collaborative leadership meant nothing to them (except three GPs who had signed up for leadership development training, who had also taken up ‘leadership’ ‘roles’ in Primary Care, as cluster leads or clinical quality leads; and those in managerial / programme levels roles who had more understanding of the wider collaboration and leadership agenda, who would occasionally ask me for input during/after meetings). If the word leadership meant anything to them, it certainly was not related to what they did as administrators, nurses, or doctors. As one of the GPs said, she didn’t go to medical school to learn how to be a leader.

Introducing my research sites (October 2019 - March 2020)

This section outlines my research sites, a mix of localities and functional groups. There were five sites pre-lockdown, and my subsequent involvement – as a participant – in an organisational initiative led to a sixth site.

My research participants came from two distinct groups within GCHSCP[26] (although with some overlap in the various meetings and committees): Primary Care staff located in a neighbourhood, including GPs, pharmacists, surgery-based nurses, surgery managers, administrators, and health professionals supporting several GP surgeries. The second group comprised executive, managerial and programme-level staff with strategic oversight of Primary Care. Many of this second group had backgrounds in Social Care – rather than Primary Care – and were mostly current or former employees of the local authority. The first group typically worked together on a day-to-day basis, whereas the second group met with the purpose of progressing transformation activities (and latterly, strategic COVID-19 response).

The table below summarises participant contact once ethical approval had been obtained, and prior to the first lockdown:

Date	What	Duration
17/10/2019	Polymnia meeting	1.5 hr
22/10/2019	First shadowing workflow meeting at Calliope	1 hr
30/10/2019	1:1 conversation with Dr Gail at Clio	1 hr
31/10/2019	Shadowing at Calliope	3 hrs
05/11/2019	Calliope workflow meeting	1 hr
13/11/2019	Shadowing at Calliope	3 hrs
10/12/2019	PASC training at Hampden Park	4 hours
11/12/2019	Euterpe meeting	1.5 hrs
16/12/2019	1:1 meeting with Helen from Polymnia	1.5 hrs
09/01/2020	Team shadowing at Calliope	2.5 hrs
14/01/2020	Melpomene meeting	3 hrs
15/01/2020	Visit to Clio to discuss project and attend Euterpe meeting	2 hrs
21/01/2020	Calliope workflow meeting	1 hr

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[26] As a resident of Glasgow City, I avoided contact with my local GP Practice and its associated cluster, to minimise any potential conflicts of interest or compromise of integrity or privacy.

Date	What	Duration
21/01/2020	1:1 chat with Dr Elsa at Calliope	30 mins
23/01/2020	Polymnia workshop at Gartnavel Hospital	6 hrs
23/01/2020	1:1 chat with Sally from Polymnia	45 mins
04/02/2020	Melpomene meeting	2 hrs
06/02/2020	Clio surgery	2 hrs
10/02/2020	Polymnia meeting	2.5 hrs
13/02/2020	Clio surgery	2.5 hrs
27/02/2020	Clio surgery	2.5 hrs
04/03/2020	1:1 meeting with Helen from Polymnia	1.5 hrs
05/03/2020	Clio surgery	2.5 hrs

Figure 4 Field work contact log, COVID-19 lockdown was announced 13th March 2020

Since March 2020, the NHS has had to innovate, re-organise, and adapt – in a matter of hours and days – to adjust to the impact of COVID-19, setting up and staffing a parallel health care service. What started out as a project about collaborative leadership became untenable when my fieldwork ended, four months into its planned nine-month duration.

After several weeks of no contact with GCHSCP since early March, I was asked to observe several online meetings with one group to see whether it might be viable to recommence my study and with what focus. The objective for my participation was more about familiarisation rather than continuing with shadowing. I had 1:1 conversations with some participants – those wanting to update me on what was happening for them and in my research sites. Members who had been instrumental in setting up the COVID-19 response were returning to their substantive roles and the transformation of Primary Care, as well as the parallel COVID-19 service. This led to my brief involvement in one final project, as a participant, and outside of the scope and design of my original study.

These additional meetings are recorded below:

Date	What	Duration
24/04/2020	1:1 chat with Helen	1 hr
27/04/2020	Polymnia meeting	2 hrs
28/04/2020	1:1 chat with Eleanor	1.5 hrs
28/04/2020	1:1 chat with Sally	1 hr
01/05/2020	1:1 chat with Helen	1 hr
11/05/2020	Thalia briefing with Sally	1 hr
12/05/2020	Polymnia meeting	1.5 hrs
15/05/2020	1:1 chat with Abi	1 hr
20/05/2020	Polymnia meeting	1.5 hrs
29/05/2020	1:1 chat with Helen	1 hr
17/06/2020	2 x Thalia interviews	2 hrs
18/06/2020	1 x Thalia interview	1 hr
23/06/2020	Thalia interviews debrief	1 hr
26/06/2020	1 x Thalia interview	1 hr

Figure 5 Lockdown contact log, with Polymnia and Thalia

Calliope: a GP Practice

Calliope[27] is a large, suburban GP surgery implementing 'workflow optimisation' processes[28]. It is situated within a health centre comprising two other surgeries, a community pharmacy, and other community health services. It has around 10 GPs, and a large clinical and administrative support team. One of its GP partners – Dr Elsa – is actively involved in the Primary Care transformation and has put herself

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[27] All research sites have been given pseudonyms, inspired by the Greek Muses. However, there is no significance in which name each site has been given.

[28] There are several developmental initiatives underway across Scotland to facilitate enhanced multidisciplinary team working. One of these is the Practice Administrative Staff Collaborative (PASC). Its aim is to support practice administrative staff to develop their quality improvement skills while improving key GP practice processes to improve outcomes and care experience for people, families, and staff. There are two quality processes being rolled out: 1) workflow optimisation and 2) care navigation. My inquiry focussed on workflow optimisation (correspondence management) as this minimised any potential contact with patients, the public, and/or clinical data.

forward for leadership development training. Calliope was my first participant group and comprised Dr Elsa, Mhairi, the surgery manager, and a team of administrators who self-identified as ‘the Girls’. I shadowed Calliope several times, over three months, in team meetings, as they went about their administrative tasks, and sharing lunchbreaks with them in the staff room. Sessions became less frequent, despite offers from Dr Elsa that I could sit in on their management meetings. When the first lockdown necessitated terminating my field work Dr Elsa offered to continue with shadowing, saying that with the right protective equipment she could keep me, and her team, safe. However, University guidance was such that I had to decline this offer. The last contact was from Dr Elsa, saying how useful WhatsApp was for the surgery and cluster, not just for sharing information but as a way of letting off steam.

Clio: a GP Practice

Clio is a small, ‘deep end’[29] GP surgery in a deprived inner-city location, in a neighbourhood known for drug addiction, alcoholism, crime, and very low life expectancy. Clio is situated in a large, new health centre, comprising several other GP surgeries, and other health and care services. There is one lead GP – Dr Gail – who is supported by a handful of part time locum (freelance) GPs, a nurse, community links worker, and administration. We agree that I will shadow her and the team, with the potential for the shadowing to evolve into a more participatory ‘action learning’ type project. Dr Gail is also the lead for her cluster and wants me to co-facilitate a leadership learning project for the cluster. I shadowed Clio around

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[29] Deep End is a Glasgow University project investigating 100 GP practices (76 of which are in Glasgow city) serving the most socio-economically deprived populations in Scotland. These surgeries were selected to participate in Deep End, which has been running since 2010, because their patients experience ‘blanket deprivation’: where multiple morbidity and social complexity are the norm, and in a younger age group than the general population, and where NHS policies and services are ineffective, but it is recognised that the role of GP practices in improving health inequalities could be significant.

once a week, for a few weeks. The cluster project never happened due to a lack of time and interest (see Euterpe, below).

Melpomene: a locality-based improvement group

Melpomene is a locality-based (GCHSCP is divided into three localities – NE Glasgow, NW Glasgow, and South Glasgow) and multidisciplinary group of senior Primary Care practitioners with oversight of the PCIP implementation in their area. They meet quarterly. I miss one meeting due to not having ethics approval in time. At a second meeting, participants are slow to sign the consent forms, with one participant only signing the form at the end of the meeting. A few attendees are also participants in other groups, and I already have their consent. This group engages deeply in challenging conversations, but I was only able to attend two meetings during my fieldwork. Dr Caitlin, who chaired this group, offered her own surgery as a potential research site, which could have involved shadowing meetings over a period of weeks, or something more participatory, such as group coaching. Due to the pandemic, we were not able to pursue this, and many of this group's participants were involved in setting up the COVID-19 response in Glasgow (see Thalia, below).

Polymnia: a programme management group

One of the transformation programme workstreams has an organisational development (OD) remit, specifically to a) assist in identifying the leadership and multidisciplinary team working learning needs of Primary Care staff; b) developing or sourcing the tools and resources to support the development of skills and capabilities for multidisciplinary team working and organisational change; and c) providing a menu of individual and group interventions and trainings that have either been designed or procured by GCHSCP, or offered nationally to all NHS Scotland as a standardised improvement initiative.

I attend their meetings as a means of fact finding and cultural immersion prior to ethics approval (April to October 2019). Notes and conversations from this time were not included in my research data. Once ethics approval was granted (by the NHS and University) I shadow this group as they engage in reflection and learning for developmental practice. Our shared hope that this practice can be used by the group as a 'test of change' with a view to rolling out this learning approach, as well as sharing the learning from the work that will be done together. Therefore, participants are being asked to take part in a process that will inform not only my research but also to support their own development and to shape the support offered to general practices and clusters as they move towards enhanced teams.

Euterpe: an inquiry group

An earlier proposal for a collaborative leadership and learning inquiry group, an adaptation of co-operative inquiry (Heron and Reason, 2011), despite interest from potential groups, and financial support available (via GCHSCP) to provide locum cover while GPs attended these sessions, had not translated into a project. Prospective participants recognised the value of an inquiry group but felt – as front-line staff – that the time commitment was too great, the co-creative process too uncertain, and the absence of pre-defined outcomes / outputs that could be applied to quality improvement questionable.

My intention had been that that these could be co-created and emerge from the learning process, informed by the work being done by the Scottish Government on 'practising change together' (Sharp, 2020). One cluster was receptive to an approach that allowed for the possibility of modelling collaborative leadership as an inquiry group (collective development) and sharing their group learning with others (collective voice) in a more opportunistic, ad hoc, manner. The idea was that we would form a small group, starting with Clio staff, to sit together once a week as work was being undertaken to see what might emerge and how the wider cluster could engage. Their agenda was to produce an output, a document that voiced the frontline frustrations and barriers of implementing the PCIP. Due to the pandemic, this never started.

Thalia: a review process

As the impact of COVID-19 on the NHS and public health was becoming clear, and following guidance from the Scottish Government, Community Assessment Centres (CACs) were set up across Scotland so that COVID-19 patients did not visit their GP surgeries. In the space of 10 days, and from a standing start, premises were identified in Glasgow, fully equipped with computers, telephones, office and medical equipment, including PPE. Over 200 health and care workers from all levels of GCHSCP volunteered to staff the centre for Glasgow City, some taking on new roles or roles they had not performed for years. Their CAC design was used as a blueprint for other centres and other services[30]. Thalia was a 'lessons learned' process involving some of the volunteers who set up and staffed the CAC. The design and analysis of 1:1 interviews and an online staff survey was managed by GCHSCP. I was asked to interview three CAC volunteers. I did so with the shared understanding that these conversations would not form part of my research data, although my own experiences may. I include Thalia because I had conversations with some of my original research participants – who were also involved in the lessons learned process, but not as interviewees – and these conversations inform one of the vignettes (situations) in chapter 6.

Caring awakenings

This section outlines how my interest moved from a focus on collaborative leadership to questions of care and caring. I segue from empirical context to

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[30] https://glasgowcity.hscp.scot/news/community-assessment-centres-cacs-vital-tool-our-covid-19-armoury

conceptual awakenings. I situate the ethics of care as a theoretical movement which sought to emphasise the relational, contextual, and practical aspects. As this theoretical movement was developed by feminist, psychology, and political scholars, so the concept of care as practice formed the basis for continued development of acknowledging the doing of care work in its socio-political context. However, parallel streams of literatures emphasised the process of caring. It is these literatures, from nursing theory and moral philosophy, that guide my movement towards practising caring rather than care as practice.

From March 2020 onwards I had time to re-evaluate my research focus and approach. With the ‘data’ I had, my inquiry around collaborative leadership was no longer viable. Nor did it seem likely that I could start again without a fundamental rethink about the design and focus of my fieldwork during lockdown. It was when I read Mol’s *Logic of Care* (2008), that I noticed my field notes contained experiences of care: from the way a GP talked about their patient, to the level of attention a receptionist gave to a caller, to the design of a work process or a staff restroom, the rapport and trust between a group that enabled mistakes to be made and learned from. Additionally, when care seemed absent: in the meetings with barely contained hostility towards one professional group and the irritation of being asked to attend yet another meeting and being asked the same questions, with the expectation that the answers would not lead anywhere this time.

Mol critiques the idea of increasing individual patient choice as the means to improving patient outcomes. Instead, she argues, care comprises ongoing and collaborative adapting of knowledge, technology, disease, and complex lives. In this collective effort, the patient is a knowledgeable and agentic actor. The notion of care as habitual actions is developed by Mol, and colleagues (2010a), who contrast care in the public sphere as a ‘product’ for sale in a market, even (or especially) within healthcare, where its quality can be assessed, or care as emotional labour, and care as embodied verbal and non-verbal practice. This latter form *“may involve* *putting a hand on arm at just the right moment, or jointly drinking hot chocolate while chatting about nothing in particular"* (Mol, Moser and Pols, 2010a: 10). This was the care I experienced with my participants, as well as an awareness of a unique but tacit social dynamic in every team and situation.

I was interested to explore Mol's logic in *practice*, not from the perspective of standard operating procedures, advanced medical technology and community health and care interventions, but the day-to-day dynamics of organising, relating, and sensemaking.

Care even in a healthcare context is not just clinical, however. It can also be in the small details of a relationship developed over many years. Dr Gail tells me more than once that for many of her patients, her job is not to write another prescription, or to give them another lecture, but for them to feel seen by another person.

I wanted to widen the focus on care to the teams involved in planning for and delivering Primary Care: not just health professionals, but administrators, receptionists, and surgery managers.

These perspectives offered me a way back into my data (still believing then that data comprised my field notes and nothing else). It was empirically grounded, not just in terms of field work, but in looking to learn more about a dilemma in Primary Care that touched practitioners in a way that collaborative leadership did not: how to keep going when interventions did not militate against the deprivation their patients experienced. It was already in my field notes; I had not seen it until I *felt* it.

What was being revealed for me – in my own experiences, in sitting with my participants and listening to them talk with each other and occasionally discuss patient matters, and in reading Berger's account of Dr Sassall – was the divergence of what we think care – in a healthcare context – might mean and how it happens.

I recalled how reassuring it felt to me, when participants talked about their patients as people they knew, whose lives and loves were of interest to them, and with whom there was a shared history. I remember on one occasion when I was sat with ‘the Girls’ that one of them came into the office with a baby asleep in a pram. It was the child of one of the patients, someone they had known since she herself was a child, and so had let Elaine look after the baby while she had her own medical appointment. Or the time that Dr Gail commented that one of her male patients had spent so much of his life caring for his sick mother that he had never learned how to relate to women as potential girlfriends or partners, and that perhaps she should give him some tips about buying flowers and chocolates, and how to ‘be’ around the opposite sex.

I remembered how it felt to be ‘seen’ by my doctor or a health care professional. My dentist who tried to get in touch with me during my honeymoon. My husband and I were in Southeast Asia at the time of the 2004 Indian Ocean earthquake and tsunami. She wanted to check that we were OK (we were). The doctor who could remember the course of my respiratory condition and medication over several years without recourse to his notes. The doctor who disarmed me by asking me if I was unhappy and feeling troubled (I was).

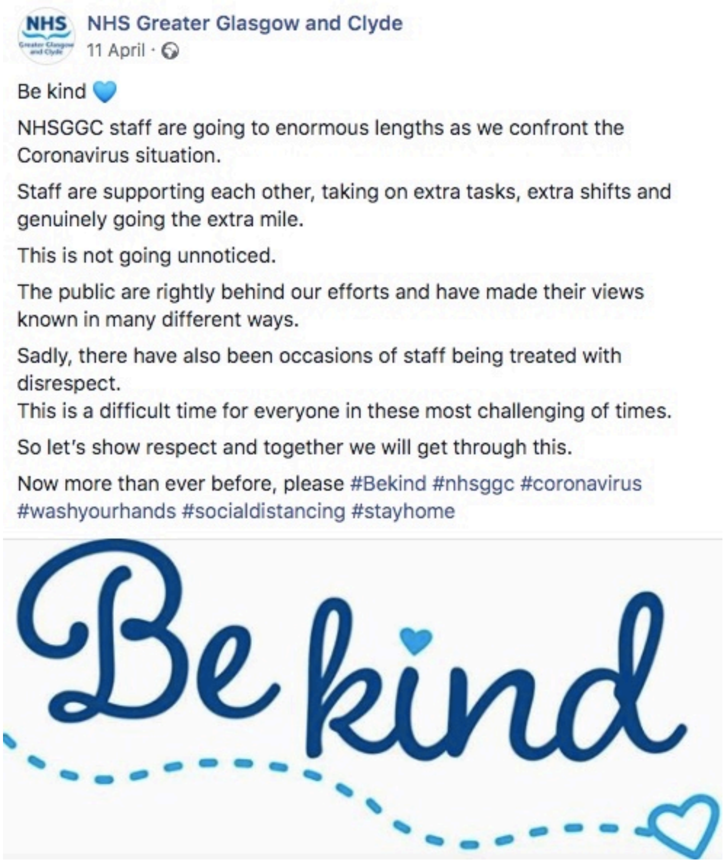
I have also experienced how it feels to not be seen when receiving clinical care. Ten days before Scotland goes into its first lockdown, I attend an outpatient appointment to get the results of cancer-related diagnostic tests. The vignette below recounts this experience, while also referencing themes that are developed in subsequent chapters. While I did not realise it at the time, this appointment was a pivotal moment in showing me how my experiences were entangled within the wider inquiry, and something to pursue in re-engaging with empirical materials.

The consultant in telling me that I didn't have ovarian cancer but that I should still have a full hysterectomy – womb, ovaries, and cervix – presented me with a situation where I had no choice or voice. To opt not to have the surgery was a bad choice, a delay of the inevitable and for no 'good' reason. The loss of my identity as a woman, even though I have never had children – by choice – and therefore perhaps didn't 'need' the parts of my body that she wants to remove, overlooked their other functions … as a source of potency, vitality, producing the hormones that sustain my wellbeing. My biology as a woman was literally to be whipped out overnight in a violent transition to cronedom. Taking HRT would no longer be a choice, reviewable with my GP, but a medical necessity for the foreseeable future.

Where the hell was the 'logic of care' or even the 'logic of choice' in that conversation? That to remove my cervix, ovaries and womb was preventative in terms of cancer or other complications at some later date? I left the consultation with a double shock: the shock of a procedure I could not refuse alongside the relief of it not being cancer, and the shock of violation that I had not been 'seen' as an agentic person. And annoyed with myself for being so lost for words and incapable of thinking that I failed to ask why it's so necessary that I probably will think about as soon as I get home and talk with my husband.

What this tells me about caring, is that it extends beyond interventions, diagnostics, and appropriate treatment. As exemplified by Dr Gail perhaps treatment is touch, a kind word, or small gesture. Tinkering, in Mol's terms, an ongoing relationship of shared and co-created experiences where all participants have agency and a capacity to be caring and be cared for.

I note how this caring cannot always be reciprocated. I have asked my current GP, when I can get an appointment with her, how she is from time to time, more as a courtesy perhaps although I notice that she never answers. And how this contrasts to my former dentist of over 15 years, me sitting in her chair, unable to speak as she prodded and scraped inside my mouth, but crying with laughter as she, her hygienist and I caught up like old friends, with robust banter and shared jokes. One of the many aspects of Dr Sassall's life, as Berger told it, that resonated with me was his entanglement. He was able to 'see' his patients – and to become them – because he too was seen, not as a remote practitioner but as kin.



NHS Greater Glasgow and Clyde
11 April ·

Be kind 💙

NHSGGC staff are going to enormous lengths as we confront the Coronavirus situation.

Staff are supporting each other, taking on extra tasks, extra shifts and genuinely going the extra mile.

This is not going unnoticed.

The public are rightly behind our efforts and have made their views known in many different ways.

Sadly, there have also been occasions of staff being treated with disrespect.
This is a difficult time for everyone in these most challenging of times.

So let's show respect and together we will get through this.

Now more than ever before, please #Bekind #nhsggc #coronavirus #washyourhands #socialdistancing #stayhome

Figure 6 From Facebook, 11th April 2020

The fundamental role of healthcare organisations ought to be to care for patients, centred around the principle of 'careful and kind care' (Allwood et al., 2021). This principle informs the transformation of health and care in Scotland (Calderwood, 2018), with its focus on 'realistic medicine'; delivering the right care to the right people at the right time in the right place.

Careful and kind care contrasts to ‘pathologies of care’ that turn caring from a fundamental relational activity into industrial processes conducted by interchangeable clinicians with interchangeable patients (Allwood et al., 2021).

As I sat at home during the first weeks of the lockdown, I notice NHSGGC promoting the message ‘Be kind’ in its social media (see figure 6 above). Handwashing, social distancing, and face covering become collective acts of social responsibility – protecting individuals, communities, and the NHS. The Carnegie Trust promotes kindness, the importance of leadership and a focus on relationships to enhance wellbeing outcomes in Scotland (Ferguson and Thurman, 2019; Thurman, 2020; Unwin, 2018; Wallace, 2019). Zoë Ferguson and Ben Thurman describe ‘relational kindness’ as an intersubjective dynamic acknowledging the vulnerabilities and complexities of relationships and allowing deep, meaningful connection between individuals (2019: 3).

Show empathy, solidarity and love for each other

“Remember that now more than ever, we need to look out for each other. So try to do that. Be kind when people around you are feeling a bit down - or just completely scunnered. We all have days like that. So offer help, if you can, to people in need - even a smile can help.”

First Minister of Scotland
Nicola Sturgeon

Figure 7 Scottish Government’s invitation for us to take care of ourselves and each other.

What was noteworthy for me – as a relative newcomer to Scotland – was the ease with which Nicola Sturgeon (figure 7 above is but one example) – Scotland's then First Minister – used the language of solidarity, love, and care in calling for us all to help each other make our way through the pandemic. Mask wearing was an act of collective responsibility, taking care of the NHS, as well as ourselves, loved ones, and complete strangers. These emotional appeals from Sturgeon – as well as from Jacinda Ardern in New Zealand – contrasted with 'war like' metaphors employed by other (mostly male) heads of government (Dada et al., 2021). Behind these metaphors I also saw a question about the extent to which calls for inclusivity and participation reflected and/or catalysed caring public behaviours (Lilleker and Stoeckle, 2021). If we talk about 'love', might we become more loving in practice? Is it a permissive practice?

Words (and the messy emotions behind them) like 'love', 'care', 'kindness' and 'healing' – particularly in European leadership and organisational research – are still, perhaps, perilous to explore in policy and academic contexts (Unwin, 2018). Feelings arising from heartfelt concern for another's well-being can collide with professional expectations to maintain 'appropriate' detachment, say Dirk Lindebaum, Deanna Geddes, and Yiannis Gabriel (2017: 653). To feel, and to act on our feelings is potential career suicide. Yet organisations are emotional arenas (Fineman, 2000; Lawrence and Maitlis, 2012; Maitlis et al., 2013) where everyday frustrations and passions are woven into the relational dynamics of performing, organising and leading; conflict and resistance; enactment of roles; how decisions get made; power and trust negotiated. More than that, perhaps love, in its various forms, is a social dynamic that mobilises and fuels creativity, caring, collaboration, trust, innovation, progress, and wellbeing (Argandoña, 2011; Caldwell and Dixon, 2010; Hummels et al., 2021; Pirson, 2022).

When I speak with Helen, she tells me that much OD emphasis is now on providing emotional and psychological wellbeing support to health and social care staff. I now notice all the ways, perhaps I am now looking out for it, that care is talked about not just in terms of the work that the NHS is doing, but that we should all be kind, that care can be manifested through touch, tone of voice, holding hands, many of the forms of social bonding that must now be withheld. Indeed, the inability to touch even makes the news as care home residents cannot be held by their family members due to the risk of transmission[31].

As I move on to deeper engagement with care literatures, so I summarise my transition. While my participants worked in health care, I had not been focussed on the 'what' of their day-to-day, but initially how they practiced collaborative leadership. Realising this line of inquiry was no longer tenable, I had to look again at my field notes to find an alternative. It was on meditating with Mol, and her perspective on care, that I began to see the potential of a study into how my participants enacted care as a practice, beyond care as work.

Situating the ethics of care

Does care mean care as (low) paid work commoditised as a product or service in a market, care as family responsibility and dependent relations, commodified as self-care, care as compassion or feeling (West et al., 2020), care as attentiveness (Howard-Grenville, 2021: 9), repair (Cozza, Gherardi, et al., 2021), interpersonal relations or 'connective tissue' (Dutton, 2003)? Is care an individual, intersubjective, or intra-active phenomenon? An innate (human) capacity or learned skill? Is it a private (domestic) or public (market) concern? Can we care for/with non-human others in the same way that we might care for/with other humans? Is care (as a noun) the same as caring (as a verb)? I address these perplexities in this section.

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[31] https://news.sky.com/story/coronavirus-care-home-uses-glass-screen-to-let-residents-see-loved-ones-11997782

Of particular significance for my study is the conception of care as a practice, with its attendant ‘care ethics’ or ‘ethic(s) of care’. Its focus is as a practical, situational, and relational ethic (Gilligan, 1977, 1993b)**.** Such an idea is not new, even if the theoretical movement is only 40 years old (although one scholar provocatively suggests the ideas in care ethics can be traced back to Aristotle (Curzer, 2007)).

The ethic(s) of care, which emerged in the 1980s, comprised a feminist articulation of a situated and relational morality in opposition to what Carol Gilligan described as a more masculine and universalist (Kantian) ethic of justice (Edwards, 2009; Hawk, 2011; Slote, 2007), where ‘justice is a rights-based ethic and care is needs-based’ (Noddings, 2015). This dualism between care and virtue ethics has been challenged (Covrig, 2000; Engster, 2005; Hawk, 2011; Held, 2006, 2015; Sander-Staudt, 2006), with scholars offering alternative theorisations that, they argue, more equitably unify care and justice. Another prevalent dualism that some care ethicists sought to challenge, is reason/emotion (Sander-Staudt, n.d.). Maureen Sander-Staudt (2015) points out that this dualism is also rejected by pragmatists and feminists, who acknowledge the importance of feelings in our daily interactions, while highlighting the political potential this may hold for societies. Despite some attention to feelings, mainly by Virginia Held and Daniel Engster, it remains an under theorised and contested aspect.

Much of the early literature on care arose from feminine and feminist scholarship, political and psychological sciences, education and the caregiving professions (Gilligan, 1993b; Held, 2006; Kroth and Keeler, 2009; Noddings, 1984; Tronto, 1993). Care ethics is polyphonic (Engster, 2015: 18–19) with many different and divergent views – largely informed by a relational ontology – some of which I explore in the following chapters. Following Frans Vosman (2020), therefore, I write about care ethics in the plural: care ethic(s).

Nel Noddings (1984) established its philosophical foundations (Lawrence and Maitlis, 2012), also stating that as a relational ethic, care ethics recognises the roles of both carer and cared-for in establishing and maintaining the caring relation, although reinforcing a dependent dynamic: when the cared-for completes the relation by acknowledging the efforts of the carer (Noddings, 2015). For care ‘supposes concrete asymmetrical relations’ (Brugère, 2014a). For Noddings, it represents a personal investment that must always remain at the level of "I", as caring at the more abstract level of "We" is an illusion (Liedtka, 1996: 183), because caring can only exist in the relationship between the one caring and the one cared for, a position challenged by Held and Michael Slote (2007). It reinforces individualism and separateness, as well as static and dependent relations.

This emphasis on who knows what needs to be done in a care encounter – typically assuming that the care giver knows best on the basis of power or expertise – has been challenged (Kittay, 2011; Mol, Moser and Pols, 2010b). Mol, and Eva Kittay, for example, suggest that the care receiver knows what is needed, and should form part of the care giving. I can see resonances between Scotland’s National Clinical Strategy and a view on care that recognises patient ‘expertise’. Nonetheless, prevailing literatures – in extending care ethics theory or applying care thinking to questions of organisations and organising – reinforce this dependency dualism rather than envisaging knowing as a situated and social inquiry.

Subsequent care literature assumes that care is a product or service (Chatzidakis et al., 2020; Dowling, 2021; Tronto, 1993, 2013a); subject to marketisation and the exploitation of marginalised labour (women, people of colour, migrants – low paid and precariously employed) for the provision of this ‘dirty’ work. Such caregiving organisations are distinguished by some people caring for others (Kahn, 2005), in responding to the needs of those who experience welcome and other times frightening changes to their health and wellbeing. Or that care is a private, domestic, concern, typically taken up by women in their roles as mothers and carers for ageing relatives, modelling what is typically the earliest relationship of care between a mother and her child, often while trying to maintain their own careers (Bunting, 2020; Noddings, 1984; Tomkins and Simpson, 2018).

While Joan Tronto moved care into the public domain, with its attendant questions of power and democracy, care is still theorised in terms of *'caring for'* – as healthcare practitioners are paid to do – rather than *'caring about'* (our colleagues, environment, work, as well as patient care) others with whom we are relationally connected (Price-Dowd, 2017). While caring for and caring about may be an aspiration in caregiving contexts, caring about offers the possibility to extend a practice of caring into wider questions of social, political and environmental justice, as well as organisation studies. The risk is that caring about becomes another practice / routine that separates good carers from uncaring ones.

This normative (Atwijuka and Caldwell, 2017; Barnes, 2012) ethical practice has since been applied to care as paid and unpaid work, and in particular the caring professions, but has wider, organisational and societal (human, beyond-human and ecological application (Barnes, 2012; Curtin, 1991; Hamington, 2008; Haraway, 2016b; Montes and Paris Pombo, 2019; Puig de la Bellacasa, 2011, 2012; Sama et al., 2004)) – to questions of stewardship, justice, equity, solidarity, and democracy. I will return to this point in chapters 6 and 7.

Organisational scholarship typically offers a Critical orientation that perpetuates dualistic (and contested (Noddings, 2015)) conceptions of care in 'caring organisations' (as opposed to care-giving organisations) involving role-based power relations of dependency and followership (Fotaki, Islam, & Antoni, 2019; Gabriel, 2009; Hawk, 2011), or sees care as an organisational practice rather than individual competence (Gherardi and Rodeschini, 2016; Mumford et al., 2020b).

On the whole, critical literatures associate care with vulnerability, pain, suffering, and dependency (Brugère, 2014a; Bunting, 2020; Sander-Staudt and Hamington, 2011); typically for the cared-for in the care dyad, but also at times for the one-caring. Indeed, Fabienne Brugère (2014a) suggests one cannot reflect on the ethics of care without subscribing to an 'anthropology of vulnerability' of both the cared for and the carers.

I now move on to a pivotal theoretical development in care ethics, the notion of care 'as practice'. As I mentioned in chapter 1, there is now broad consensus among care theorists that however care is named and theorised, it is all praxis. I diverge from this perspective, as I will go on to explain.

Care as practice

In responding to the ethic of care as a 'feminine' women's morality, tied to notions of naturalness in caring, which removes care from the realm of choice, Tronto (1993) stated that any ethic of care must be placed in its full moral and political context. From this feminist perspective, Tronto argued, care is a practice, rather than a set of rules or principles, which involves both 'particular acts of caring' and a 'general habit of mind' that together inform all aspects of a practitioner's moral life (Tronto, 1993: 5). This sub section explores the 'as practice' development of care.

Care practices are ongoing, messy, and complex. In this context, 'good' care happens when the activity of caring and the disposition to care are both present, and where all phases and moral aspects fit together as an integrated whole. With more practice, we get 'better' at caring. This normative definition of care, provided by Berenice Fisher and Tronto (1990), has formed the basis of Tronto's subsequent work on an ethic of care (1993, 2015).

In *Moral Boundaries* (1993), Tronto outlines four moral aspects – attentiveness, responsibility, competence, and responsiveness – recognising that they are rich with moral dilemmas around inequality; such as parochialism and paternalism, the sublimated needs of the caregivers, and detached care and otherness. As care is about meeting needs, it is always relational and infused with power. Therefore, for Tronto, an ethic of care remains incomplete without a corresponding political theory of care.

Despite the more expansive definition of *caring* above, which forms the conceptual basis of Tronto's (1993, 2010, 2013a, 2013b, 2015) subsequent work on care ethics, she narrows her theoretical focus on the acts of 'care work', reimagining care as a gendered 'public practice', or product, in a market economy – dirty work undertaken by marginalised and precariously employed women, including migrants, working class, and women of colour – as opposed to the 'private' care that women undertake in homes for family members. Thus in stating that any ethic of care must be placed in its full moral and political context (1990; 1993), Tronto moved care ethics into the public domain with its attendant questions of power and democracy. In this context, 'good' care happens when the activity of caring and the disposition to care are both present. With more practice, we get 'better' at caring.

While there is consensus among care ethicists that care is practice(s) (Barnes, 2012; Engster, 2005; Held, 2006; Liedtka, 1996; Mol, Moser and Pols, 2010b; Monchinski, 2010; Olthuis et al., 2014; Tronto, 1993, 1998, 2015), and particularly a face-to-face practice where work is undertaken on a 'direct level' (Hamington and Sander-Staudt, 2011), most scholars continue to theorise care by extending its political philosophical scope, rather than its application in public policy or practical action (Engster, 2015). Sander-Staudt and Maurice Hamington (2011) widen the thinking about care to include epistemology, goal, motive, emotion, skill, virtue, practice, and orientation, as well as some combination of these.

In the so-called third generation of care ethics (Vosman, 2020) – that is scholarship building on the work of Noddings, Gilligan, Tronto and others – more attention is paid to care as practices (i.e. activities), extending the contribution of care ethics to aesthetics, and design thinking etc.

Exploring *how* caring is practised *ongoingly* – as a process rather than practice(s) – revisits the foundational but subsequently overlooked idea of *caring as a process,* first articulated by Mayeroff, Noddings' (1984) articulation of a feminine care ethic based on 'natural', maternal, caring, later developed in Fisher's and Tronto's feminist theory of caring. Both works laid foundations for the political and feminist 'ethic(s) of care' movement even if their scholarship (and others) has moved towards a politicised and contested idea of 'care'.

I suggest this oversight in understanding Mayeroff's distinctive contribution presents an opportunity for my study to develop a more performative articulation of caring, as an entangled 'knowing how' (Mayeroff, 1971; Ryle, 1945); emphasising a doing orientation rather than 'knowing what' or expertise.

Of particular relevance for my study is a perspective on care practice offered by Gherardi and Giulia Rodeschini (2016). Care is not an innate human capacity, they say, but an emergent organisational competence or practice, a situated *knowing* that a group of professionals enact while attending to everyday tasks. Their aim was to rethink care from dyadic relations between patient and professional caregiver — where care competence is identified as attentiveness, responsibility, and responsiveness — to an organisational context where caring is performing collective know-how with a shared orientation to a matter of concern. They shift the focus of care from the individual actors to the collective doing of caring.

Is 'care' a noun or a verb, and why might this be significant? Gherardi and Rodeschini suggest the difference matters: *"While 'care' as a noun leads to the* *exploration of values and concerns about moral order and the understanding of good and bad, 'caring' as a verb leads to the exploration of the practices whereby care is performed and its value is asserted or contested in the context of practising"* (2016: 268).

There are many empirical overlaps between their study, which took place within a nursing home for the elderly in central-northern Italy, and my study within a health and social care partnership. Their study consisted of an organisational ethnography of care practices based on participatory observation, shadowing, and in-depth interviews. My study began with a similar design but for a different intent. They identified care practices that comprised taking physical care of the residents, taking care of the physical premises, and administrative, bureaucratic, and managerial work done 'in the background'. My focus was solely on the 'background' work. The intention of their study was to develop Mol's 'logic of care' thinking. My study was designed around a different motivation – collaborative public leadership in practice – only 'arriving' at Mol after my fieldwork had ended. I wasn't looking for care, but it emerged in my data regardless. Mainstream care ethics literatures seem to suggest that my experiences do not constitute 'care' as they define it. I develop this point in chapters 4, 5, and 6. A divergence is that Gherardi's and Rodeschini's study of caring theorises posthuman and sociomaterial practice, whereas my study inquires into the social dynamics of practising caring, informed by feminist technoscience and (feminist) pragmatist ideas (bodies of activist thinking with a focus on emancipation and social progress (Seigfried, 1996)).

Tronto was the first to situate care ethics in its political context, so that we might understand the market, gendered, and patriarchal forces that determine who gets care, and who does the care, and what care means as a practice. Feminist technoscience scholars, however, propose a more generative politics of care, where *"what we must do is take better care of how we care"* (Martin et al., 2015: 7). It was in reading Mol and care ethics literatures alongside feminist technoscience scholars such as Bellacasa, Haraway, and Barad, that I began to understand how *“caring differently can bring about ontological shifts in our conceptions of time and our relationship with others”* (Martin et al., 2015: 9).

Having highlighted the potency of distinguishing between care as a noun, and caring as a verb, I now go on to think with caring theorists, such as nursing philosophers.

Caring theory

In this section I introduce caring theory and its diverse literatures in nursing and moral philosophy, as a significant and processual counterpoint to care ethic(s).

Noddings later stated that caregiving should not be equated with caring as a moral way of life (Noddings, 2012). However Simone Roach (2002: 2) said caring *is* the human mode of being, expressed in *“virtuous action and in habits acquired over time”.* For Roach, caring is not an exceptional human quality, nor the response of an exceptional few. Opportunities to be caring are not usually dramatic events, she continued, but the simple, unobtrusive encounters of daily life - a smile, a helping hand, a word of encouragement, an expression of sympathy, or being caring enough to reprimand. Caring is something we practice, ongoingly, with others.

Amongst the first contemporary philosophical works on caring were Mayeroff’s essays (1965, 1971), in which he proposed a ‘logic of effectiveness’ within an ongoing relational process of caring. Caring, Mayeroff said, is to help another grow, whether ‘another’ is a person, an ideal, idea, work of art or community. While some care ethics and management scholars reference Mayeroff’s ideas (Fisher and Tronto, 1990; Hamington, 2010; Kahn, 1993; Kroth and Keeler, 2009; McGuire et al., 2021; Nicholson and Kurucz, 2019), even using care and caring interchangeably, none engage with and develop his *processual* articulation of *caring*.

A philosophy of human caring also has roots in nursing theory and practice. Nursing theorists such as Roach (2002), Katie Eriksson (2002; Östman et al., 2019), Jean Watson (1997), Madeleine Leininger (1996), and Anne Boykin and Savina Schoenhofer (1990), and many others (Alligood, 2018; George, 2014), explore the phenomenon of caring in nursing with an emphasis on practice(s). Caring comprises one of nursing's 'grand theories' (Alligood, 2018; Parker and Smith, 2010: 316). Boykin and Schoenhofer (1990: 372) state that *"the full meaning of caring cannot be restricted to a definition but is illuminated in the experience of caring and in the reflection on that experience".* This duality of action and reflection on action is redolent of the Deweyan concept of Inquiry, as well as Mol's tinkering.

Another theme in nursing philosophy is the relationship between love and caring. Eriksson (2002: 62), for example, writes of a 'caritative ethic' (where caritas means unconditional love) where *"caring relationship forms the meaningful context of caring and derives its origin from the ethos of love, responsibility, and sacrifice".* I am struck at the ease with which nursing philosophy embraces love in its caring praxis (Arman and Rehnsfeldt, 2006).

Some nursing theorists extend their conceptual focus to other helping professions, and to wider societal concerns. In describing caring as a mode of being Roach (2002) outlines caring for human and non-human others (including the universe) as well as caring for ourselves. She invites us to move beyond thinking about care in the context professional roles so that we might understand caring in relation to 'being-in-the-world.' For Watson (2010) love and caring come together, extending to ourselves, others, nature, and the larger universe. If care is limited to human endeavour, as the care theorists opine, perhaps caring offers a more sociomaterial, human and beyond human, potential, or the tinkering that Mol imagines.

Haraway and Barad, among others, extend the concept of caring as ongoing, non-binary, human**e** and beyond human response-ability; with urgent provocations to ‘think with care’ (Puig de la Bellacasa, 2012). Barad (2012: 216) explains to me that perhaps it takes encountering our inhumanity – who and how we other – before caring can emerge, to rupture our *in-difference*. They speak of *com-passion* (Barad, 2012: 216): suffering together with, participating with, feeling with, being moved with. More than a response to another’s vulnerability, pain, suffering and dependency (Brugère, 2014a; Bunting, 2020; Kittay, 2011; Noddings, 1984; Sander-Staudt and Hamington, 2011), it seems to me that in caring we are responding to a mutual desire for justice, growth, and change. Iris Murdoch (1970) says that although scholars might talk of justice or freedom, they rarely talk of love, which is how we come to know others.

Barad (2012) says this is troubling we need to stay with, for troubling is at the root of caring. Realising that caring might become a creative line of inquiry in my research was a breakthrough in helping me see that my research participants may also be experiencing conflictual feelings as caregivers, colleagues, and friends, in discerning how to respond caringly in vexatious situations.

Kathy Burnett and Guy Merchant (2020), in developing Brian Massumi’s (2015) idea of caring for belonging, propose an ethic of caring that comprises the ambitions of 1) unsettling established ways of knowing, ordering or understanding the world, 2) sensing possibilities to be otherwise, and 3) nurturing relations that are equitable and socially, politically and environmentally just.

As I reflect on Burnett and Merchant, so I see connections between their ethic of caring and Addams’ (1902, 1911) social ethics. We are motivated by troubling feelings – or perplexity – to inquire into the specifics of a problematic situation. This inquiring enables us to take a tentative course of action. These collaborative actions exemplify ongoing participation in democracy as social progress.

There is much more to Addams' social ethics, a point I return to in chapter 8, but it is these three aspects that influence how I structure my analysing – with a focus on attuning (chapter 4), inquiring (chapter 5), and coattending (chapter 6). While those who theorise 'care' agree that what sets it apart from theories of justice or moral sentiment is a focus on situated action, how we are mobilised to act, with whom we act, and how these actions matter, is more problematic.

Chapter summary

In this chapter I outlined the empirical and conceptual context of my study. As I explained in chapter 2, my understanding of what constitutes 'data' moved from what was captured in my field notes – and with an emphasis on what was said – to the totality of a situation. In this chapter, I show how this different understanding of data was, and my experiences were, at odds with what care ethics literatures tell me 'care' looks like.

Care, caring, the ethic or ethics of care, care ethics, all are used by different authors and sometimes more than one is used by the same author. Monchinski (2010) argues that these terms are compatible if not interchangeable, given their shared commitment to praxis. I have a different perspective. These definitions typically focus on the *what* of care – what is it – and the *who* – who does it and who do we care for/about (our family, friends, people we are paid to care for); although some also focus on the *why* – cui bono.

In picking up the feminist ethic of care *as practice*, and further developed by feminist technoscience scholars, I ask what 'as practice' means 'in practice'. A processual understanding of caring – as a verb – is foundational to my inquiry. This perspective affords attention to situated social dynamics, calling into question how we know what is discernible and how we then act (Mayeroff, 1965: 468).

The spirit, language, and vocabulary of practising caring can be found in three theoretical sources: in the philosophy and practice of nursing, as one of its grand theories; as an explicit concept in the early work of Tronto, Mayeroff, and Noddings; and implicitly in the works of Addams, Haraway, and Barad.

What these voices tell me is that caring – as a verb or action – is central to all social experience. It is not limited to health or social care, women's work, and/or other undervalued labour. Caring engages the whole person and not simply the mind or body, sense, or reason. It is a becoming in relationship with (an)other(s) that develops and deepens over time (Mayeroff, 1965, 1971). In taking the needs and concerns of others as the basis for action (Barnes, 2012: 8), we might respond with tenderness and a feeling of oneness (Mayeroff, 1965: 464). For Mayeroff, this other may be a person, or it could be an idea, an ideal, a community, or a living non-human entity.

I now move on to explore three caring dynamics – attuning (chapter 4), inquiring (chapter 5), and coattending (chapter 6) – that may tell us something about how caring happens. One of the more challenging aspects of writing this thesis has been working out how to divide the empirical and conceptual materials into chapters that helped to build an argument, while at the same time not giving the impression that the argument was preformed prior to writing. I make extensive use of vignettes in chapters 4, 5, and 6, and I had thought to use one vignette per chapter as a basis for exploration for several caring themes. This would have shown how each vignette is more a more complex entanglement of social dynamics but would also have led to repetition across many chapters, where there were recurrent themes/dynamics.

Due to this risk of repetition, it seemed to make more sense to highlight specific dynamics that might say something novel about how caring happens in practice. I have selected three, but in doing so I do not rule out other dynamics – such as a more sociotechnical perspective. Nor do I suggest that these dynamics themselves comprise a linear process through which caring happens as an outcome. That said, when I reflect on my own experiences, my understanding of pragmatist inquiry, and diffraction, so I can see that a felt awareness of difference in a situation is a first response in caring. Whether we then move to inquiry or straight to action – or indeed take no action at all – is determined by the needs of the situation. Dewey's logic of inquiry might suggest inquiry before tentative action, and so the following chapters reflect this sequence, and how caring manifests in each aspect.

What connects these subsequent chapters is a noticing of the limitations of the ideas and language of care ethics and critical organisational scholarship. My intent is to answer the first part of my motivating question: **how is caring experienced from a processual perspective?** As I diffract empirical experiences, literatures, and my resonances, so I see potency in more generative, performative, and processual perspectives. These alternatives call for different language and vocabulary, which I will discuss in chapter 7.

Chapter 4 – attuning

Introduction

In the last chapter I outlined the empirical and conceptual context of my inquiry. As my field work was undertaken in healthcare, my initial interest in care literatures was how a different thinking about care practices in relation to caregiving might lead to novel insights. As I moved with literatures such as caring theory and moral philosophy, so I began to understand care in more processual terms – as caring – that was as much about our embodied responses as taking collaborative action. This helped me see caring as a social process, potentially saying something different about how caring – as a verb – is enacted, and not just in caregiving organisations. It was from this position that I became curious about the seeming ambivalence in care ethics literatures about feelings and other bodily responses as a mobilising and ethical dimension in caring encounters.

In this chapter I investigate how relationality, as ontology that pervades care ethics literatures, reinforces separation rather than entanglement. This separation perpetuates dualistic and dyadic notions of vulnerability, dependency, and detachment. Thinking with Barad, Addams, Mayeroff and others, and from a processual perspective, I see entanglement as the condition of human and beyond human existence and becoming with. From here, I understand our feelings as embodied experiencing of the other from the inside. What we feel – and however we feel – is a troubling, an awareness of difference and the potential for the situation to become different. Arguably, this is how we become mobilised to inquire into what needs to be done. This is what I mean by attuning, for *“troubling is at the root of caring* [where] *exposure to the other is crucial … we are … opened up to the other from the ‘inside’ as well as the ‘outside’”* (Barad, 2012: 216).

After retelling an empirical situation, I explore how literatures and my personal experiences may be engaged to notice differently what insights are afforded by care literatures' response to felt experience, before analysing consequential emergent themes using processually oriented caring theories and social ethics, as an experimental process of 'documenting the invisible' (Pallesen, 2017). I then discuss the practice-theorising potential of attuning – noticing and being moved by our feelings – as an aspect of a caring ethos.

Situation 1 - becoming one of the Girls

Although there is variation in representation between different staff groups and levels of seniority, women make up more than 78% of the NHS workforce in Scotland. The median age of the workforce is 45, and nearly 25% is over 55[32]. Not only were most of my participants female, but older women, particularly those in administration, Learning and Development, and nursing.

I am increasingly sensitive to what it means to become older, experiencing the menopause – as all women[33] do – and our subsequent transition into elderhood. I started using hormone replacement therapy (HRT) around the same time that my fieldwork commenced. My eventual choice felt like an admission of failure at the time, giving in to the difficulties I was experiencing on a day-to-day basis: including an incapacity to think, crashing exhaustion, unpredictable mood swings, paralysing social anxiety, and omnipresent dark thoughts (not to mention the physical effects). Not such great attributes for a researcher about to spend nine months in the field for a dynamic and collaborative inquiry. My alternatives were anti-depressants and the very real possibility of having to give up the PhD.

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[32] https://turasdata.nes.nhs.scot/media/j0vdmiul/workforce-report-june-2022-formatted.pdf

[33] As well as some transmasculine, intersex and non-binary people. I refer to 'women' here although I acknowledge that is 'cishet' – cisgender and heteronormative. I am writing from my partiality as a cis woman about others who were more than likely cisgender, rather than menopausal people in the abstract.

I am shadowing a group of administrators at ‘Calliope’, whom everyone calls ‘the Girls’. I find that demeaning and infantilising on their behalf, even if they seem to enjoy the name as giving them a collective identity. I want to ask them why they put up with it, but I also wonder if they would think me an angry and too serious feminist for asking the question. So, I don’t.

This change of life depicted as the transition of the triple goddess (the triunity of maiden, creator and crone in neopaganism), is an idea of the Muse popularised by Robert Graves (1997: 22). Becoming crone is a more nuanced age of wisdom and power, as well as to relish in being a disagreeable hag from time to time, according to folklore.

In the admin room, with the Girls, talking about the menopause and how warm the room was, I joined in because I was overheating too. I was distracted by the radio, not because it was on but because they were listening to a radio station I didn’t like. I was irritated by someone for no reason. My focus wasn’t on the Girls but on my own [dis]comfort. I am so easily irritated these days. Actually, I seethe with rage.

Patient studies in the UK highlight how hormone depletion associated with the menopause can have a significant impact on attendance and performance at work. Nine out of 10 of the 4.5 million people of menopausal age in the workforce find it difficult to cope with work during the transition (Muir, 2021; Scott and Newson, 2019), with around 10% giving up their jobs due to the severity of symptoms and many wrongly identified as having ‘performance issues’ (Newson, 2018; Scott and Newson, 2019). Women just like the Girls. Menopause is a workplace and societal concern as much as a personal transition (Suff, 2019; Woods, 2021).

The menopause is a natural transition, marked by the cessation of menstrual cycles and decreasing production of the hormones that regulate physical, cognitive, social and emotional functioning and wellbeing (Gupta, 2020). However, it is more than a ‘biomedical event’ and the ending of fertility (Hyde et al., 2011). People can experience menopause as a time of change and development (Degges-White and Myers, 2006), including renegotiating identity and sense of self, as well as creative capacities (Hyde et al., 2011; van Laak, 2020).

The menopause is also becoming more topical, with television programmes, awareness campaigns, workplace studies, economic impact studies, and even product advertising. Not only does society impose shame on us that we age, medicalise a natural process so that we stay visible, relevant, and desirable by suppressing the potent changes happening inside us and their outward manifestations (Greer, 2018). Now, we do not consume enough relative to our perceived socio-economic privilege as ‘Generation M’ (Jackson and Simister, 2021).

All this information is buzzing around in my head, along with the hormone boost and anger that I let myself decline for so long. I am on a mission: to never let another menopausal person suffer. Now, when I look at these Girls, I wonder about them, looking for signs of anxiety and withdrawal, stiffness in our joints when we move, knowing glances as we feel each others’ bodies overheating, and laughter as we strip off layers, opening the window while someone crawls under the desk to turn off the radiator. Hearing these women talking about being refused HRT for no reason or misdiagnosed as experiencing burnout or stress[34].

I want to scream.

So much for the promise of careful and kind care…and this transition that all women go through, whether they experience it as a debilitating nightmare, it passes unnoticed, or a glorious liberation, challenging stereotypes about ageing and feminine fragility, where *“yes, your entire pelvic floor crumbles, and yes, you get*

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[34] https://www.themenopausecharity.org/2021/10/21/common-misdiagnoses/#:~:text=Although%20depression%20can%20%E2%80%93%20and%20does,re%20feeling%20flat%20and%20tearful.

fucking hot, and yes, no one cares … but then you're free, no longer a slave, no longer a machine with parts. You're just a person, in business…" (Waller-Bridge, 2019) riles 'Belinda'[35] in the BBC TV series Fleabag.

In those moments, I became one of the Girls, no longer distinguished by my difference as 'the researcher' or the 'spy from head office'[36], but a fellow ageing woman struggling with her own increasingly alien body and mind while feeling we are so much more than this. On writing about the menopause, Ursula Le Guin says that: *"only a person who has experienced, accepted, and acted the entire human condition – the essential quality of which is Change – can fairly represent humanity"* (1997: 6). What is perhaps notable about the writings from those whose material is menopause and the middle age, is the exploration of more complex and nuanced understandings of kinship and the communal (Feigel, 2018).

To become one of the Girls is to gain superpowers, such that it should be a crone who represents humanity in Le Guin's distant universe. I now see them, not solely as administrators (as well as the GPs, health professionals, and senior managers in my study), but crafting complex worlds, where wisdom is continuously created through reciprocal relationships, accomplishing changes that would be otherwise difficult to achieve (Spiller, Pio, et al., 2011). That is their superpower. They get shit done. Rather than essentialising women's work, Verónica Montes and María Dolores Paris Pombo (2019) argue, transformational caring is enacted through collaborative action – practices based on trust, reciprocity, and solidarity.

I got invited to lunch with the Girls. As we stand up to leave their office, Liz jokes about me being part of the team now and finding some work for me to do. I am 'one of the Girls' and it feels good. Now that I am, I feel the weight of their commitment, the pull between letting others take the lead on using the new

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[35] You can watch Belinda's magnificent soliloquy here: https://www.youtube.com/watch?v=RZrnHnASRV8

[36] Not to mention being English, with a corporate background, and of mixed cultural heritage. I really did 'stick out like a sore thumb', to use an English idiom.

processes and wanting everyone to adapt faster. I rile about the perceived simplicity of ‘doing admin’, a task that most assume does not require much skill, and the responsibility they feel about the new workflow tasks. The importance of getting it right, the consequences of missing something our getting it outright wrong. Mayeroff (1965, 1971) tells me that this ‘being with’ is how caring unfolds, when we become the other person with whom we are in a caring relationship so that we can sense ‘from the inside’ how to care.

Another time, another place. Dr Gail and Helen, and later I realise Eleanor and Abi too, all strong, capable, and accomplished professionals. At the same time beneath that – not far beneath – lie stories of naïvety, isolation, and fragility. In my field notes I have written ‘Hard boiled comes before the meltdown’ and drawn a box around it. It sounds like the title of a Murakami novel. But why did I write it? It is written on the page after I list all the ways that ‘abuse’ is experienced by my participants (and their patients). I left a site in tears once after two participants recounted tales of abusive situations as if to prove to me how tough they were in coping with the crap of GP surgery life. It felt like an initiation rite, do I have what it takes to be here too?

Dr Gail said there was a time when she felt she couldn’t talk about what was going on in her private life. It needed Tracey to come over to her and say, ‘we know you’re not well and it’s OK to talk about it’. Months later, I can see prescience in these words: ‘Hard boiled comes before the meltdown’. They were written the week before the first lockdown. A week before Primary Care changes in ways that no-one believed could ever happen so quickly.

Tuning in to the situation - contributions from care literatures

In this section, I discuss what *felt* aspects of care in practice can be discerned in the above vignette using care ethics and organisational care literatures. In anthropology of vulnerability, I show how the dyadic focus of care ethics perpetuates unequal relations between the those who give and those who receive care. In moral sentiment and professional detachment, I explain how feelings are problematic in care ethics, not necessarily to be trusted nor acted upon. I then move on to diffract these perspectives, offering a more processual perspective that draws on caring theory, social ethics, and moral philosophy.

Anthropology of vulnerability

This sub section discusses arguably the most pervasive motif in care ethics. *“Care is fundamentally concerned with relationships of inequality - whether of skill, capability, stature or experience”* (Tomkins and Simpson, 2018: 92). Vulnerability in relationships of care is a central tenet of care ethics, at all times differentiating between those who give care, and those who receive it. While some care ethicists acknowledge these relations are more fluid – we are all care givers and care receivers at various points, often concurrently – the language of vulnerability also perpetuates dynamics of dependency and suffering.

Care, and our workplace relationships, inform how we experience work in organisations (Fotaki et al., 2020a). Gilligan’s foundational work on an ethic of care was predicated on an understanding of the psychology of human relationships, that self and others are interdependent. In this context, the activity of care enhances the self as well as the other (Gilligan, 1993a: 74). Gilligan thus theorised care as a practical, situational, and relational ethic. The subsequent development of her ideas has consequences, however, reinforcing dualisms of separation, power, vulnerability, status, and voice.

On the whole, care literatures associate care with vulnerability, pain, suffering and dependency (Brugère, 2014a; Bunting, 2020; Engster, 2019; Sander-Staudt and Hamington, 2011); typically for the cared-for in the care dyad, but also at times for the one-caring. Indeed, Brugère (2014a) suggests one cannot reflect on the ethics of care without subscribing to an ‘anthropology of vulnerability’ of both the cared for and the carers. This perspective also raises questions of responsibility (Walker, 2007): who responds to the vulnerable, how are those responsibilities distributed, and is this moral order fixed.

The early archetype for these caring dynamics was the care given by ‘wives’ and ‘mothers’ (Bowden, 2000; Noddings, 1984; Tomkins and Simpson, 2018), and perhaps more broadly, ‘parents’ (Mayeroff, 1965), taking care of vulnerable others in their charge. This emphasis on maternal caring as a template for ‘good’ care has been criticised for perpetuating care as an innate – particularly for women – and gendered skill (Mol, Moser and Pols, 2010b; Tronto, 1993). Sandra Laugier (2015: 219) states that *“dependence and vulnerability are aspects of a condition common to all, not just a special category of humans, ‘the vulnerable’”,* suggesting that care and moral theories can *“reduce the activities and preoccupations of care to a concern for victims and for the weak”.*

Vulnerability *is* a theme within the vignette and is an aspect of experience – whether it is the result of ill health, menopause, abuse, and more. Care is fundamental to experience, however, and is necessary for survival *and* flourishing (Barnes, 2012; Haraway, 2011; Islam, 2013; Nackenoff, 2009; Pulcini, 2017). However, vulnerability can restore feeling as a motive for action that pervades ethics, it is argued (Engster, 2019).

While much writing on care in organisations has positioned it in response to suffering, Thomas Lawrence and Sally Maitlis (2012) suggest that feminist literature offers the potential to see care as an ongoing central dimension of relationships, experienced in the quotidian. This shifts care from being anchored in caring professions, such as healthcare, to being anchored in loving (although still dependent) relationships. Philip Linsley (2015) goes further – echoing the work of

Tronto, Gilligan and Noddings – in saying an ethic of care perceives relationships to be of primary importance, as it is through relationships that we are connected to others.

The above vignette *could* be seen as exemplifying manifestations of vulnerability. They comprise suffering at work and conflictual workplaces. I think about Dr Gail, Helen, Abi, and others, for whom it seems so difficult to ask for help, or at least to acknowledge that some days are more challenging than others. Suffering at work is understood to mean the ubiquitous (Kanov et al., 2017) lived experience of suffering due to work, where suffering is an 'intrinsic' aspect of the contemporary neoliberal organisation of work, or arising from the turmoil of everyday life – including work relations, oppression, harm, despair, burnout, personal or financial issues (Dashtipour et al., 2020; Linstead et al., 2014). These bodily experiences are 'injurious to human welfare', reinforced by the division between the personal and professional realms of life (Kanov et al., 2017). From a critical scholarship perspective, I might focus on all the ways the organisational structures perpetuate and inflict suffering – from heroic organisational cultures to sexism and ageism, and structural failings within an increasingly under resourced healthcare system. These perspectives are important to investigate, although not the focus of my study.

However, if an anthropology of vulnerability is predicated on a relational ontology, I find myself wondering how the experiences in the vignette might be seen and discussed differently from a processual ontology. More than a response to another's vulnerability, pain, suffering and dependency (Brugère, 2014a; Bunting, 2020; Kittay, 2011; Noddings, 1984; Sander-Staudt and Hamington, 2011), it seems to me that in feeling we are becoming mobilised to respond to a mutual desire for justice, growth, and change.

I return to the quote by Leah Tomkins and Peter Simpson. Care – as theorised in care ethics – does reinforce dyadic relationships of inequality, perpetuating dualisms of power, knowledge, and agency. This dualistic perspective also sees care and duty in opposition, as well as taking agency and capacity away from all participants (Kittay, 2011). It is the question of attachment and detachment that I now move on to.

Moral sentiment and professional detachment

"Perhaps the most important characteristic of an ethic of care is that within it, moral situations are defined not in terms of rights and responsibilities but in terms of relationships of care" (Tronto, 1987: 658). In this sub section I explore some of the contradictions in care ethics about the extent to which our feelings are necessary and/or get in the way of giving 'good' care. Rather than seeing care as something good (and by inference, also bad), I suggest that all feelings have ethical potency.

Care ethicists do acknowledge the centrality of feeling in moral life (Gilligan, 1993b; Slote, 2007; Tronto, 1993). Noddings states that the language of care ethics may suggest to some that caring is a warm, fuzzy feeling that cannot do much to highlight or alleviate moral problems. However the words care, attention, empathy, response, reciprocity, and receptivity all have special meaning in care ethics, where 'caring' is a moral way of life (Noddings, 2012).

From a care perspective, moral inquiries that rely on reason and rationalistic deductions or calculations are seen as 'deficient' (Held, 2006). Feelings such as sympathy, empathy, sensitivity, responsiveness, and even anger, enable morally concerned persons in specific contexts to understand how they might respond.

However, despite the acknowledgement that we cannot care without feeling for the other (itself an asymmetrical or dyadic perspective typically emphasising the carer's feelings, whether those feelings are tenderness or disdain), indeed we cannot be human(e) without feelings, some care ethicists suggest care is in need of desentimentalising (Brugère, 2014a), or categorising so that we can highlight the feelings that motivate 'good' care (Pulcini, 2017). Others opine that the relationship between care ethics and empathy (as a proxy perhaps for other feelings) is 'rife with opposing views' (van Dijke, 2018; van Dijke et al., 2019) and serves as a *"catch-all for many kinds of phenomena, including emotional contagion, perspective-taking, projection, empathic concern, and personal distress"* (van Dijke et al., 2019: 1284).

We are invited to feel as relational beings and at the same time told not to trust those feelings, or that they might even compromise our professional capacity to give good care. I find this problematic. I return to Tronto's (1993) initial 'moral aspects' of care:

1. attentiveness (caring about): a proclivity to become aware of needs of others
2. responsibility (caring for): a willingness to respond and take care of need
3. competence (caring): to do the actual work of providing good and successful care
4. responsiveness (care receiving): consideration how others perceive their position.

Not only does Tronto define how care is a practice but also integrates a moral dimension into how care is practiced. We cannot care if we do not care. Indeed, Saul Weiner and Simon Auster say that caring – even in a public context – is a sustained emotional investment in another's wellbeing, characterised by a desire to take actions that will benefit the other (2007: 126). However, for Tronto (and others), as care is about meeting needs, particularly needs in a public / market context, it is always infused with power. Therefore, an ethic of care for Tronto remains incomplete without a corresponding political theory of care. In my reading of Tronto, I take these moral aspects to manifest in dyadic, unequal relations, that these normative elements are experienced by the care giver. From an alternative processual and entangled perspective, I suggest that these aspects can be experienced by all participants in a dynamic process of inquiry.

Peta Bowden (2000: 37) highlights the debate that 'feminine' perspectives on care – which focus on the internal dynamics of caring relationships – are seen to 'fly in the face' of the 'feminist' recognition of the moral significance of institutional structures of power, and the sense of powerlessness felt by caregivers in influencing ethical decisions (in a nursing context, but arguably beyond). Care as work, and care in work cannot be separated from the wider political context that does not place value on emotional labour, typically undertaken by women (Antoni et al., 2020). As others, such as nursing theorists argue (Bowden, 2000; Roach, 2002; Watson, 1997), can it not be possible to feel caringly with others in a given situation while also recognising the systems and structures that might militate against a caring culture?

Organisational care literatures stress questions of *"how people attend to each other at work, how they feel treated by others, and the quality of their relationships inside and beyond organisational boundaries"* (Lawrence and Maitlis, 2012: 641), for example by paying attention to the dynamics between the caregiver(s) and the care receiver (Kahn, 2005; Mol, 2008; Noddings, 1984), or the 'social defences' and other relational manifestations of providing emotional containment for the anxious and vulnerable (Foster, 2001; Huffington et al., 2004; Kahn, 1993, 2005; Obholzer and Roberts, 1994). These literatures seem to problematise relationships in some way, inferring a dualism of good dynamics in contrast to more harmful ones.

Such problematisation is developed by Clare Mumford, David Holman, Leo McCann, Maurice Nagington, and Laurie Dunn (2020b). Their perspective on care practices at work discusses power relations, complexity, and ambiguity to illustrate some of the 'hidden' work of enacting care. They define 'veiled care' as self-reflexive, narrative practices that hold back from action and that obscure or create ambiguity (such as concealment of feelings to appear non-judgemental, talking rather than telling, or being gentle) in social meaning to avoid, repair or minimise damage to others. Perhaps at times it might be beneficial to be circumspect. However, I wonder how it serves the social dynamics of organisations and organising – and our own self-care – to always hold ourselves in check.

In some organisational literature, it is suggested that moral feelings arising from a *“sincere concern for another’s well-being can collide with motivations to maintain professional detachment when enacting role-prescribed responsibilities”* (Lindebaum et al., 2017: 653). Feelings are troublesome, insofar as feelings arise in contested contexts. In exploring the tensions between caring for work and caring for co-workers, Anne Antoni, Juliane Reinecke, and Mariana Fotaki (2020) opine that care allocation is an ‘inherently ethical dilemma’ involving limited resources of time, attention and emotions. Boundary work – demarcating personal and professional selves – is a political act undermining care in the workplace, they argue.

What I take from these literatures is that while we will feel our feelings, from a theorising perspective they are something of an incumbrance. While compassion and empathy might be seen as desirable for ‘good’ care – a normative concept at odds with a more processual perspective on caring – these feelings are placed in dualistic opposition to indifference, love, disgust, shame, and the range of what we may feel in social encounters. They can also be theorised as problematic insofar as to feel can be effortful and draining (Lilius et al., 2011).

Care ethics acknowledge the centrality of feeling in moral life, Noddings (2015: 75) suggests, with roots in David Hume and the moral sentimentalists who emphasised the role of feeling in moral motivation. Held (2006) opines that an ethic of care combines practice and values – where ‘care’ means the practices that take place and values by which these practices are evaluated.

Shotter (2017) by contrast describes these as ‘before-the-fact’ or ‘action-guided’ feelings, signs that we may ignore or resist of possible change ahead (Locke et al., 2008). I am beginning to understand felt experience as generative knowing – mutable, fallible, partial, and discerned from observant participation within the experience. While some scholars are wary of sentimentalism and its pejorative connotations, Sean Epstein-Corbin (2014) argues that pragmatism grew as a democratic-feminist development of the sentimentalist movement, with a melioristic focus on embodied lived experience, knowledge, and democracy (I challenge the word meliorism in chapter 5).

If sentimentalism suggested we take actions solely based on emotions rather than reason or judgement, my understanding of the work of Addams – among others – is that such dualistic thinking between mind and body, reason, and emotion, does not reflect how we live, work, and act together. The moral ‘truth’ of our feelings becomes true through inquiry and enactment, rather than as absolute principles.

My caring with the Girls emerged through growing awareness of my feelings of irritation, sadness, and withness. These were not neutral, nor were they mere feelings. Their transformational capacity led to change – not only in terms of my relationship with the Girls and how they saw me differently but also in the collective experiences of women from all levels within the health and social care organisation. From senior managers to medical doctors, surgery administrators, and myself, we had individual and collective experiences which gave rise to our capacity to adapt.

What I take from these literatures is discomfort in acknowledging how feelings have ethical potency, so as to situate ‘ethical caring’ as something distinct from ‘natural caring’ (Noddings, 2010, 2012). As I will argue, caring is ethical in its generative potential, catalysed by our perplexities in each situation.

Diffractive analysis – felt experience, caring theory, and social ethics

In this section, I employ diffraction as an analytic practice. My intention is to notice consequential nuance and difference in situational dynamics about caring that otherwise remain hidden. I do this by using my feelings as diffractive apparatus, bringing in supporting ideas from feminist technoscience, caring theories, and social ethics. This analytic practice – which I use here, and in chapters 5 and 6 – has been explained more fully in chapters 2 and 7.

Haraway (2016b: 5) provocatively suggests that being on HRT makes me a ‘queer’ ‘cyborg’ - as a semiotic thing, part synthetic, part natural. Why does this matter? Because, for Haraway, becoming queer cyborg calls into question our accountabilities, kinship, and response-abilities with whom we make worlds.

“The term queer can also be used in a dynamic way to describe identity under construction, in the act of becoming. In this sense queer is not an identity but is, instead, a critique of fixed identities” (McKenzie, 2006: 403). As I consider this, I reflect on Audre Lorde (1984), who writes *“I am constantly being encouraged to pluck out some aspect of myself and present this as a meaningful whole, eclipsing or denying the other parts of self. But this is a destructive and fragmenting way to live”.*

We are shaping the conditions for multi-species flourishing. This is not solely a scientific or cognitive process, but one that invites me to feel all my feelings. In becoming one of the Girls, I felt love, solidarity, and kinship, as well as irritation and rage. They were no longer solely Primary Care practitioners – doctors, administrators, nurses, and managers – objects to shadow and investigate.

The vignette highlights my noticing and being moved by perplexing feelings. What began as a rant moved into solidarity and kinship. My feelings were conflictual, plural, and agential.

Barad and Haraway make deliberate use of the word queering to invite attention to difference. For Barad (2014), diffraction is a boundary-crossing, trans/disciplinary queering (in all senses of the word) theory/practice of connecting and committing rather than separating or othering (Murris and Bozalek, 2019). It is a provocation to *how* we gaze as much as where and what. Becoming queer cyborg is non-binary, rather than favouring this insight over that, perpetuating boundaries of what is good, I take inspiration from Lorde and McKenzie. I am more than researcher; I am becoming with my participants in our entangled experienced. Why are some of those experiences more appropriate in our inquiring, why do we valorise some at the expense of what is more ineffable and transgressive?

Thinking about the vignette above and care as a relational ethic, the Girls were interconnected through professional and personal relationships. Some of them had known each other for decades. Kittay and colleagues (2005) remind me how feminist scholarship sees invisibility of human dependency and dependency care – such as in the attention to each others' menopause experience – in part as a product of a private-public distinction that places a premium on the public and relegates issues of dependency to the private domain. Who is responsible for allocating care? It is argued that ethics of care for co-workers entails *"boundary work that suspends the separation of personal and professional selves and constitutes the worker as a whole person"* (Antoni et al., 2020: 447). Critical and political issues of gender *are* present in the vignette, and its meanings contested, although not the subject of my inquiry.

What I take from the care literatures is how their underlying relational ontology reinforces separateness, including in what is appropriate to feel. They talk *about* relationships, and the more desirable motivations for good care. Intersubjectivity – with its attention on inter – focuses on what lies between. By reinforcing separation, these ideas also impose fixedness. Rather than seeing the Girls as entangled in a troubling experience through which they might experience change in themselves and their relational encounters, conventional care ethics approaches to relationships might invite us to linger on gender, vulnerability, power relations, a collective defence, or care as managerial tactic. Objects that I, as a researcher, can objectively study.

From a processual ontology, I understand entanglement to be the condition for human and beyond human existence. This moves me from the language of inter-subjectivity to intra-action. For Barad (2014), intra-action is not about absolute separation, but 'iterative (re)configuring of patterns of differentiating-entangling'. What I understand them to mean is that there are no absolute boundaries between here-now and there-then, self and other, for we are in a continuous process of co-creating and experiencing. We have never been separate. Difference is situational rather than a priori. My feelings might be mine, but they also open me up to the other. In entanglement, Thiele (2014: 206) suggests, the very ontology of entities emerges through relationality – they do not pre-exist their involvement.

Such feelings may be considered transgressive, 'tainting' objectivity. But such troublings *are* transgressive (St. Pierre, 1997). Caring takes the needs and concerns of others as the basis for action (Barnes, 2012: 8), where we might respond with tenderness and a feeling of oneness (Mayeroff, 1965: 464). While some care ethics and management scholars reference Mayeroff's contributions (Hamington, 2010; Kahn, 1993; Kroth and Keeler, 2009; McGuire et al., 2021; Nicholson and Kurucz, 2019), none engage with and develop his *processual* articulation of *caring*.

Informed by Buddhist ethics, Judith White (1999) offers an alternative perspective on caring relationships. Caring in the workplace reinforces feminist ethics of cooperation, relationship, and interdependence; acknowledging that everyone is both different and connected, and in contrast to prevailing patriarchal values of autonomy, rights, and individual justice. To practice 'ethical comportment' suggests that one's intentions are to be kind, caring and compassionate towards others, under all circumstances.

Attention to feelings in a specific situation has been explored by classical pragmatists (Dewey, 1894, 1895; James, 1884). Problematic situations are subjective *felt experience*. Addams' (1896, 1902, 1911) invites me to witness and walk alongside another. This relationship between love and social action – so central to Addams work – is a theme I explore in terms of what feelings 'make possible, rather than what they mean' (Gherardi, 2017b).

Sympathetic engagement

What can we take Addams to mean when she writes that *"social sympathy is one of the greatest social forces"* (1910: 71)? I explore this question in this sub section by discussing how it might be to feel connected in caring encounters.

The Merriam-Webster[37] dictionary defines sympathy as when you share the feelings of another, whereas empathy is when you understand the feelings of another but do not necessarily share them. However, the Cambridge[38] online dictionary reverses these to state sympathy is a feeling or expression of caring and understanding for someone who is suffering, and empathy the ability to share someone else's feelings or experiences by imagining what it would be like to be in their situation.

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[37] https://www.merriam-webster.com/words-at-play/sympathy-empathy-difference

[38] https://dictionary.cambridge.org/dictionary/english/sympathy and https://dictionary.cambridge.org/dictionary/english/empathy

Noddings (2010: 6) opines that empathy is a relatively recent word, compared to sympathy, but what connects them is an attitude of 'feeling with' another. It is this feeling with, that I develop, drawing on others' use of sympathy and empathy.

Addams' contribution to care ethics – and indeed philosophy, as Hamington argues – is her concept of 'sympathy', which places an emphasis on the process of caring (Anderson, 2004; Hamington, 2009). Addams contrasts different contexts – charity, industrial relations, families, political life, and education – where morality might be expanded from an individual to a lateral concern, involving *"human love and sympathy"* (Addams, 1902: 28), identification with the other, a social consciousness, creative experimentation (which may fail), and awareness of diverse lived experiences. Caring feelings, such as those towards our neighbour, must arise from a 'genuineness of emotion' which distinguishes the manner and intent of any action from care 'work' where an attitude of 'caring for' (redolent of Tronto's moral aspect) others might prevail (Anderson, 2004).

Such 'unsympathetic' caring, where the one-caring might know best, is exemplified in *The Modern Lear* (Addams, 1896), an analysis of the Pullman Strike. For Addams the move from unilateral morality to social ethics takes us from paternalistic benevolence and asymmetric relations to a pursuit of collective effort, human affection, and social justice. Charlene Haddock Seigfried (1996: 10) makes the case that for Addams social issues – such as women's suffrage – cannot be understood in isolation from others due to our entangled relations. Thus, if we live in our world feeling ourselves connected-in-general, our experience of social problems will be very different from the experience when we feel ourselves unconnected-in-general (Leffers, 1993: 74).

In his analysis of Addams' practice of 'sympathetic knowledge', Hamington (2009: 4) sees four interrelated claims: 1) human existence is plural and interconnected, and able to find a common cause, 2) when we come to know others this empathic caring has disruptive potency, 3) this empathy leads to action, focussed on growth and flourishing, and 4) a democratic society depends on caring responses. In this context, caring means participating in relationships involving emotional, material, and temporal dynamics (Hamington, 2004). I see these claims about Addams social ethics as in harmony with a caring ethos, as I develop in this chapter, 5, and 6.

Thus, sympathetic knowledge is more than emotivism. Hamington (2009: 4) argues that knowledge, in all its quotidian, disruptive, embodied, and transformative flows, *is* a question of morality. Seigfried (1996: 10) opines that social ethics for a pragmatist *are* ethics, starting from a position of (human) interrelationship, giving weight to subjective experience, and other data in a given, problematic situation.

Noddings (2010, 2012) reminds me that in caring, we are open to the other, even vulnerable to what the other may be feeling. However, what we feel in response, she continues, may not be in harmony with the other. To that end, is this troubling feeling comparable to 'feeling with'? Thinking with Addams and Barad, I see 'sympathetic engagement' (as I am calling it) as ethical and world making in its potential to mobilise us to inquire into and act on what we find troubling (or perplexing, as Addams called it). Brugère (2014b) reminds me that caring begins through an apprehension of *differences*. Hamington (2009) and Melissa Anderson (2004) suggest to me that an alternative understanding of caring begins with *all* of what we may feel in response to another, beyond warm and harmonious relations.

In a COVID-19 new normal (2020-22), as it seems to be called, GPs no longer 'see' patients. A patient calls their GP surgery, and they are asked to tell the receptionist if they have COVID-19 symptoms. If so, they will be redirected to a Community Assessment Centre (CAC) (which I discuss in chapter 6). All other patient requests are then 'triaged', and a patient receives a call back from a GP or nurse, or another health professional. A telephone consultation takes place. If necessary, and appropriate, a video conference is then set up. If a face-to-face consultation is deemed necessary, an appointment is made for a visit to the surgery or a home visit (Health Protection Scotland, 2020)

There is a tacit understanding that receptionists undertake many clinically related duties without formal training specific to these roles (Litchfield et al., 2022). I think about the Girls[39], and how they have become the frontline of the NHS, gatekeepers to a service, deciding who gets triaged. Receptionists always did, but now they protect GP surgeries – to help keep them functioning – as much as trying to facilitate the right care a patient needs. It's an unpopular job and the abuse receptionists now receive is newsworthy[40].

I remember how much these Girls were part of their communities. How and when do my participants get to grieve for the patients they have lost to the virus (let alone the impact of the virus on health and care staff and their families), the ones they had to have 'do not resuscitate' conversations with, the ones most at risk, or those they did not expect to lose. I have learned from spending time in two GP surgeries that many of these patients have been known to the staff teams for years, their lives (and loves) intertwined in the giving of care during visits. They are not patients or health codes, but Mary with the 'mental' mother, Samir who just wants a girlfriend, or Billy who doesn't like the way the receptionist speaks to him when he says he's 'lost' another prescription.

I am troubled by my imaginings of the Girls, sitting around drinking tea, listening to the radio, on the phone to local pharmacists, or nipping into reception to say hello to a patient, but now as the front line to Primary Care. NHS workers have likened working through COVID-19 to a war zone[41]. Women without formal clinical training, low paid, making decisions about who gets triaged, and protecting clinical teams.

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[39] Most of the Girls took on reception duties as part of their administrative roles.

[40] https://www.theguardian.com/commentisfree/2021/sep/08/gp-receptionists-like-me-shouldnt-have-to-play-god-with-who-gets-the-covid-vaccine-the-abuse-we-receive-is-profound

[41] https://www.ft.com/content/b466d0d3-45f4-47e4-b681-fead24ae1f08

Who protects them from the abuse they receive when they must tell a patient that they cannot see a doctor, that they can't have a vaccine, and that the wait time for an appointment could be days or weeks and not hours? When I think about my own surgery, I struggle to see receptionists with the same humanity as I do the Girls. What I experience – as a patient – is that I am being unreasonable in asking for a doctor's appointment because I know my body well enough to know that what I am experiencing is problematic. I can't imagine the Girls speaking to their patients – their friends – in the same tone.

Maybe they do, maybe they have had to in constantly having to say no to what should be reasonable and appropriate. I feel into the Girls, what I remember, and all the times I have felt seen by a healthcare professional. Most recently, the receptionist at my surgery who phoned me to tell me she had arranged for a prescription to be sent to my pharmacy, a prescription that another receptionist had previously told me I needed to see a GP before I could request a repeat, even though the wait time for an appointment was weeks and not days. The local pharmacists who have kept hold of a specific HRT in short supply until I can get the prescription for it, another pharmacist who offered to add some items I planned to purchase to a prescription (prescriptions are free of charge in Scotland) to save me some money. I feel such immense gratitude that I pop in just to say thank you. Through a more sympathetic engagement, I now understand these receptionists and pharmacists are doing their very best in vexatious circumstances to make sure we all get the care and attention we need in scarcity. Just how different would I be if I were in their shoes?

Rather than antagonism, I try to feel solidarity. I remember listening to a series of podcasts with health and care staff during the lockdown (Thomas, 2020). A common theme was that as care workers they respond and work well together in a crisis, moving like starlings in an 'emotional murmuration'. From a processual perspective, my feelings are not good or bad, helpful or unhelpful, but emerge from and through my entanglement with the Girls. What I now see is response-ability – an ethical capacity of *"cultivating collective knowing and doing"* (Haraway, 2016: 34), where individual caring feelings – about the work, about each other – coalesces into intra-action, entangled agency in a process of mattering (Barad, 2007: 141).

In this subsection I have explored how being troubled or perplexed in our social relations has ethical potential, when we may be stirred by an awareness of difference. I now move to discuss one troubling, love and its caring affects.

Love and its caring affects

Addams believed that emotions had ethical potency: *"Reason is only a part of the human endowment, emotion and deep set radical impulses must be utilised as well"* (1915: 22). However, they need to be cultivated and guided by experience to yield 'sympathetic knowledge' (Fischer, 1997). It is not enough to feel, but feel we must, to be able to act.

In this sub section I build on my previous ideas to inquire how perplexity can manifest. Sympathetic engagement is an invitation to be mobilised by our feelings. I focus now on one – perhaps transgressive – feeling: love, and its caring affects. I ask *how* love matters. I use 'affect' as a verb, to have an impact, rather than its psychological connotations (Shouse, 2005). In this more ordinary usage I follow Gherardi (2017b), Kathleen Stewart (2007, 2011), and Erin Manning (2010) – affects are 'atmospheric' collective worldings that amplify experience within everyday ongoingness, which can so easily pass unnoticed. Noticing affect invites us to bring certain futures into possibility from a multiplicity within a situation.

The first care ethicists (Gilligan and Noddings) conceived of care not just as something that exists in caring professions, but being anchored in *loving* relationships (Gilligan, 1993b; Lawrence and Maitlis, 2012). Addams (1902: 28) reminds me that we all have the capacity to give (and receive) love, and for that 'natural outgoing' to have caring affect. This is less about professional obligation, and more about seeing ourselves intra-connected within all social experience, however different from our own, striving towards change and progress. Nursing theorists write of love as forming the ontological basis of caring concepts like compassion, empathy, sympathy, relationship, and presence (Arman and Rehnsfeldt, 2006). For Watson (1988: 353) this relationship between love and caring connotes inner healing for self and others, extending to nature and the larger universe.

Such feelings have been regarded in the academy as a 'contaminant to understanding', regardless of the knowing it might afford us (Eisner, 1997: 264). Individually and collectively, we cannot participate fully as relational beings in our families, professional, political, or social situations without loving experiences (Cantillon and Lynch, 2017: 170), and yet most branches of social and political sciences neglect 'love relations', instead focussing on contractual models of social relations (Cantillon and Lynch, 2017: 172).

On writing about Dr Sassall, Berger said: *"Good general diagnosticians are rare, not because most doctors lack medical knowledge, but because most are incapable of taking in all the possibly relevant facts – emotional, historical, environmental as well as physical"* (Berger and Mohr, 1967: 76).

Berger's observations prompt me to think about Dr Elsa, one of the GPs at Calliope, and how she adapted her style depending on which meeting she was in. With the Girls, she tried to be more of a coach, offering encouragement and reassurance, whereas the Partners expected her to be more directive. I think about one of the private conversations we had, after a meeting had ended. For some reason the menopause came up, and we had both recently started using HRT. Neither of us had anticipated just how much of a difference it would make to our capacities to function, to show up. What really shocked me was that neither she nor her own GP connected her debilitating symptoms to the menopause, with her GP advising that it was most likely burnout as the cause. I did not know this at the time, but GPs do not learn about the menopause at medical school (some post qualification training is now being developed), although more recent health campaigns in the UK are slowly changing levels of support and responsiveness to menopausal people[42].

Something changed after that encounter with Dr Elsa. She had been the first person to agree to become a participant in my study and with the wider surgery team. Calliope was a proactive and learning oriented GP surgery, not only were they signed up to the national workflow improvement programme, but also customising the processes to meet their local needs. Dr Elsa was one of the few health professionals I met who had put themselves forward for leadership training. On a personal level, I had found her remote. This changed after our menopause conversation. Dr Elsa asked if I might be interested in shadowing the Partners at Calliope. I was, but unfortunately the onset of the pandemic meant this could not happen. Dr Elsa offered to continue with our project once lockdown started, assuring me that they could keep me safe from them, and them safe from me. When it seemed likely I would not meet Dr Elsa and the Girls again, she emailed me to say how things were going, how WhatsApp had become a vital tool for GPs and other staff in the cluster, not just to stay in contact, and share information, but also to let off steam from time to time. It's as if Dr Elsa became one of the Girls too.

Following their review of the management and social science literatures, Duncan Coombe (2011: 94) defines love as the *"intentional expression of concern, care, acceptance, acknowledgment of legitimacy and appreciation for another",* where love combines attention, intention, and action. I wonder how love, as defined by Coombe, rather than being a 'transgressive' (St. Pierre, 1997) or 'subversive'

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[42] https://www.gov.uk/government/news/nations-unite-to-tackle-menopause-taskforce

(Jaggar, 1989) phenomenon, is an aspect of knowing in caring social experience and therefore of concern for organisational scholars. I wonder how love connected these Girls – many of whom had known each other for decades – that went beyond professional roles and formalities of GP surgery life, to a more profound kinship.

Stefano Tasselli (2019) states that because love is personal, passionate, and ineffable, it is hard to make generalisable knowledge claims. For Sara Cantillon and Kathleen Lynch (2017), love, in relational equality, matters as a condition for social justice. Tasselli argues that people change when triggered by love, and this is consequential for organisations and organising. Love has been explored in the context of emotional cultures (companionate love) at work that positively relate to employee satisfaction and teamwork (Barsade and O'Neill, 2014), as a practice for modern leaders (Caldwell and Dixon, 2010; Pirson, 2022), in making the case for agapeic social relations in business (Argandoña, 2011; Hummels et al., 2021), or in proposing that the practice of corporate citizenship is an expression of love (Coombe, 2011).

I am uncomfortable with suggestions or inferences that firms are more efficient, and leaders more effective, when love is 'practiced' in organisations and organising. Yet it prompts me to ask what I might be saying that is different. There are a couple of aspects, as I develop below. Firstly, loving relations may not necessarily comprise solely human relations. Secondly, in asking cui bono? For what purpose love? I do not understand love to be a top-down initiative to be rolled out, but rather a social dynamic within the everyday of work.

The human and beyond human potential of love and caring is a theme in Mayeroff's development of caring as a process. Caring, he wrote (1965: 465), is helping another grow, whether another is a (specific) person, an ideal, idea, or community. Haraway (2011, 2016b) suggests caring kinship extends to all living things, including pigeons, dogs, other 'critters', and indeed the entire multispecies 'Chthulucene' that we collectively make (and Anthropos destroys) as home. Feminist technoscience, STS scholars (such as Mol), and posthumanist informed Practice scholars (Cozza, Bruzzone, et al., 2021; Gherardi and Cozza, 2022) would argue technology also, such that these *"kinships and alliances become transformative connections – merging inherited and constructed relations"* (Puig de la Bellacasa, 2017: 73).

To conclude, Barad (2007: 2) prompts me to suggest that in thinking about love *diffractively*, it is processual rather than representational. It is not a thing or a state, but a social process of becoming with. Love and its caring affects take me beyond attending to the suffering and growth of others, and particularly those with whom we have social connection (whether that means organisational colleagues or those for and with whom we undertake care, human and beyond). Such love invites us to see entanglements as an ethical matter – because they are consequential in highly specific configurations.

Theorising potential – attuning as an aspect of a caring ethos

In this section I theorise attuning. In doing so, I find it hard to experience caring without the full, messy rush of conflictual feelings, as a guide for collaborative action and as profound connection with another.

Scholars write of 'affect' and 'emotions' with their respective 'political affordances' (Shouse, 2005; Willis and Cromby, 2020). We give emotions names, we analyse them, some emotions are seen as having more desirable and appropriate effects. I favour the word 'feelings' to describe 'visceral perturbations' in a world of 'pure experience' (James, 1912: 138). They attune our senses to the situation. My interest in feelings lies in their troubling, perplexing, atmospheric, ineffable, embodied and yet change-full potential. As Shotter reminds me, they are 'action-guiding' (2006) in their potential. For Dewey, our capacities to transform what is to what might become should not exclude our imagination and the *"embodiment of ideas in an emotionally charged sense"* (1934: 33).

For Pragmatists (Dewey, 1894, 1895; James, 1884) problematic situations are a *felt experience*. Being perplexed by what we feel as a stimulus for inquiry and action is suffused in Addams' work (1896, 1902, 1911). This relationship between feelings and social action is a theme I explore in terms of what they make possible, rather than what they mean (Gherardi, 2017b).

A relational ontology underpins care ethics. This can be discerned in the writings of Gilligan, Kittay, Noddings, Tronto, Held and others. Arguably, relationality is a dualistic ontology of separateness (Barad, 2007; Keevers and Treleaven, 2011; Shotter, 2010a) – of inter-subjectivity (entities existing prior to connection). To be(come) in relationship with others, from a processual perspective, goes beyond inter-subjective connection, to performative intra-action or 'withness' (how we become, entangled, within this specific situation). We are only ever *in relationship*. As Mayeroff (1965: 463) writes, caring is not something external that exists between the one who cares and the one cared-for, rather it is a *relationship* that changes and develops over time.

When observing caring *in practice*, as a posthuman practice, we should pay attention to the ongoing texture of connections Gherardi and Rodeschini (2016) opine, not to identify 'what is done' or 'who does what' but rather how things (human and more than human) stay connected, are reconnected, and whether the texture of connection is repaired if damaged. This line of inquiry seems more helpful for me.

When I think about the vignette, the way of thinking offered by Gherardi and Rodeschini opens the possibility to theorise from how the Girls ongoingly perform their work tasks and navigate their menopausal experiences, rather than inquiring into the roles (who) and practices (what) of care, which would be the concern of conventional care ethics.

Such a perspective invites a different way of seeing and experiencing how and what we feel, to see them not only as part of our entanglement, but also to acknowledge their ethical and generative potential. If we inquire into what is felt in a situation, it becomes a world-making act, we make choices favouring a course of action.

Addams goes further than this, in suggesting that without our feelings, there can be no ethical inquiry and action, there can be no awareness of difference, no commitment to change. Addams' social ethics, and how 'sympathetic knowledge' has been subsequently interpreted (Addams, 1902, 1910; Hamington, 2001, 2004, 2009; Ladkin, 2020; Lake, 2014, 2021; Leffers, 1993), Tronto's (1993) vision of care practice(s) grounded on 'moral aspects', and Mayeroff's contention that *"[I]n caring it is the process rather than the product that is primary"* (1965: 468), inform my proposition that *attuning* is a performative and generative dynamic in caring.

I see a connection between Barad's idea of 'com-passion', Haraway's (2016b) concept of 'troubling' and Addams' use of 'perplexity'. Troubling invites us to engage with the 'thick present', to be troubled, and to cause trouble, not as an act of sabotage (for its own sake, arguably), but to make kin and to become capable together. Troubling for me is being troubled by our feelings – by pain and joy – and to make agentic connections. Perplexity is a catalytic feeling that arises out of specific situations that disrupts our custom morality and habits of thinking, inviting us to become more collaborative and creative in our responses (De Cruz, 2021). There is no progress without perplexity. For Addams' (1902) perplexity arises when we are called to consider our unthinking actions and reactions, as a process of moral deliberation within the 'concrete relations' of life. For me, com-passion, troubling, and perplexity have consequential potency, for ourselves and others.

I am arriving at attuning through a diffractive analytic process, to notice differently what is consequential that more conventional analytic practices might overlook or discount. In diffracting how I am 'troubled', using my own feelings to affect what may be discerned, I now see how Addams' sympathetic disposition is an ethical stance, inviting us to feel all our feelings, even love, and to be mobilised by them. Caring is more than doing, and we could not survive and thrive without this doing, it is a way of be(com)ing in relation. Care literatures employed with a more conventional research logic would lead me to theorise based on the appropriateness of moral sentiment and unequal social relations.

I think of attuning – as a verb, or process – as noticing and being moved by perplexing feelings and their affects in a given situation; where attuning comprises a posthumanist and processual *"matter of feeling a 'vibe' and of tuning our sensibilities and bodies to appreciate the material forces that structure situations"* (Gherardi and Cozza, 2022). My analytic focus has been on (my) feelings, but as Gherardi and Michela Cozza suggest, there may well be other 'forces'. Our collective menopausal experiences are one such force, beyond how this kinship transformed my participation in the experience, and how I subsequently write about it.

Shotter (2012) writes of this as 'withness thinking', which invites us to become attuned to different ways of noticing our 'inner moves', such as feelings of disquiet, telling moments, or something arising and taking shape.

I am not suggesting that feelings mobilise us at the expense of reason, but to restore feeling as a source of knowing/reasoning in problematic situations. Rather than creating a dualism, feelings are a type of affective reasoning. They are experienced holistically – mind and bodily feelings. Furthermore, while feelings are individually experienced, Dewey (1894, 1895) argues, they are 'public affairs', dispositional, relational, and socially constituted.

Mayeroff, Addams and Gherardi remind me that caring is not solely intention or feeling but requires expression through action. Moral judgments are situated within problematic situations, they are individual and social, inviting us to make decisions about growth and progress (Seigfried, 1996: 7). Indeed, Seigfried (1996: 10) argues, *all* ethics are social. Hamington (2004) notes that while care ethicists share Addams' belief that experience is a necessary condition of caring, she goes further by claiming that avoiding the experiences of others 'violates the democratic spirit', suppresses our caring nature, and limits our caring imagination. What's important in this fidelity to experience is the processual and performative, the capacity for multi species flourishing, the centrality of feelings as a guide for consequential action, as well as other situational data, the ethical nature of our entanglement as we *become-with* in troubled times. It's about love, as a practice of care, commitment, trust, responsibility, respect, and knowledge (Hooks, 2001). For as Roach (2002) says, 'caring is about loving'.

Chapter summary

In this chapter, I introduced the idea of attuning as a social process of becoming troubled by our feelings to notice difference in a specific situation. In the vignette about the Girls, I speculate how initial feelings of disdain and rage, and a desire to remain different to my participants changed as we learned more about each other's menopausal experiences and how they impacted our capacity to show up and work. My feelings towards my participants changed, seeing them more as kin than objects of study, and I experienced feelings of acceptance and solidarity. Attempting to make sense of my experiences with conventional care ethics literatures would lead me to focus on suffering and vulnerability in workplaces, that feelings get in the way of professional relations, and that there was no care in these experiences. However, by engaging with different literatures, and by allowing myself to become perplexed by my perplexities, I come to see that our feelings have ethical potency. All our feelings, whether love or rage, connect us with others, and perhaps enable us to notice differently. In the next chapter, I explore becoming mobilised by our feelings, to inquire what needs to happen.

Chapter 5 – inquiring

Introduction

In the previous chapter I suggested that rather than being a contaminant to understanding, our feelings have worldmaking potency through their capacity to affect. In this chapter I investigate how we inquire into what needs to be done in a problematic or troubling situation. This feeling of 'doubt', as Dewey (1939: 7) calls it, is a tension that finds expression and settlement (however tentative) in a process of inquiry. I introduced Deweyan Inquiry in chapter 2. To recap, it is a dynamic and self-correcting (Bernstein, 1971: 177; James, 1907b) social process of transformation, ongoingly changing relations and conditions within a given situation. The aim of inquiry in *everyday* life is the co-creation of actionable, future-forming possibilities in response to 'perplexities' (where rigid morals and our habitual understanding and responses are no longer adequate to explain or transform a situation (Seigfried, 2002: xxv)). There is no inquiry that does not involve the making of *some* change in conditions (Dewey, 1939: 34).

The guiding principle of inquiry is experience, examining possible action and its practical consequences (James, 1907a: 45). There may not be a 'best' course of action, but one that yields movement, and where all participants are actively engaged in responding to the contingencies of change (Bernstein, 1971: 177). Arguably, those with lived experiences of what is problematic about a situation have a perspective on what needs to be done that others may not, no matter how well intended and informed a spectator might be (Addams, 1902).

From my processual reading of organisational and care literatures, what needs to be done can be determined as a dialogical accomplishment – that care is alleviation enacted through talk and touch. Other literatures suggest that what needs to be done is a task for those with competence to decide (i.e., leaders). More recent organisational literatures propose care is an organisational and/or sociotechnical accomplishment, and not solely the province of individual actors. Practising caring, as I explore, is less about expertise/knowledge and alleviatic practices – and its associated vocabulary – and more about creating conditions for response-ability through our entanglement. In a diffractive process of reading my empirical experiences through alternative literatures and my own affects, I come to see caring inquiring as both pluralistic and oriented towards mutual flourishing.

This chapter begins with two vignettes, involving Calliope and Clio. In analysing these speculative experiences using care ethics literatures, I discern two themes: that care is a dialogic practice and is reliant on the competence of the care giver(s). In critiquing these themes, I suggest that they reinforce dualistic notions of inter-subjectivity and separateness. Diffractive analysis leads me to propose that if caring is an ongoing social process, then it unfolds as a pluralistic inquiry into mutual flourishing, with resonances beyond the immediate situation to wider societal (arguably ecological, beyond human, and planetary) concern. These alternative perspectives use a different language and vocabulary, emerging from a more processual stance.

Situation 2 – no-one’s going to die on a letter

‘Read codes’ (PHS, 2020) are an NHS-wide method of categorising patient-related correspondence, such as letters from outpatient clinics or test results, which are added to patients’ records. A large GP surgery such as Calliope, with thousands of patients, could receive several hundred items of correspondence per day. Every item of correspondence that comes in must be read, and many then coded, which means deciphering the main issue in the letter and coding it accordingly. Not only is this time consuming, but with over 80,000 possible codes available, it requires a level of expertise; even if there were more common categories used (such as denoting respiratory or psychological symptoms). A further challenge is some of the technical medical language used, and different terms for the same condition. For this reason, such correspondence would normally be dealt with by senior administrators or clinical staff. However, spending time on correspondence management means less available clinical time with patients and healthcare colleagues.

Across NHS Scotland, in line with the national strategy for Primary Care transformation and new GP contracts[43], it was determined that valuable GP time needed to be freed up to spend on clinical contact and quality. A 'Workflow Optimisation' strategy was being rolled out nationally at all GP surgeries. This involved training non-clinical staff to manage all incoming documentation, including clinical correspondence, redirecting only the most appropriate information to GPs.

A group of administrators from Calliope was involved in the rollout of new correspondence workflow processes for their surgery. These staff had no experience of coding. It was agreed that inexperienced coders would call on the senior administrator, or a GP mentor, for guidance or to check when several codes were possibly relevant. For example, when a patient with diabetes presented because of backache and a cold, codes would be recorded for new conditions but not for diabetes (it would already be on the patient's records, and so only new/revised clinical information from correspondence is logged).

Despite Calliope designing their own correspondence workflow protocols to meet the needs of their surgery, as well as following national best practice, two administrators were uncomfortable about coding cancer-related conditions. They were worried about miscoding the correspondence and the impact this might have on patient care.

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[43] https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2017/11/2018-gms-contract-scotland/documents/00527530-pdf/00527530-pdf/govscot%3Adocument/00527530.pdf

Dr Elsa reassured them that the likelihood of the admin staff causing any harm, even with cancer related correspondence, was minimal. Dr Elsa made the point that ‘no-one’s going to die on a letter’ and that the most important skill requirements for them to take on the correspondence management were the ability to read and interpret the contents. They had all been patients themselves, she continued, they ‘knew what these letters typically contained, and were mostly for information purposes rather than requiring action’.

Dr Elsa also reassured them not to over-code, something the nurses did, apparently. All that needed coding were the ‘big’ health concerns in the correspondence, what does not seem quite right, or if there is new diagnostic information that the surgery did not already have about that patient. Examples included: overdoses, strokes, cancer, limb breakages in older people, psychiatric letters, and urgent referrals that had been downgraded.

With the agreement of Mhairi, the surgery manager, and the experienced administrator, cancer-related and other ‘difficult’ coding correspondences were passed directly to the senior coder for action until such time that the other administrators felt more confident to take on this coding task. This enabled staff to develop their coding experience with reduced anxiety, in an environment conducive to learning. It enabled the senior administrator to oversee the coding process and keep involved in a task she enjoyed, and it met Calliope’s strategic objective of implementing freeing up GP time to focus on patient care and clinical issues.

It was weeks after my experiences of shadowing these administrators that the importance of the read codes became clear to me: they were the basis upon which doctors’ surgeries across the whole of the UK compiled their ‘shielding’ lists (gov.scot, 2020) for the protection of people defined on medical grounds as ‘extremely vulnerable’ to COVID-19. As someone with an underlying health condition that made me susceptible to the virus, according to the guidance, I potentially met the criteria to be shielded. This would have meant self-isolating for 12 weeks as well as being eligible for care support. My eligibility hinged on medication I had been prescribed in early March 2020.

Although I cannot verify this, I suspect my patient record was not updated with the read code to signify this change in medication. Hence, I never received communication asking me to shield. News reports at the time suggested many thousands of people across the UK who thought they were eligible for shielding support, did not receive formal notification, and therefore some of the most vulnerable people – I do not include myself among them – did not receive the individual care they needed. This is why correct coding matters.

The staff involved in this situation did not follow a defined or linear method to work out how to move forward: they worked collaboratively and creatively, involving GP surgery leadership, to agree what was problematic for them about the situation and to explore ways it could be resolved. This enabled more confident administrators to take on a wider range of coding and supported the less confident to take on the task and learning at their own pace. It allowed individual differences while working on a shared goal of increasing GPs' capacity for patient care, as well as creating a climate that supported learning and collaboration.

Situation 3 – when expectations collide

Dr Gail, the lead GP at Clio, asked me to come along to her cluster meeting, so that I could pitch the idea of a collaborative project (Euterpe) to the quality leads. This is the first time I attend a cluster meeting. I assume, based on what I have seen in other GCHSCP meetings, lots of formality, structure, organisation, and paperwork. I take a bus to a part of Glasgow I have never been to before. One of those neighbourhoods that is evidently deprived. Flats along a main road, council or social housing, tiny windows, open spaces with no grass or trees, a wide road with commercial buildings. The GP surgery has security fittings over its windows. Inside the surgery I am guided to a room at the back. Mostly faces I have never seen before. Cheryl, the pharmacotherapy representative from Melpomene is there. The room is sweltering. There is nothing to drink and no-one offers to make one.

Dr Gail arrives, and the meeting starts. She has brought an agenda: a piece of paper with two lines on it, one relating to Cheryl, the other to me. It transpires that although she had sent out my one-page proposal to her colleagues, she had not explained the context or the fact that I would be at this meeting. They had not discussed it at their previous meeting, which is what Dr Gail told me would happen. But the issue with Cheryl, and why she is here, is most pressing. In fact, this discussion takes up most of the allotted meeting time.

There is significant frustration about the lack of pharmacotherapy provision in this cluster. What was promised has not materialised, and an already cynical group of quality leads is losing what little trust they had in the overall improvement programme. The anger is directed at Cheryl, for breaking her promise.

There is no resolution to this situation. Cheryl says the promises were not made by her (they were not), they were promises she knew could not be kept so would not have made them were she asked to. Then there is the structural issue, that the funding provision in the improvement programme for pharmacotherapy, the shortfall of resource allocation of pharmacotherapists in terms of headcount, and the actual need at GP surgery level for support did not add up. The improvement programme was undeliverable in its current form, something everyone involved in its delivery knew, and that she was trying to do the best with the funding and the resources available to satisfy the demand.

Cheryl tries to steer the conversation to an acceptance of her constraints, and in acknowledging those, giving her some indication of what pharmacotherapy support *would* be workable – by skill level, location, hours per week, and purpose. She tries to push back at the anger being directed at her, without reciprocating. The room is stuffy, it is hard to think.

The meeting ends, and some of the quality leads leave before we discuss my reason for attending. The energy and interest in the room has dissipated. There is no enthusiasm for what I have to offer. I suggest coming back the next month to pick up the conversation perhaps once they have had a chance to reflect, but I know this will go nowhere.

For Terri Givens (2021), a political scientist who has written about the ongoing racial divides and inequality in the US, empathy is a practice not a state of being. It is moving beyond walking in someone else's shoes and requires taking actions that will not only help that person but will also improve our society. Practising this *radical empathy* can help to create real change in people's lives, but Givens emphasises the word *practising* – having empathy is different from practising empathy. This is a point also made by Kae Tempest (2020), writer and poet: immersion in other people's stories is a collaborative process that cultivates empathy. Radical empathy goes further, they say, to see everyone – the CEO of a global financial company, the homeless person you step over on your way to the train, or the barista who makes your coffee – as being full of stories and a history.

Should I look again, listen again, to these people? What anger and disappointment were they expressing about how powerless they felt, caught in a change programme that they could only resist for so long and for which they saw no positives? Maria Puig de la Bellacasa reminds me that care can open new ways of thinking (2017: 28). New ways of thinking can lead to change.

Inquiring into the situation(s) - contributions from care literatures

In this section I analyse the above vignettes using care ethics and organisational literatures. The consideration of care as an organisational phenomenon is nascent (Fotaki et al., 2020b; Gabriel, 2009; Gherardi and Rodeschini, 2016; Hawk, 2011; Lindebaum et al., 2017). For example, the economic field aims to propose an alternative ethics of management and organisational behaviour that favour actors' well-being (Le Loarne-Lemaire and Noel-Lemaitre, 2020). This can be contrasted with organisational care literature that stresses questions of *"how people attend to each other at work, how they feel treated by others, and the quality of their relationships"* (Lawrence and Maitlis, 2012: 641). While these approaches consider caring in practice terms (Olthuis et al., 2014; Tronto, 1993), most perpetuate the conception of care as individual role-based manifesting in relationships of dependency. A further limitation of these literatures is to not see situations as a *totality*, with a narrower focus on the roles (who) and normative acts or practices (what), at the expense of situational dynamics (how) of caring in practice.

Deweyan inquiry *is* dialogic. However, there is more to dialogue in inquiry than clarification of needs. Arguably, one of the aims of early care ethics literature was to give voice to those who were invisible in ethical deliberations. The word 'dialogue' has a more nuanced meaning – to engage conversationally in reflexive practice, to see situations from another perspective (Bohm, 2004; Simpson and Buchan, 2018). However, I am using 'dialogue' interchangeably with 'talk', 'narrative', and 'conversation' to denote everyday interactions. Much care ethics literatures do not engage with this nuance. Had dialogue continued to be a principal form of data in my inquiring, I would not collapse these terms.

Dialogical accomplishment

"What is missing in all of these cases is the activation of genuine caring-for, the person-to-person relationship characterised by attention, dialogue, recognition of expressed needs, and immediate response moved by the feeling aroused when people are in direct contact with those in need" (Noddings, 2015: 76). This sub section explores whose voice – and with what tone of voice – has authority when giving care, and how care is done through talk.

When we think of care in a public or private context, it is typically understood as physical or emotional intervention, or 'embodied work' (Fotaki et al., 2020a). In a healthcare context this could be performing surgery, listening to a heartbeat, or changing a dressing. Even within this context, there is a wider sociotechnical aspect of care of attuning bodies and technologies (Mol, 2008). Within Mol's logic, care is also corporeal, verbal and non-verbal, which *"may involve putting a hand on arm at just the right moment, or jointly drinking hot chocolate while chatting about nothing in particular"* (Mol, Moser and Pols, 2010a: 10).

Katharina Molterer et al (2019) develop the notion of a 'practical ethics of care', an ethics which is performed through ordinary, situated and embodied social practices. A practical ethics is composed of activities like laughing when someone makes a joke, agreeing when someone expresses an opinion, or patting someone's hand when comfort is needed; a point also made by Mol. They propose a 'logic of affect', exemplified through the practice of clowning in a care home for elderly people (Molterer and Hoyer, 2020). The moral dimension here, it is suggested, is transformation and flourishing, enabling us to become more fully open to the other and alleviation of suffering through prosaic actions. Clowning, Molterer and Patrizia Hoyer propose, is transgressive in its capacity to disrupt rules and boundaries, inviting traditionally marginalised groups (clowns) to influence how joy and suffering is experienced. While this transgressiveness may stimulate episodic moments of permissiveness, it strikes me as reinforcing a dyadic emphasis on the skills and capacities of the 'clown' to loosen up a relational encounter. This is not a collective effort, as Mol and her colleagues explain 'tinkering'. The question for me is whether such ordinary practices are response-able. It is possible to see why Noddings asks us to be careful in how we think about care, to not dilute its moral potency.

Making women's voices heard is the first aim of feminism, according to Laugier (2015). Gilligan's foundational work on care ethics was intended to present an invisible voice, informed by how women make ethical choices. For Gilligan, being in a relationship of care was essential. Arguably, one of the ways that relationships form and are maintained is through *"continual dialogue and negotiation to establish needs and how they should best be met"* (Barnes, 2012: 19) – albeit in 'circumstances of inequality' (Barnes, 2012: 24) – as well as other practices.

In this context, Paul James (2020) asks if 'good' ethics comprises the process of ongoing dialogical deliberation on normative questions for the purpose of instituting principles for action. Noddings describes this as caring for, a *"person-to-person relationship characterised by attention, dialogue, recognition of expressed needs, and immediate response moved by the feeling aroused when people are in direct contact with those in need"* (2015: 76). For Margaret Walker (2007) moral agents express their sense of self, situation, community, and agency in the responsibilities they discover and/or claim as theirs. Thus, narrative is a principal source of evidence in negotiations directed toward resolving moral problems (Code, 2002). However, it is noted that dialogue is 'suffused' with issues of power and control (Mumford et al., 2020b), such as in the distinction between 'talking' and 'telling'. Talking connotes 'to and fro' to find a mutually workable solution, and telling implies uni-directional, and the giving of instructions, for example.

The care and organisational literatures do offer a way to see the ‘conversational realities’ (finding shared understandings, coordinating activities, as well as developing relations (Shotter, 1993)) in these vignettes, even if predicated on static and dyadic understandings of who needs care and who is giving it. For example Kahn (1993) opines that caregivers help others to help themselves toward growth and healing by simultaneously staying in relation with and keeping themselves apart from those others. Behavioural dimensions of care – such as ‘accessibility’, ‘inquiry’, ‘attention’, ‘validation’, ‘empathy’, ‘support’, ‘compassion’, and ‘consistency’ – are woven into daily interactions, such as dialogue.

Clare Mumford et al (2020a, 2020b) address the question of how care might be performed as a discursive, practical accomplishment in social interaction. They explore the concept of gentleness through a discussion of practices of ‘being gentle’ at work. Gentle practices comprise some of the ‘hidden work’ of care, with ‘self-reflexive practices that hold back from action and that obscure or create ambiguity in social meaning to avoid, repair or minimise damage to others’. Such ‘veiled care’ can be characterised as being slow and soft, friendly, calm and quiet; intended to *“obscure social cues of hierarchy, formality, control, imposition or direction”* (Mumford et al., 2020b: 11).

Is Dr Elsa’s reassurance that ‘no-one’s going to die on a letter’ a form of veiled care to give the administrators more confidence in their capacity to learn? I can see it could be argued as such, and indeed, my experience of Calliope was to see some acknowledgement that clinical and patient expertise did not always lie with the doctors. Sometimes, given the tenure of some administrators, they knew far more about some patients than doctors did. Dr Elsa informed me privately that she adapted her way of speaking and use of positional power relative to who she was talking to – being more direct and directive with fellow doctors, and especially partners in the surgery – with a more deliberate effort to be gentle and collaborative with administrators. This is resonant of Mumford et al’s point above, about the distinction between ‘talking’ and ‘telling’, and the generative effects when the administrators were involved in working out how to implement new workflow processes rather than being told what to do.

Lawrence and Maitlis (2012) explore how an ethic of care could build resilience in organisations, arguing that it would involve dialogical practices (talking and listening) embedded in enduring emotional relationships. The connection they propose is more likely to happen when certain organisational structures are present. These include promoting diverse relational networks, placing a value on the meaning of work and relationships, and skilled practitioners who have the capacity to learn how to care and how to be cared for. I understand Lawrence and Maitlis to focus on processes of meaning making to nurture belief systems of ‘possibility’. They argue that an ethic of care is enacted through narrative practices. Conversation is an aspect of inquiry. While I did not capture the specifics of dialogic exchanges in my fieldwork, the flow in both situations can be discerned.

For example, in situation 2, there was sufficient care and resilience such that the administrators could voice their fears about the correspondence processes, assurance was given that they were unlikely to cause any harm, and processes were tailored to each individual administrator so they could take on the new task. A notable difference between situations 2 and 3 is the social history between the groups. Calliope is a group who work together on a day-to-day basis and have done over a period of years. In situation 3, the group is still getting to know each other, and in a context where collaboration was not encouraged (or rewarded). Situation 3 is more conflictual, with one person being blamed for the failings of the wider programme and its local impacts, as well as a more general environment that I experienced as less conducive to trust. However, I understand inquiry and care to result in action as well as sense making. The implication of sense making practices is that they lead to static understandings – this is how it is – rather than fallible working hypotheses.

Mol and colleagues (2010b) counsel that stressing the verbal comes at the expense of the non-verbal, touch, shared moments in care practice. I wonder if Gherardi and Rodeschini (2016) might offer an alternative perspective, when they state that caring is an ongoing and emergent sociomaterial process where people (and technology) collectively learn how to do care, how to talk about it; and how to do it within a broader healthcare system and in dialogue with the society in which they live. They reimagine 'care' from a dyadic interpersonal relation – between patient and professional caregiver – to an organisational context where caring practices are *"sites of knowing, accomplished as ongoing, adaptive, open-ended responses to care needs"* (2016: 268).

This widens my understanding of both situations, seeing the unfolding relational experience in a bigger context of strategic, operational, and clinical transformation within the NHS in Scotland. It is a transformation which is being resisted by some professional bodies, that (certainly prior to COVID-19) was regarded as inadequately funded and resourced to meet the espoused vision; and where on a local level, everyone was doing their best to maintain patient care. This meant to collaborate in ways that were unprecedented in the history of the NHS (doctors surgeries operate as small businesses and so have historically been in competition with each other for patients), all while transitioning to a new multidisciplinary and patient-centred model. In situation 2, there was a level of insulation from the wider challenges, as the surgery management could exercise discretion about how their staff adapted. Situation 3 highlighted a contested landscape and the fight for resources, which while some care ethicists would suggest this is an example of poor or absent care, I instead look to the creative potential in conflict (Addams, 1896; Mayeroff, 1971), which has not been realised in situation 3, depending on how we respond. Fotaki, Islam and Antoni (2020b: 11) warn that caring in organisations can be instrumental and as such is *"contested on the basis that it requires considering* *other people as ends in themselves rather than as a means for achieving organisational aims*".

Dialogue is essential to Deweyan inquiry. As I reach the end of this subsection, I now wonder if – from a more processual perspective – practising caring invites a polyphonic and performative conversational to and fro, that may at times comprise the giving of care (diagnosis or instruction), but is also bringing new possibilities into being (Austin, 1962; Barad, 2003; Butler, 2010). This calls into question who has a voice, and how collective voice can be co-creative in its discordance. Arguably this was Gilligan's (1977) intent in arguing for the voice of women to be heard in ethical deliberations. This is more than modulating authority, or veiled care. However, caring acts can be verbal or non-verbal, harmonious or discordant, directive or mediated, and as a basis of generative knowing rather than solely expertise. It is this question of expertise – or competence – that I now move on to.

A question of competence

This sub section inquires into who is qualified to give care / to know what is needed, where care giving is situated in individuals and practices, topics of concern for critical scholarship.

In chapter 4 I discussed how care is viewed as a relational practice. Care as work (activities), transaction or commodity – which is gendered, low status and low paid, and inherently founded on relations of power and privilege (Fisher and Tronto, 1990; Held, 2006; Tronto, 2015) – are not discussed fully in this analysis despite the fact that my field work was undertaken in a care giving context. I acknowledge the interplay of care work and a broader understanding of care. My focus in a healthcare context is on ways of working together rather than patient or service delivery, which is care as 'practice' and 'practices' (things to do, caring acts), with their normative and entitative connotations of *good* care.

Care, and our workplace relationships, inform how we experience work in organisations (Fotaki et al., 2020a). Gilligan's foundational work on an ethic of care was predicated on an understanding of the psychology of human relationships, that self and others are interdependent. In this context, the activity of care enhances the self as well as the other (Gilligan, 1993a: 74). The subsequent development of Gilligan's ideas has consequences, however, reinforcing dualisms of power, vulnerability, status, and voice.

Power relations are evident in the work on care ethics and leadership, which typically assumes that care is modelled by leaders and given to (or withheld from) subordinates. Jennifer Binns (2008) conceptualises leadership as a social/relational practice, where ethics is understood as a critical, reflexive, and feminised, practice through which leaders come to understand the effects of their power and conduct and are able to transform or restyle themselves in their leadership relationships. In this context Yiannis Gabriel (2009) suggests that an ethic of care commits the carer to look after and take responsibility for the well-being of the cared-for especially in times of crisis (Ciulla, 2009), limiting the cared-for's autonomy and personhood (Mumford et al., 2020b).

For Gabriel (2009) this does not mean the ethical relationship should be uncritical in its quest for how people sustain fragile networks of relations that allow people to grow and prosper, developing trust, respect and responsibility for each other. Followers expect the power, wisdom, and courage of these heroic leaders to be used to promote collective ends, rather than the leader's own selfish ends (Gabriel, 2015), 'fostering nepotism and discrimination' (Mumford et al., 2020b). For followers (Ciulla, 2009; Covrig, 2000), this duty of moral leadership occurs when leaders rescue followers from despair or moral ambiguity through moral guidance and care.

The above literatures represent a critical stance that views relational leadership in terms of power relations, where the task of the leader is to 'moderate' their power and view of the other in their relations. They also cast the 'leader' in dualistic terms, as 'saints or devils' (Gabriel, 2015: 316), not to mention theorising leadership as an individual performance or role. This is dualistic perspective also sees care and duty in opposition, as well as taking agency and capacity away from all participants (Kittay, 2011).

I suggest that caring might encompass not only the professions and organisations committed to looking after people in need, such as caregiving organisations (Kahn, 2005), but also the broader social and performative processes of diagnosing, informing, and encouraging. Here, competence in caring is constituted by collectives as the work of arranging, modulating and resolving bonds and not solely as a matter of 'good sentiments and warm relations' (Mol, Moser, Piras, et al., 2010), emphasising the performativity of practice.

Other literatures - informed by feminist and science and technology perspectives - view care not an innate human capacity but an emergent organisational competence or practice, a situated knowing that a group of professionals enact while attending to their everyday tasks. This shifts the emphasis away from the individuals who do the caring, the caring values, or the caring acts undertaken, to how care is a sociomaterial accomplishment.

Gherardi and Rodeschini (2016: 268) posit that care is *"emergent capacity within a cultural system—professional, organisational, industrial, social—which produces situated ethical conceptions of what is involved in 'care' and what is not, which attitudes and behaviours towards caring are appropriate, and how people are involved in/by what they do 'as care'."*

A central theme in their study is the hidden, aesthetic, knowledge within practices, such as corporeal, pre-verbal, and non-rational knowledge, where care is an everyday accomplishment within a shared orientation by all (human and non-human) actors. Of particular interest for my study was Gherardi's and Rodeschini's focus on administrative, bureaucratic, and managerial work undertaken to support work (for residents and for premises) in a care home.

For Laugier (2015: 218), ethics of care is attention to ordinary life, *"to what we are unable to see, to what is right before our eyes and is for this very reason invisible to us".* These vignettes pay attention dynamics unfolding within the quotidian aspects of organising, which many organisational scholars eschew studying (Shields, 2006). I learn from Addams that this is where the interesting and change-full work happens.

Critical care literatures – such as Tronto, Fotaki, Gilligan focus on care and normative outcomes. There is a binary or dualistic focus – assigning certain acts or behaviours as 'good' while problematising the systems and structures where care happens. Mol and her colleagues invite a way of seeing caring as *"persistent tinkering in a world full of complex ambivalence and shifting tensions"* (Mol, Moser, Piras, et al., 2010: 84)**.** Caring is intervention rather than factual evaluation or judgement of practice (Mol, 2008: 84). This perspective invites a more processual understanding, where *"it is only in the present that one can attend to another"* (Mayeroff, 1965: 468).

Noddings (2015) says that while organisations can address some needs, they cannot care in the sense required by care ethics; and to assume otherwise is to corrupt the idea of care theory. Large organisations such as social services, schools and nations cannot care directly – that is, they cannot care-for in the relational sense prescribed by care theory. What it can do, Noddings continues, is to provide and support the conditions under which caring relations can prosper (care-about). This raises an interesting question about the broader socio-economic and political context that we find ourselves in, and how care might have local and societal resonances. While Tronto did situate her theory of care as practice within a broader political theory related to markets and exploitation, her core theory was predicated on providing direct care. As I have mentioned previously, it was many years later that Tronto (2015) added a fifth moral aspect, 'caring with' as a democratic practice.

How might a caring practice become care of everybody and everything? Rather than seeing care as a practice between those who are proximate and known – as Noddings, Tronto, and Madeleine Bunting, might argue – Regine Bendl et al (2020) and Elisabeth Conradi (2015) invite us to reimagine what we might mean by organisations and organising, moving beyond socially constructed differences, and where equality is the starting point of every social interaction (rather than an idealised goal). Their invitation to see care as a practice of emancipatory solidarity and societal transformation has resonances with the caring ideas of Mayeroff, Roche, Addams, Mol, and others, which I develop below and in chapter 6.

In this sub section I moved beyond understanding competence as being the preserve of experts or leaders, to suggest it is socially situated knowing. This has implications for how we organise, collaborate, and intervene in situations. As I move to the next section, so I revisit Deweyan inquiry as a different perspective on transforming problematic situations.

Diffractive analysis – felt experience, caring theory, and social ethics

In this section I critique the perspective offered by care ethics. A more diffractive stance, combining my felt experience and alternative literatures, opens my curiosity to re-engage with Dewey's logic of inquiry and its ethical and transformational aims that extend beyond the immediate situation. While inquiry *is* a dialogic practice, its motivation is collaboration, learning, and transformation.

The vignettes above comprise Deweyan ‘situations’ (1939) (the concept was explained in chapter 2), that is a ‘contextual whole’ of environment, conversation, social relations, events, pre-cognitive and felt uncertainty, and more. Inquiry for Dewey is a collaborative process of transforming these problematic or ‘indeterminate’ situations such that new insight and action may follow. My felt experience in both situations was discomfort.

In situation 2, the discomfort arose from empathic connection with the administrators such that I felt the overwhelm of responsibility for coding patient correspondence. As I shadowed the staff, they would talk me through the process, occasionally showing me extracts of correspondence (that could not be attributed to a specific patient). These letters could be ambiguous, or highly technical. While most of the administrators had several years’ work experience in healthcare, they were not clinically trained. I had been shadowing the team on an occasion where a mistake was made. I sat with the individual concerned as she felt distress and embarrassment at having made an error. The surgery manager, and other colleagues, were incredibly supportive, seeing the situation as an opportunity to learn and clarify the process for everyone. It was safe to get it wrong, but that did not make it feel OK.

In situation 3, I witnessed an entire meeting turn its anger towards one person whom they held responsible for several strategic and operational failings. In addition, the room was suffocatingly warm. I remember feeling it was a struggle to stay in the room, not just because I wanted to take in gulps of fresh air, but I was also waiting for them to turn on me when it came to my ‘slot’ on the agenda. In the end, the attendees had lost all energy for me, and I was relieved as well as being angry that Dr Gail had not fulfilled her side of our agreement by discussing the project proposal with her colleagues beforehand. I knew this would have consequences for my study, and at the same time this exchange felt too challenging.

I am curious how, in care ethics, encounters are predicated on the expertise and resources of care giver(s) to alleviate the suffering of the care receiver, with a normative focus on 'good' care. What this implies for the vignettes above is a focus on some*one* who has the capacity – either through resources or position – to alleviate a situation. For example, Dr Elsa – along with Mhairi the surgery manager – could have devised a correspondence process for Calliope and told the administrators how to implement it. They could override the concerns two administrators have, or reassign them to other tasks, thereby taking away a learning opportunity and the chance to contribute to the new process. However, rather than taking a directive approach, based on seniority and clinical expertise, Dr Elsa works with the administrators to identify a way of working that balanced the GP surgery needs with an individual's pace and confidence in taking on the new responsibilities.

This was more than a dialogic process, although the accomplishment did involve the to and fro of talk. Dr Elsa's approach helped to reframe competence as a resource to be shared rather than located within an individual. The experienced coder, Dr Elsa, and the administrators enacted caring through a collaborative process of learning and experimentation. The process was performative, bringing into being different realities, mediated through language, gesture, and other corporeal actions (Barad, 2003; Butler, 1988, 2010).

Traditional ethics focus on the virtue of individual motives or dispositions, regardless of action and outcome, Addams claims (1896). Her social ethics do not separate motive from action as both are needed for us to be ethical. This does not mean that every action should be judged as good or bad, but part of a creative and collaborative process of experimentation (what Mol et al (2010b) would call 'tinkering'). An individual's skills and capacities are still essential to this collaborative inquiry. I see resonances here between Addams and Mol in what this means in practice. Mol et al remind us that engaging in care is not innate, nor necessarily learned by imitating our mothers, but rather *“is infused with experience and expertise and depends on subtle skills that may be adapted and improved along the way when they are attended to and when there is room for experimentation”* (2010b: 14). We may be motivated by our feelings for others and how we then act on those feelings becomes a social concern.

In the context of practising caring, I understand inquiring to be a collaborative process of determining what needs to happen to transform a problematic situation such that a tentative course of action can be discerned. Organisational and care literatures might infer that what needs to happen is a dialogical accomplishment or the responsibility of leaders to decide and act. This leads me to ask, who decides what needs to be done, and with what motivation? Vosman asks us to consider whose knowledge/insight/expertise ‘counts’ in care – even if the answer to that is contested (for example, in the extent to which women’s voices, other minority voices, and the voice of the care receiver, are heard). Much care ethics literatures reinforce the dualism of care giver and care receiver – predicated on an epistemology of vulnerability.

Pragmatist and feminist technoscience literatures suggest to me that such inquiring is more than sensemaking and dialogue, but results in consequential action, and where the determinations of how to proceed are collaborative (and even sociomaterial). Opportunities for caring are not usually dramatic events, Roach (2002) opines, but come disguised in the simple, unobtrusive encounters of daily life. Caring is something we practice, ongoingly, and with others. Collaboration in inquiry does not necessarily mean everyone is the same, individual perspectives, experiences, and specialisation – and difference – are brought to bear for a shared purpose.

From a diffractive stance, I see how inquiry into a problem oriented around a shared commitment to resources for patient care gives rise to creativity and a capacity to act. In situation 3, it was Cheryl, inviting participation to find a way forward that would meet the cluster's expectations, and be within her capacity to deliver. While it might be seen that the cluster members were exercising their power over Cheryl to make their demands, she was also exercising power in appealing to work towards a mutually satisfactory outcome.

What I take from the care literatures is how their underlying relational ontology reinforces separateness. They talk *about* relationships, care. Intersubjectivity – with its attention on inter – focuses on what lies between. By reinforcing separation, these ideas also impose fixedness. Rather than seeing encounters through which participants experience change in themselves and their social relations, conventional care ethics approaches to relationships might invite us to linger on gender, vulnerability, power relations, a collective defence, or care as managerial tactic. Objects that I, as a researcher, can objectively study.

The dualistic notion of what constitutes care, might not favour the emergence of caring in the vignettes above. When observing caring in practice, as a post-human / sociomaterial practice, we should pay attention to the ongoing texture of connections Gherardi and Rodeschini (2016) opine, not to identify 'what is done' or 'who does what' but rather how things (human and more than human) stay connected, are reconnected, and whether the texture of connection is repaired if damaged. This line of inquiry seems more helpful for me because its processual orientation is more congruent with practising Deweyan inquiry, to see each tentative action in a wider context of social flows and movement. This perspective also strikes as acknowledging our ongoing entanglement, in a Baradian sense.

I now see alternative perspectives on inquiring into what needs to be done in a problematic or troubling situation. These diffractive themes of pluralistic inquiry and flourishing relations are discussed below.

Pluralistic inquiry

"Inquiry is the controlled or directed transformation of an indeterminate situation into one that is so determinate in its constituent distinctions and relations as to convert the elements of the original situation into a unified whole" (Dewey, 1939: 167). In thinking of inquiry as a process – which is consistent with Dewey – I see an emphasis on response-ability within inquiry. What that means is a participatory process, responding to the immediate needs of the situation, with consequential resonances. In this context, inquiry is neither good nor bad, but rather ongoing. It is the focus of this sub section.

All care theories and practices assume that action is taken, that care is more than intent. However, care ethics have developed as an intensification of the epistemological question: whose experience-based knowledge of, or insight into what is 'good' counts? Epistemology and power are subjects that most in care ethics regard as important (Vosman, 2020). As a result, inquiring into what care is needed (in the conventional care literatures) reinforces dualistic and asymmetric relations – of giver and receiver, active and passive, qualified and unqualified etc – and with normative good and bad ends. This is not how I understand inquiry from a Deweyan perspective.

Following Simpson's and Hond's (2022) readings of pragmatist literatures, and Barad's articulation of diffraction (Barad, 2007: 185) as a process of 'mattering', I understand inquiry to be an ethical, dynamic, creative, and *plural* experience. Participants (human and beyond human, from a sociomaterial perspective) bring differing experience and expertise, as well as capacities to respond, enlivened in a situation by a spirit of reciprocity and interdependence (Seigfried, 1996: 10). This is no abstract rule or heuristic, but manifest within the particulars of the community and the situation.

Thinking about caring from a processual orientation, informed by pragmatism and feminist technoscience, the potential to initiate and enact change does not rest solely with those in positions of authority or seniority but can be taken up by those who collectively respond to the need for a situation (such as a task, ways of working, or shared beliefs) to alter in some way. Indeed, those with lived experience of what is problematic about a situation have a perspective on what needs to be done that others may not (Addams, 1902; Kittay et al., 2005; Mol, Moser and Pols, 2010b). As there are no spectators in inquiry, diverse participants are active experimenters in a creative process (Addams, 1902; Follett, 1919; Whipps, 2014). Inquiry, then, is a collaborative and pluralistic process to continuously improve (for there is no time when care is done). While care theorists focus on an epistemology (or anthropology) of vulnerability, thinking processually valorises epistemology *within a situation* and the various (and even conflictual) ways of (tentative) knowing, informed by feelings, intellect, and experiences.

Thiele (2014) and Barad (2012) help me understand that inquiring into caring is less about calculating who is responsible and for which other, but how through response-ability we are collectively and ongoingly responding and transforming problematic situations; agentically reconfiguring our entanglements as Lather says (2016: 126). Recognising the wisdom in another empowers everyone with no one person wiser than another, Catherine Chamberlain, Doseena Fergie, Amanda Sinclair, and Christine Asmar (2016) opine. It is a collaborative practice based on a deep care for others, mentoring to foster wisdom, skilled practice and emotional intelligence to engender trust, and ability to respond within emergent change.

The emphasis on diversity and difference as integral to participatory practices of change were fundamental to Addams, where *"a standard of social ethics is attained … where all must turn out for one another"* (1902: 6). Contact with different others leads to concern, concern leads to affinity, and affinity results in response-ability, a shared capacity for generative action, according to Addams' social ethics (although I am using the word response-ability, inspired by Haraway).

Response-ability has the potential to also change how we think about power and possibility in a situation. For Follett (1924), 'coactive power' asks not where to place power but rather how it is developed for the purpose of social advancement. Coercive power, held by few, rearranges what already exists but does not produce anything new or different. Power for Follett (1919) is a plural social process that goes beyond asking how power might be allocated or divided in a situation but is created through a collective will to inquire and act on a shared goal.

When I think about the vignette of situation 2, I do see a shift of power and agency. While Dr Elsa adapts her leadership style to work differently with the administrators, the invitation for coactive power is taken up such that the administrators can voice their concerns and work collaboratively to reimagine how the workflow process could be implemented differentially while holding on to the strategic intent. Different expertise and experience are brought to bear – clinical, administrative, and managerial – and each is valued and needed in the prosaic doings in a GP surgery. This contrasts with situation 3, where there was resistance to an invitation to work collaboratively to meet the cluster's needs for more pharmacotherapy resource. The result was a breakdown in relations and the exercise of coercive power, which Cheryl was attempting to transform into redress.

In writing about Addams' practice of 'being-together-across', Danielle Lake (2021: 412) notes how an ongoing and sustained commitment to be with diverse others creates space and time for 'deconstructing positionalities' creative and collaborative action can be pursued. I see such a practice in Cheryl's responses in the meeting.

In contrast to the contemporary ideas about care as a relationship of power (Tomkins, 2020), caring is what Addams advocates (and practices) for democracy and its various institutions. For Addams (1910), care (as sympathetic engagement) results in (inter)action. Caring activity, stimulated by 'sympathetic knowledge' (Addams, 1912) of the other, is a theme in her writing and social activism.

I see resonances with pluralism and 'communities of inquiry' (Shields, 2003), which Shields suggests is a way of focussing conversations on problematic situations and subsequent data collection and interpretation, as well as a shared commitment to the potential to make a difference. Communities of inquiry need expertise, leadership, and wider participation, all engaged in a process of experimentation and learning from experience to address the specifics of a problematic situation.

In this sub section, by re-engaging with Dewey's concept of inquiry, I see a more collaborative perspective on problem solving and care giving, and who has the power and influence to determine a course of action, where pluralistic inquiry is a process of mattering. It is this mattering I now explore.

Flourishing relations

In this sub section I begin to ask why we inquire, beyond the needs of the immediate situation. Rather than focussing on amelioration, I understand the purpose of inquiry to be about mutual flourishing.

Gilligan's perspective on care is predicated on an understanding of the psychology of human relationships, that self and others are interdependent. In this context, the activity of care enhances the self as well as the other (Gilligan, 1993a: 74). However, an alternative take on interdependency proposes that it *"is not a contract, nor a moral ideal – it is a condition"* (Puig de la Bellacasa, 2017: 70). This has consequences for how we understand what needs to be done, from an ameliorative practice to social flourishing. This means seeing each situation not as isolated incidents or interventions. In chapter 3, I briefly discussed Glasgow's deprivation and health inequalities as the broad context within which healthcare – and its strategy for transformation – was given. I return to this context here, and again in chapter 6.

Care ethics does have a concern for questions of flourishing (Barnes, 2012, 2015; Bendl et al., 2020; Conradi, 2015; Fotaki et al., 2020a; Held, 2015), although I would argue that moral and political theories and resultant policies fall short of Fisher's and Tronto's vision of 'caring as a process', involving *"…everything that we do to maintain, continue and repair our 'world' so that we can live in it as well as possible."* (1990: 40). For Hamington (2001), care is a commitment to the flourishing and growth of *individuals*, while acknowledging our interconnectedness and interdependence.

Lawrence and Maitlis (2012: 642) highlight how feminist writing sees care as a central dimension of relationships, regardless of whether the experience is suffering or flourishing. I see the potential – certainly in how Gilligan defines care as a practical, situational, and relational ethic. However, in my reading of the care literatures, there is a sustained focus on individual vulnerability and amelioration, rather than entangled and oriented towards flourishing and while experiencing suffering. A further problem with a focus on vulnerability and amelioration is the related notion of *repair* (Cozza, Gherardi, et al., 2021), to put things back to how they were, but – processually – how things *were* cannot be how they might *become*.

Critical and political perspectives on care problematise the structures within which care is undertaken (in a market), asking questions of exploitation (women and marginalised others). These are important and persistent concerns, which COVID-19 and the ongoing fragmentation of care systems are exacerbating (Bunting, 2020; Chatzidakis et al., 2020; Cozza, Gherardi, et al., 2021; Dowling, 2021; Francis, 2021; James, 2020). Care *is* in crisis, in many ways that we might understand and practice care, although this is not the focus of my study.

It is the potency of *mutual flourishing* (which I use as a development of the pragmatist term 'meliorism', which Simpson and Hond (2022: 134) define as the idea that humans can always act to improve their situations) in caring inquiries that I now develop, informed by pragmatist social ethics, caring theory, and feminist technoscience. Mayeroff (1971) reminds me that the other must participate in the process of growth, it cannot be imposed no matter how much we might want the other to grow.

The suggestion of an 'ethic of caring' was first made by Massumi (2015: 43), and developed by Cathy Burnett and Guy Merchant (2020). It comprises the relational work of 'working for change differently', with attendant 'sensitivity to feeling', as a practice of 1) unsettling established ways of knowing, ordering, or understanding the world, 2) sensing possibilities to be otherwise, and 3) nurturing relations that are equitable and socially, politically, and environmentally just.

I see these themes contributing an understanding of flourishing – within a dynamic of human and beyond human caring – where the human(e) 'starting point' (in *this* moment) is solidarity and an active commitment to social progress, rooted in an immediate situation. Following Haraway (2016b), 'social' is more than 'human' or 'relational', suggesting diverse and entangled response-ability across species and technologies.

Entanglement for Barad (2007: ix) is more than being intertwined with another, as in *inter*-subjective joining of separate (human) entities. Rather, individuals emerge through and as part of entangled, multi-species *intra*-relating. This is not a one-time event or linear process, but an ongoing, iterative re-configuring (rather than repairing), extending entanglements and response-abilities of which one is a part through each intra-action. This is resonant with Mayeroff's (1971) invitation to see others as extensions of ourselves and also independent, needing to grow and flourish in their own way. *"Caring has a way of ordering our other activities around itself; if we think of the figure-ground relationship, then we may say that caring comes to be the figure with other values as the ground"* (Mayeroff, 1965: 473).

Flourishing then, is aspiration and process, just as equality is a hoped-for future as well as a living commitment practiced in each encounter; emerging from sustained relationships across difference (Lake, 2021). As Addams (1896, 1902, 1912) highlights, individual morality – our customary obligations to family and friends, which can be experienced as feudal benevolence and not just in familial relations – cannot address social problems.

Theorising potential – inquiring as an aspect of a caring ethos

The purpose of pragmatist inquiry is social progress, with each action situated in a specific context. Inquiry, then, is always ethical, in its world-making orientation. What this means is that inquiry goes beyond stimulus and response (Simpson and Lorino, 2016), and where meaning making cannot sit with one individual but rather emerges as a social process, oriented towards action. In this section, I offer a theorisation of inquiry as an aspect of a caring ethos.

Dewey, and Addams, suggest that ethical deliberation begins in *problematic situations* rather than with abstract ethical principles (Fischer, 2019). They are individual and social, and invite us to make decisions about growth and progress (Seigfried, 1996: 7). Furthermore, given our entanglement in social relations, we deliberate agentically as participants within this situation, rather than observers from the outside (Fischer, 2019). For Addams, morality is open-ended inquiry requiring scrutiny and continual revision in a given context, informed by experience as well as the morality that preceded it (1902: 1). We cannot assume that the principles that guided our moral compass in former situations meet the needs of the current (or future) perplexities we find ourselves in. Additionally, Addams' social ethics are proactive, inviting us to seek out different others with whom we can develop caring relations, rather than reactive (or avoiding contact and opportunities to learn) (Addams, 1902; Hamington, 2004; Lake, 2021). As Shotter (2012: 4) highlighted, felt noticings *"call for 'reversals' in our taken-for-granted ways of thinking about how our inquiries might best be conducted".*

These perspectives encapsulate how I understand *inquiring* – as a verb, or process – as an aspect of a caring ethos oriented towards mutual flourishing, while we attend to others who may need our involvement, as we too need others. I am arriving at inquiring through a diffractive analytic process, to notice differently what is consequential in these vignettes that more conventional analytic practices might overlook or discount. I see beyond dialogical accomplishments and questions of competence, to questions of pluralistic inquiry and flourishing relations.

In diffracting how I am 'troubled', using my own feelings to affect what may be discerned, I now see how inquiring is an ethical – world making or 'worlding' – practice, in its moral imperative is to *"always transform the present situation"* (Simpson and Hond, 2022: 138). I think of how Haraway (2016b) uses worlding, referring to the co-operative and conflictual ways of 'world-making' in which different species, technologies and forms of knowing interact. Worlding is an ethical and political 'mattering'. Thus, the cuts we make, the semantic boundaries we place, are consequential in how (what and who) we privilege. Seigfried (1996: 10) reminds me that we may need to temper our individualistic partiality. Mayeroff (1965: 465) suggests how we might accomplish this – in understanding that there are times when we take action and times when we do not, in recognising the choice and capacity of the other.

I think of inquiring as being mobilised by our perplexities (brought into awareness through attuning). This does not mean we know what needs to be done, or that we are called to act. A potential first step is in seeking to appreciate the other's situation is being fully open to the other's perspective (Watson, 1997; Weiner and Auster, 2007).

My readings of care literatures suggest that the care giver always know what needs to be done, or makes a suggestion, and it is for the care receiver to confirm the intervention has had its intended effects. This is not pragmatist inquiry. I am reminded of Addams' (1896) analysis of the Pullman Strike, which I discussed in chapter 4, and the move from unilateral paternalistic benevolence and to a pursuit of collective effort. One of the limitations of extending care ethics as a theory – even care as practice – is the seeming lack of focus on how care is practised and adapted ongoingly, how is it decided what needs to be done and who will do it. Sociomaterial theorisations of care do emphasise collaborative agency in the processes of tinkering, bringing together different knowledges and perspectives.

Pragmatism is a revolutionary philosophy because diverse experience is seen as the starting point of any philosophical investigation, it is suggested (Pappas, 2014). Addams and Follett, as well as Dewey, are credited for their works that directly addressed issues of power, inequality and inclusion in their socially progressive 'feminist ethics' (Gross, 2009; Leffers, 1993; Seigfried, 1999; Shields, 2006; Whipps, 2014). While Dewey and his contemporaries engaged in social and progressive issues of the day, arguably it was the women pragmatists – Addams and Follett – who exemplified this experimental philosophy in practice (Skorburg, 2018).

Pragmatism and Feminism share a practical view of philosophy that emphasises pluralism, experience, and public engagement to address the complexities of lived experience across diverse spaces (Kaag, 2011; Lake and Whipps, 2021), valuing the embodied and relational nature of personal and social change. In these social ethics I see a move away from ideas of expertise and authority situated in an individual, to a more collective perspective of situated knowing, or knowing from the inside.

In *Democracy and Social Ethics* (1902), Addams emphasised the need to dispense with a dualistic ethic of individualism in favour of a social ethic of cooperation/association. For Addams, democracy implies a system of relationships where people genuinely care for each other and adopt habits indicative of their willingness to act on those sentiments (Hamington, 2004). Even though Addams was not averse to exercising her power and influence over the residents of Hull House and its wider community, particularly in its early days, she practised and advocated stepping back so that the group might take action on a collaboratively determined agenda, rather than continued reliance on her own moral intuition, even if what ensued seemed chaotic (Knight, 1997, 2009). Follett (1924) describes this as the authority/values inherent in the situation rather than attached to someone's position or motives.

Addams argues that a group's clumsy and often ineffective efforts can be more socially valuable than the more effective action taken by an individual, because the process of collaborative action – community building (Follett, 1919) – is as significant as its outcome (Hamington, 2004). This is redolent of tinkering.

Louise Knight (1997) suggests that Addams' thinking and social work progressed from an ethic of paternalistic benevolence to an ethic of social justice (or care). If benevolence was the ethic that justified the assertion of power by one person, nation, class, race, or gender over another, as dispensers of benevolence, then justice, in its newer definition, was the ethic that justified ending that imbalance of power. It was this benevolent ethic that Addams progressively rejected throughout her adult life, believing it was better to work 'with' people rather than 'for' them.

Addams and Follett teach me that in trusting the generative capacity within the group, my own moral compass and experiences, which may serve me well, may not serve the situation we find ourselves in. The question of taking collaborative action – or coattending – as an aspect of a caring ethos is what I develop in the next chapter.

Chapter summary

In this chapter I set out to investigate how we inquire into what needs to be done in a problematic or troubling situation.

After re-telling two perplexing situations – one where a group of administrators are implementing a new correspondence workflow process, and the other in a conflictual meeting about the lack of provision of promised resources – I explore how critical care theories might make sense of these situations. It seems likely that neither situation would 'qualify' as good care, but more than that, our attention might be drawn to the tasks within care – such as talk and touch – and questions of competence in providing care. Situation 2 shows how flourishing emerges through caring. Situation 3 is still problematic; moves are being made to reorient the group.

From a perspective of practising caring, I notice how the vignettes show me inquiring as collaborative process of determining what needs to happen in a problematic situation. Inquiring is pluralistic – drawing on the needs and capacities of everyone involved in the situation – as well as being future oriented. This is not to say suffering is irrelevant – it does need to be attended to – but that it is seen in a wider context of flourishing and growth.

Having asked (in chapter 4) how we come to know that a situation is problematic, through perplexity and an awareness of difference, and how we then determine what needs to be done (in this chapter), through a process of inquiry. I now move on to ask how action is taken, for "*action is indeed the sole medium of expression for ethics. We continually forget that the sphere of morals is the sphere of action, that speculation in regard to morality is but observation and must remain in the sphere of intellectual comment, that a situation does not really become moral until we are confronted with the question of what shall be done in a concrete case, and are obliged to act upon our theory*" (Addams, 1902: 61).

In the next chapter, I investigate how consequential action is taken. This is less about what gets done, or who does it, and more about affects and resonances. Morality is revealed in practices of response-ability that reveal understandings about who we are, what we value, and to whom we are accountable for what we do. Morality is collaborative as we reproduce or shift our moral understandings together in many daily interactions of social life. For this reason, moral practices cannot be separated from other social practices (Walker, 2007).

Chapter 6 – coattending

Introduction

In the previous chapter, I suggested that inquiring is pluralistic and oriented towards flourishing relations, to determine what needs to be done in a troubling situation, and where there is no normative or prescribed course of action. What is distinctive about pragmatist inquiring is its always ethical orientation, in its concern for participation, learning, and future oriented action. In this context, awareness and attuning arise as a felt and whole bodied troubling, which prompts us to inquire what it is in this situation that needs to be different. It is this inquiring, following Mayeroff, that helps us to discern when we act and when we do not. The next question is *how* to act.

This chapter pays attention to consequential action, or coattending. Care ethics literatures typically focus on the who, what, and normative ends of care (as I discussed in chapter 3), where action is performed by someone/thing to (a dependent) someone else. In this context of care, action is dyadic (and dualistic) – where the (known) care receiver 'confirms' the outcome – and often routinised.

I explore *how* caring action happens, as a development of Mayeroff's 'logic of effectiveness', which potentially invites progressive experimentation as a mutual process of learning and growth, solidarity, and acting and holding back to allow others. It is consequential in that our choices, entanglements, and actions ongoingly (re)make alternative worldings that extend beyond known and proximate others, calling us to consider our accountabilities across time and space. Each problematic situation, no matter how mundane, is a microcosm of local, societal, and beyond (non-human, ancestral, and even cosmological) resonance, inviting a concern for solidarity as we become-with (Addams, 1902; Conradi, 2020; Haraway, 2016b; Mayeroff, 1971; Montes and Paris Pombo, 2019; Roach, 2002; Watson, 1997).

Coattending then is an ethical and consequential process of mattering for sustainable and flourishing relations, and not solely survivalist or instrumental ones (Puig de la Bellacasa, 2017: 70).

The vignettes that follow show how consequential action was enacted by my participants – affecting social relations, possibility, and the ‘situation’ in small acts of printing, buying hand cream, being asked for an opinion, adapting standard operating procedures, or saying ‘no’. I speculate how these actions might ripple out and their permissive resonances. What is shared in both situations is how caring transpires in the everyday, a place which can so easily be overlooked as mundane.

In analysing these vignettes through care literatures, my focus is on care given to known – or at least proximate – others. This is because care ethics requires an outcome or confirmation of care received to be classified as ‘good’. It follows then that doing care (ethics) typically normalises practices. Parvati Raghuram (2016) reminds me that while care ethics assume ‘universal’ care practices, these are typically predicated on an Anglo-American / European norms, at the expense of more situated and global understandings of care in practice.

This is perhaps the most speculative of the three chapters on caring dynamics, as I suggest that any action might be seen in a broader social process of solidarity, accountability, and world making – even with a context of organisations and organising – not that we know at the outset what may follow from our coattending.

Situation 4 – responding to COVID-19

One of the first major responses to COVID-19 was frontline support for patients with COVID-19 and protecting the wider NHS from being overwhelmed by the virus. Community Assessment Centres (CACs) opened in March 2020 to help manage the flow of suspected COVID-19 patients into the health service, so that they did not visit their local GP surgeries. While the setting up of CACs was a national mandate, with plans for more than 50 new centres announced by the then Health Secretary for Scotland[44], no guidance was offered as to how they might become operational.

In the space of 10 days (from when the national initiative was announced), and from a standing start, 'Thalia' was designed, staffed, and operationalised[45]. Mothballed premises were identified, equipped with computers, telephones, office, and medical equipment, including PPE. Over 200 health and care workers – cleaners and security personnel, administrators and clinicians, as well as senior managers – from all levels and functions within GCHSCP volunteered, some taking on new roles or roles they had not performed for years[46].

My field work had ended when the first lockdown was announced. As I sit at home watching the UK and national (Scottish) news, so I see some of my participants who are now the faces of Glasgow's COVID-19 response strategy and delivery. Weeks later, Primary Care Improvement Programme (PCIP) related meetings and planning activities resume. I am invited to listen in on meetings, to catch up on what has been happening. I hear about the impact of and lessons from setting up Thalia: that organisational, procedural, and behavioural changes within Primary Care that many thought would take a generation to transform, happened in the space of days and weeks. Some of the structural changes associated with the PCIP that had not been implemented were now in question. A new national digital wellbeing hub had been set up for staff, carers, volunteers, and their families to access support to aid physical, mental, and emotional resilience as the workforce responded to the impact of coronavirus (Scottish Government, 2020) as well as anger from members of the general public (which I mentioned in chapter 3).

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[44] https://www.bbc.co.uk/news/uk-scotland-52022833

[45] https://www.channel4.com/news/scotlands-nhs-using-unique-system-to-treat-coronavirus-patients

[46] https://glasgowcity.hscp.scot/news/community-assessment-centres-cacs-vital-tool-our-covid-19-armoury

I am chatting over the phone with Abi about her experiences in volunteering for Thalia. An experienced senior nurse and manager, she co-led the clinical service design, guided by the patient journey – how the patient would physically move through the building from being greeted by security to either going back home or to hospital – rather than taking a siloed profession-based approach to how each clinical team would normally deliver its care. Standard operating procedures were adapted – frequently daily, sometimes more than once – as more was learned about how to run Thalia as a 24x7 operation, and patient experience and outcomes.

Abi tells me these are innovations in service design, which are now being adapted by the other CACs within the Health Board. Innovations created in the CAC by staff having to respond quickly, working across professional silos, and performing unfamiliar roles, are being 'gifted' to other Primary Care services, such as out of hours GP services, and liaisons with residential care homes. Gifted so that they take ownership for it rather than something being 'rolled out'. As soon as you put a process around something, it squashes innovation, Abi says.

In amongst the intensity of long hours, constant change of protocols and parameters, anxious and exhausted staff, and the patients in chronic distress, Abi says she and those she speaks with believe they have never done anything so intense and with such meaningful impact. People felt ownership of the processes and protocols they created. There was a 'can do' attitude with camaraderie and goodwill. Feedback about what wasn't working led to change, even if there was too much change. Old power allegiances and cliques were broken up. Staff felt safe, protected, and motivated to keep volunteering rather than to return to their substantive roles.

But then Abi questions what it means to be valued: *"I did a 100-hour week and my husband asked me if I was going to Aldi to get the shopping and I was like 'are you joking?' and he said 'we need shopping and if I go I'll have to queue' and so I went* *and I showed my NHS pass and the security guy let me in and I nearly kissed him, I was almost in tears … it's the small things, isn't it … and yet surgery Nurses don't have the right passes [because they're employed by the GP surgery and not the Health Board] and so they can't go in [to supermarkets] during key worker hours … so are they valued or not?"*

She tells me that Secondary Care – the hospitals – get 'all the glory' in responding to the pandemic, and that Primary Care – frontline response via GP surgeries, CACs, community care – are invisible. That the Scottish Government refers to Primary Care as the 'front door' of the NHS but that they struggled to furnish Thalia – PPE, trollies, IT equipment, desks etc. Grace – a senior programme manager – drove her car to various HSCP locations to take spare equipment to fit out the building, because it would take Procurement four weeks to even begin to understand what was needed, let alone source it, by which time it would be too late. Staff needed three changes of PPE for each patient they saw at a cost of £2,000 per patient. These costs are unsustainable, particularly as COVID-19 cases continue to rise, and so the operational question now is 'what does less [cost] but good [care] look like'? How can the CAC continue its 24x7 operation, with high levels of safety and service, in a more cost-efficient manner?

NHS Greater Glasgow and Clyde

2 hrs ·

We've designed and produced a new reusable visor for our staff to protect against COVID-19.

Our Medical Devices Unit produced thousands of the new visors with the support and funding of energy companies Total, Shell, Baker Hughes and the Oil and Gas Technology Centre.

Not only have we made it easier for these visors to be decontaminated, they are more comfortable to wear and have improved splash protection. Staff can also write their names for patients to see.

https://www.nhsggc.org.uk/about-us/media-centre/news/2020/06/new-reusable-ppe-visor-designed-and-produced-by-nhsggc/

Figure 8 From Facebook, 18th June 2020

The NHS is notorious for its slow uptake of technology*,* Gavin Francis (2020a) writes. As well as procedural innovations centred around the patient experience, NHS Greater Glasgow and Clyde (which is the overarching health board that GCHSCP is affiliated with, as I outlined in chapter 3) was involved in several technical adaptations, such as the new visors in figure 8 above, as well as implementing telehealth platforms. The agility of the NHS response to the crisis was marked, even if needs were played off against each other across the health and social care systems (Dowling, 2021; Francis, 2020a, 2020b).

I also talk with Sally about her experiences of helping to get Thalia up and running. She had been asked to contribute as an organisational development (OD) advisor, to work with its management team on staffing, roles and responsibilities, and induction into the new and ever-changing operating procedures around patient management, PPE, and staff wellbeing. Sally had been surprised that she was even asked to provide support, that Thalia's leads realised OD input might be needed. It was a signal to her how clinical leaders were now starting to get the value of counsel on staffing, culture and collaboration, and other workplace matters.

Sally tells me about the 'heroic' behaviour of the nurses, not observing social distancing or wearing full PPE, because they do not think they matter in the way that their patients do[47]. That heroism is almost expected of anyone who works at Thalia, but it makes her uncomfortable despite her desire to become 'one of them' and to help one way or another. Sally is pleased that as a non-clinician she does not have to go to the CAC every day.

She tells me that just before Thalia was due to open, she had gone into the staff room and noticed that while there was plenty of sanitising gel, and tissues, there was no hand cream. Nothing to provide a restorative balm against the high alcohol cleaners that leave hands safe but stripped of their natural oils. Imagining how many times a day each staff member would need to clean their hands, and the impact of this, not just physically but in terms of morale and wellbeing, Sally went to the local supermarket to buy hand cream to leave in the staff room. Not the cheapest, nor the own brand stuff you can get for 99p, but something nicer, something that would make you stop and think 'someone took the time so that my hands feel nice and smell nice'. That 'that person really cared'.

"Everything about the way we work has been transformed. The number of face-to-face encounters with patients has dropped by 90%. Home visiting is both more time-consuming (because of the requirement for PPE), and perfunctory (to cut contact

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[47] In the very early stages of the pandemic, PPE was in short supply across the health and care sectors, and epidemiologists and public health experts were still learning about how the virus spread.

time). Dread has given way to fatigue, but not to complacency. I'm worried that too few people are being tested, that the test itself is often inaccurate and that our PPE provision is inadequate. The health gap between rich and poor, already wide from a decade of cuts to councils and benefits, is being stretched wider" (Francis, 2020a).

Francis, a GP and writer, offers an inside view of providing health care in the early days of the lockdown. He highlights how the diagnostic currency of Primary Care – subtleties of communication, empathy, touch, eye contact, silence, and body language (Francis, 2020a) – being in the same physical space as your patient, has given way to telephone and online consultations, sitting as far away from your patient as possible until you need to physically examine them. Before lockdown, a typical GP might see 40 patients a day. Every request is now triaged: *"The appointments book is filled as usual, but now with names for the clinicians to phone back, rather than with appointment times for patients to come in"* (Francis, 2020a).

Is this 'new normal' sustainable and desirable? What does this mean for the set-up of doctors' surgeries and the role of the GP as an 'expert medical generalist', in line with the Primary Care Improvement Plan vision? In a conversation with Eleanor, a Primary Care Development Officer from one of GCHSCP's three 'localities', she tells me that only one GP surgery she has spoken to (out of around 45) wants to go back to how things were before COVID-19. But what about the most deprived patients? Those with multiple co-morbidities who do not have the money for internet access at home – or a smart phone – to do a video consultation and cannot visit their doctor or nurse? Patients with severe mental health problems exacerbated by isolation and loneliness with no-one to physically look and see what state they are in (and are they taking their medication)? Patients who have lost their precarious and low paid jobs, live in poor quality housing and are losing the social structure of life, and who do not know how to access what they need to get help?

Situation 5 – stickers are medicine

Dr Gail is printing payslips to give to her team members. She hands one to Tracey and says: “You say I keep forgetting to give these out to you, and I do”. I had not expected that ‘payroll’ would be quite so basic as printing the payslips yourself on the budget black and white printer under the desk. Printing is the focus of attention at ‘Clio’ today. Louisa is going on holiday and so is trying to get the next two weeks’ worth of printing done now: papers for the next cluster meeting, outgoing correspondence, and stickers. Stickers are medicine, apparently, and Dr Gail is out of her supply.

Dr Gail tells me she has a few stock ‘prevention lectures’ for her patients: how harmful fizzy drinks are and that perhaps those symptoms would go if they stopped drinking them, that getting some exercise might do more good than the medication the patient is asking for, that rather than asking for more painkillers on prescription (prescriptions are free for all NHS patients in Scotland) the patient could get a box of paracetamol for 35p from the supermarket, that no the patient cannot have those sleeping tablets just because their pal in the ‘close’[48] got some.

She says a lot of her clinical work is saying no to patients, something she is used to, but that a lot of the younger GPs find difficult, especially when the patient becomes abusive. Sometimes, ‘medicine’ is giving the patient a hug, showing them they have been ‘seen’, even if there is nothing that a doctor can do to ameliorate the patient’s situation, and when the root causes are systemic socio-economic deprivation – poor housing, unemployment, isolation – exacerbating the already complex health needs (discussed in chapter 3). ‘Shit Life Syndrome’, as Dr Gail and her colleagues call it.

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[48] A communal staircase in a Glasgow tenement, behind a main door, with entrances to private dwellings. It is also used to refer to proximate neighbours: https://www.dsl.ac.uk/entry/snd/close_n1 (no 4).

Stickers are the medicine for children. When children come in to see her, she says, they always get a sticker and leave the consulting room ‘better’ and ‘dancing down the corridor’, even if they also had ‘the lecture’ about fizzy drinks. Each time they come in, the children will get a different sticker, printed in the surgery office. It does not matter that the sticker is in black and white, it’s a sticker. And the fact that the printer doesn’t seem to want to print more stickers is a drama for everyone, more problematic than the lack of meeting papers.

“Good general diagnosticians are rare… because most are incapable of taking in all the possibly relevant facts – emotional, historical, environmental as well as physical. They are searching for specific conditions instead of the truth about a man which may then suggest various conditions” (Berger and Mohr, 1967: 76). Berger’s quote about Dr Sassall reminds me of the complexity and simplicity of bearing witness to a patient’s ‘shit’ life and death (Jones, 2015), and where there is no medical cure for deprivation and its impacts.

In reflecting on Berger’s account of Dr Sassall, Jeffrey (2016: 476) writes that Sassall presented himself to his patients as an equal, prepared to share his vulnerability, where *“empathising is a creative process that changes and develops with experience*”. Jeffrey also opines that while doctors need empathic concern for their patients and help to learn emotional regulation, it is not good enough to provide training to become more empathic but expect doctors to work in an environment that does not support empathy.

Now, when I recall the time spent with Dr Gail at Clio and in other meetings, I am left with a sense of ‘tough love’ she showed towards her patients and her team. A side of her I did not see in programme meetings, or in her reputation for being formidable and iconoclastic. This empathic connection, which I think of as caring, in Berger’s study adopts a broader approach highlighting cognitive, affective, behavioural, and moral aspects. David Jeffrey (2016) argues that kindness is a relational process rather than a personal attribute.

Kindness was the theme of 2020’s Mental Health Awareness Week. Dr Phil Moore, Chair of the NHS Commissioners Network[49], in writing about the importance of kindness for mental wellbeing, highlights how one small act of kindness can change another person’s future. He also makes the point that *“while an individual clinician can be compassionate, for compassionate care to be effective it must be integral to an organisation’s values and ways of working”* (Moore, 2020). I am reminded of the British idiom: to place a sticking plaster over something, which means ‘dealing with a problem in a temporary and unsatisfactory way’[50]. Stickers, sticking plasters, tools of the trade, and compensatory tactics in untenable situations.

Attending to the situation(s) - contributions from care literatures

In this section I explore how doing care manifests in the above vignettes, by engaging with care ethics literatures. These literatures call me to focus on two aspects – the giving of care to known others, and the normative practices associated with good care.

Known others

In this sub section I ask what is meant by giving care to known others as a measure of a good care. Care ethicists are clear that care is given to a *particular* and *human* other (Engster (2007). However, the meaning of ‘known others’ seems to divide care literatures. Leininger (1996) suggests that in care – as a professional practice

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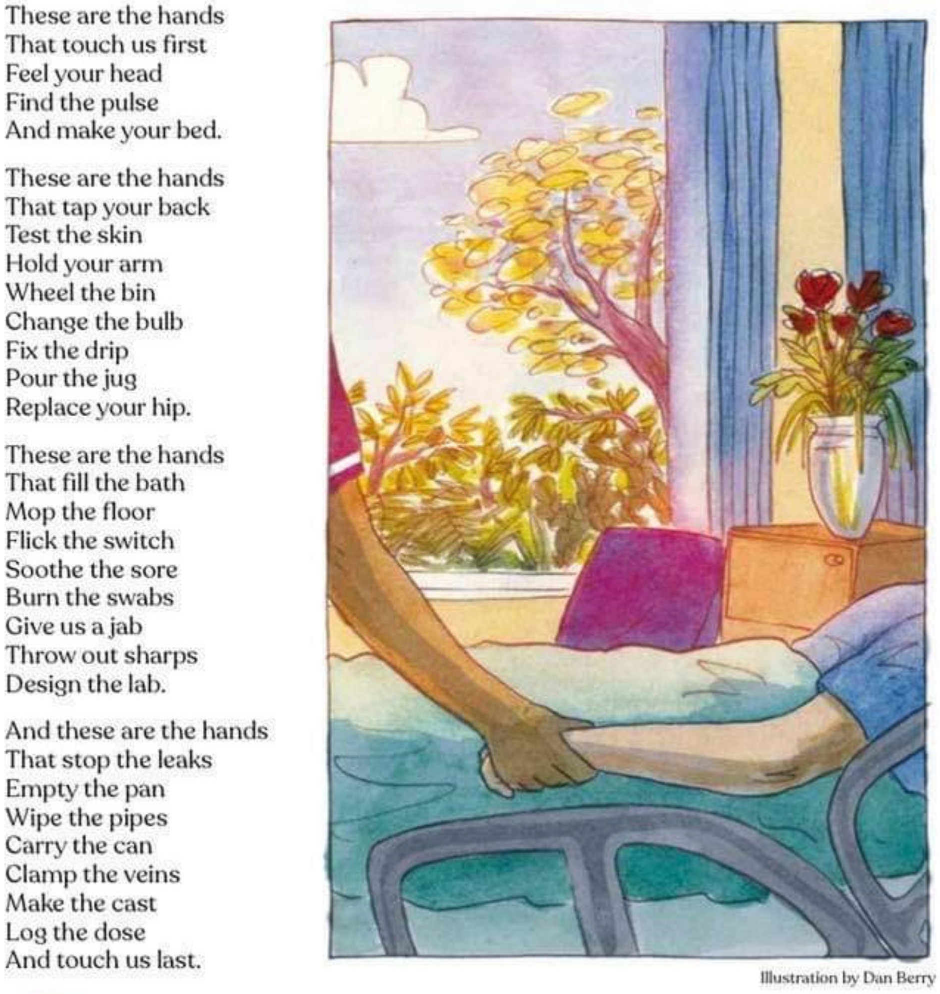
[49] Commissioning is the process by which health and care services are planned, purchased, and monitored by the various NHS trusts in England (which operate as ‘internal markets’, separating the purchase of services from their delivery). This is not how the NHS operates in Scotland, as commissioning is done nationally rather than at health board level. https://www.kingsfund.org.uk/publications/what-commissioning-and-how-it-changing https://www.nss.nhs.scot/browse/specialist-healthcare/commissioning-services

[50] https://dictionary.cambridge.org/dictionary/english/sticking-plaster

such as nursing – clients are acted upon by strangers using unfamiliar techniques. In this transactional view, these others may be unknown but are proximate, such as a one-off or short-term contact.

Care is face-to-face practice(s) (Barnes, 2012; Engster, 2005; Held, 2006; Liedtka, 1996; Mol, Moser and Pols, 2010b; Monchinski, 2010; Olthuis et al., 2014; Tronto, 1993), where work is undertaken on a ‘direct level’ (Hamington and Sander-Staudt, 2011). Engster says these practices encompass everything we do *“directly to help others meet basic needs, develop or sustain basic capabilities, and alleviate or avoid pain or suffering”* (2005: 55). For this reason, Marian Barnes (2015) opines, care ethicists have been ‘uneasy about the inclusiveness’ of Fisher’s and Tronto’s definition of care – as more than a dyadic relationship between two people (or uni-directional) – a point I raised in chapters 4 and 5.



These are the hands
That touch us first
Feel your head
Find the pulse
And make your bed.

These are the hands
That tap your back
Test the skin
Hold your arm
Wheel the bin
Change the bulb
Fix the drip
Pour the jug
Replace your hip.

These are the hands
That fill the bath
Mop the floor
Flick the switch
Soothe the sore
Burn the swabs
Give us a jab
Throw out sharps
Design the lab.

And these are the hands
That stop the leaks
Empty the pan
Wipe the pipes
Carry the can
Clamp the veins
Make the cast
Log the dose
And touch us last.

Illustration by Dan Berry

Figure 9 'These are the hands', shared by the National Education Union in May 2020

Michael Rosen (2015), who wrote the above poem for the 60th anniversary of the NHS in 2008, exemplifies how a patient might experience direct and indirect care (in a market such as the NHS), as visceral and temporal acts. These words have taken on a new poignancy. Rosen spent seven weeks in an induced coma and on a ventilator, and a further three weeks in a rehabilitation ward, so that he could learn to walk again, after having contracted COVID-19 in March 2020. In paying tribute to the health workers who treated him, he described the NHS as an 'incredible feat of the imagination' where you are cared for by 'complete strangers' (Ferguson, 2020).

My focus is less on the giving of care to another, whether or not they are known and proximate, and more about how caring action is *consequential*.

Hamington (2018) says that enacting care at a social level means taking risks to change, such as listening to the stories of unfamiliar others, a defining theme of Addams' work. In situations 4 and 5, relational familiarity even in the face of proximity and distance, and uncertainty, is a theme. In situation 4, the leadership team was staffed by senior Primary Care members of GCHSCP, many of whom were participants in my study. Some of them had known each other and worked together for years. Did the pre-existence of a shared history – with all its differences as well as commonalities – goodwill, and trust in each other's commitment and capacities make it easier to take calculated risks and work at speed in the setting up of the CAC? In situation 5, Dr Gail's practices of care for her patients can be seen in a wider context of socio-economic understanding, family dynamics, and direct relationship. What kept these 200 or so volunteers at the CAC committed to this new and dynamic service, with all its risks?

Slote (2007: 94) opines that people are likely to develop more empathy for (groups of) people they know than for those they do not. For this reason, Noddings argues that to think of caring organisations, as I have explored in previous chapters, is to devalue the principle of care, for *"what is missing in all of these cases is the activation of genuine caring-for, the person-to-person relationship characterised by attention, dialogue, recognition of expressed needs, and immediate response moved by the feeling aroused when people are in direct contact with those in need"* (2015: 76).

The question of how care ethics might respond to global concerns, divides care theorists. Noddings states that to think of care in scenarios such as foreign aid or homelessness – with unknown others, no matter how much in need of care – is not the kind of care the theories intended. In contrast Barnes (2012, 2015) and Held

(2006, 2015) – who look at care from a policy and social justice perspective – widen caring to include unknown others, invoking our moral imagination. Just as Addams (1911) did in her Settlement work at Hull House, by bringing diverse communities together within a neighbourhood to collaboratively address local issues of shared concern (such as sanitation). In Addams' work, social morality expanded through seeking out and acting with different others. There was safety in limiting one's knowing to familiar others, but this safety came at the price of ignorance and intolerance of difference, and ultimately complacency with the status quo, which in Addams' view was not moral (Banerjee, 2022; Lake, 2014).

This social morality is like Mayeroff's process of caring, oriented around mutual growth. The *specific* other may be a person, an idea, or a community. They may not be proximate, or known to us, but they are not a generalised other. We learn and grow in our affective relations with the other. Perhaps what kept the volunteers at Thalia was not just the chance to provide care, or the sense of public service that motivates so many health and care workers, but also personal growth through being part of something so dynamic and innovative.

Barnes (2015) invites us to consider how we might conceptualise a multidimensionality of care, beyond its typical dyadic focus with 'known' others. Such 'collective care' involves networks or groups of individuals in caring relationships. This does not mean consistent harmony (thinking back to the conflict in chapter 5), nor does it preclude a network's attention on one individual for a specific purpose. What characterises these relationships is the greater equality between those who 'care for' and those who receive care in what are often reciprocal relationships, as interdependency is multidirectional. Networked care is relational and social, emphasising dialogue and praxis to enable learning, a necessary aspect of ethical care. I think of Barad's concept of entanglement, and Follett's (1919) proposition that community is a process. Caring, and the various roles that may be taken up, is performative: bringing into being different realities, through language, gesture, and other actions (Barad, 2003; Butler, 1988, 2010). I think instead of mutuality in a process of caring, all participants learn and grow.

In this sub section I have critiqued the focus on giving care to known others, which is the concern of care ethics. Mayeroff and others remind me that caring action involves mutual growth, to that end, we can still grow in extending our caring to distant others.

Normative practice(s)

As I wrote in chapter 3, one of the distinctions of care ethics from other moral theories are its emphasis on practice. In this sub section I explore how a normative focus on care as practice(s), reinforces a dualistic attention to 'good' care (a satisfactory outcome, confirmed by the care receiver). If care is not good, it is not moral, according to care ethics. However, by rethinking all social practising as inherently moral, it becomes possible to widen our noticings of care in practice.

Care practices are ongoing, messy and complex, Tronto (1993) writes. In this context, 'good' (or normative) care happens when the activity of caring and the disposition to care are both present, and where all phases and moral aspects fit together as an integrated whole. However, Tronto continues, as care is about meeting needs, it is always relational and infused with power. Therefore, for Tronto, an ethic of care remains incomplete without a corresponding political theory of care. I have discussed an alternative way of understanding power, informed by Mary Parker Follett, in chapter 5, but in this chapter I will develop an idea of caring actions that change situations and relations in a wider context of solidarity and social progress.

Care means not only achieving certain aims for someone but also doing so in a caring manner that moves beyond emotional or psychological motivations to questions of moral duty. The problem with care, as Engster (2007) defines it, is that it privileges the morality and expertise of the care giver. And, as Tronto (1993) and others point out, these care practices must be more than caring intent – they should also have a 'good' result.

In situation 4, the CAC leadership team had to design a standardised workflow for patients with COVID-19. Infection and health risks to other patients and CAC staff had to be minimised. The CACs were a national initiative, with several opened within greater Glasgow. They needed to function consistently so that staff could move between CACs and operational procedures optimised. Arguably, this standardisation, with the aim of minimising risk and patient throughput, enabled the CACs to function as a 24x7 service during the height of the pandemic. Action was contingent on exemplifying a logic of efficiency, which also reinforced dyadic relations between caring professions and patients. Perhaps during an emergency, when action needs to be taken in life-or-death contexts, this is how it should be.

In situation 5, one of the dilemmas for Dr Gail is what it means to be an 'expert medical generalist'[51] within a multidisciplinary team. The vision for the PCIP was to place the patient at the centre of care relationships, enabling other health care professionals to provide care that did not require a doctor, so that the GP could focus on more complex care, care quality, and leadership.

Dermot Breslin (2022) states that reciprocity, trust, and informality in developed (but dyadic) care (as work) relations create solidified task routines. He contrasts ostensive and performative aspects of care routines. Even in situations that are not 'problematic' in a Deweyan sense I wonder whether these ostensive routines really are identical in each performance, even when the routine is being performed by technology. While the printing of stickers – and payslips – might be a routine task for Dr Gail's surgery, there are variations. Someone is on holiday, their payslip may

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[51] https://www.bmj.com/content/359/bmj.j5626

not be printed until they return, or it may be locked away. A new idea for a sticker emerges, and someone needs to find an image to use. No matter how seemingly mundane, these are also creative and collaborative acts. The group is formed and performs not to meet individual needs – for a payslip, or a supply of stickers – but to further a shared aim, in the case of situation 5 the running of a doctor's surgery.

This caring (rather than care) – according to Gherardi and Rodeschini (2016) – is not to be understood as a harmonious or shared set of values and behaviours, but as an activity, where a plurality of meanings, professional and non-professional logics, meet and clash. This shifts the emphasis from the efficacy of an individual routine, to the ongoingness of community as a process (Follett, 1919). Here, caring is constituted by collectives, arranging, modulating, and resolving bonds and not solely as a matter of 'good sentiments and warm relations' (Mol, Moser, Piras, et al., 2010), emphasising the performativity of practice. Thus, normative judgements about 'good' care and 'bad' care, could be reframed as processes of negotiation, decision-making, and learning (Gherardi and Rodeschini, 2016), no matter how conflictual (Mayeroff, 1965).

In this context, we might turn our attention from normative care practice(s) to practising caring, and from routines as 'action patterns' (Breslin, 2022) to social habits (Hamington, 2004). Hamington opines that for Addams, certain 'habits of caring' – active listening, participation, connected leadership, and activism – would allow society to flourish and grow (2004: 93). For Walker (2007) morality is revealed in practices of responsibility that reveal shared understandings about who we are, what we value, and to whom we are accountable for what we do. It is collaborative as we enact or revise our moral understandings together in our social interactions.

Moral practices, therefore, cannot be separated from other social practices, nor moral identities from social roles and institutions in particular ways of life. I think instead of practising response-ability, in how the CAC volunteers operationalised and enhanced a new health service, meeting the immediate needs to manage high patient volumes, while at the same time creating a wider legacy and contribution to how health care can be delivered. These actions were creative and consequential, contributing to a wider learning orientation, two aspects of caring in practice that I will go on to develop.

Diffractive analysis – felt experience, caring theory, and social ethics

In this section, as I diffract the vignettes and care ethics literatures to notice differently, I draw on a family experience to then meditate on consequentiality. I cannot bracket the tragic death of my father-in-law from the fabric of this inquiry.

"That the virus (COVID-19) spreads through speech and touch was one its cruellest twists", writes Francis (2021: 80)*, "attacking the most basic elements of our humanity: how we connect, empathise and show love".* Some of the more difficult conversations during this period related to withholding: GPs having conversations with patients they had known for decades about what choices to make should the patient contract the virus, chances of survival for the most clinically vulnerable, whether DNR – do not resuscitate – should be added to a patient's medical records. Even touch between family members – holding the hands of ageing relatives while visiting them in care homes – became a deadly risk. Cruel to withhold but crueller still to unwittingly infect.

These words above take on a new poignancy in the space between first writing them, and when I next read them. Malcolm, my father-in-law, contracts COVID-19 while in hospital following a serious fall two days before Christmas 2020. Within the space of two weeks from being admitted into hospital (in England), he is dead. No visitors on the ward, limited and perfunctory mobile phone conversations, and no verbal caress to reassure. Malcolm's cognitive decline due to inadequate oxygen supply to his brain too rapid to remain or sustain lucidity, my husband's family devastatingly unaware of how serious the situation was until they were told to 'expect the worst'. Malcolm – in a state of confusion – thought he had been abandoned by his family. Twenty-four hours later, he is gone. Not one family member got to visit or say goodbye.

Three weeks later, we watch Channel 4 News commemorate the grim milestone – 100,000 dead from the virus in the UK. The BBC reports that the UK is the first European country to record more than 100,000 deaths linked to the pandemic[52]. Malcolm but one of those numbers. Ironically, he was also one of the first over 80-year-olds to receive a first dose of the new vaccine, but without enough time for the antibodies to develop before his fall and admission to hospital. These are very troublesome firsts.

By mid 2022, the UK had the highest death toll in Europe in absolute terms[53]. There are now more than 220,000 hearts on the National COVID Memorial wall in London (figure 10), each heart representing a casualty of the virus[54]. My husband's family is still raging, but not with the health care staff.

But did Malcolm *really* die 'peacefully', which is what they were told? How might his fortune have been had the hospital staff centred their COVID-19 response around the patient, as the CAC did?

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[52] https://www.youtube.com/watch?v=NgCMFnarf5U
[53] https://www.theguardian.com/world/2022/jul/13/number-of-uk-covid-deaths-passes-200000-ons-data
[54] https://nationalcovidmemorialwall.org/

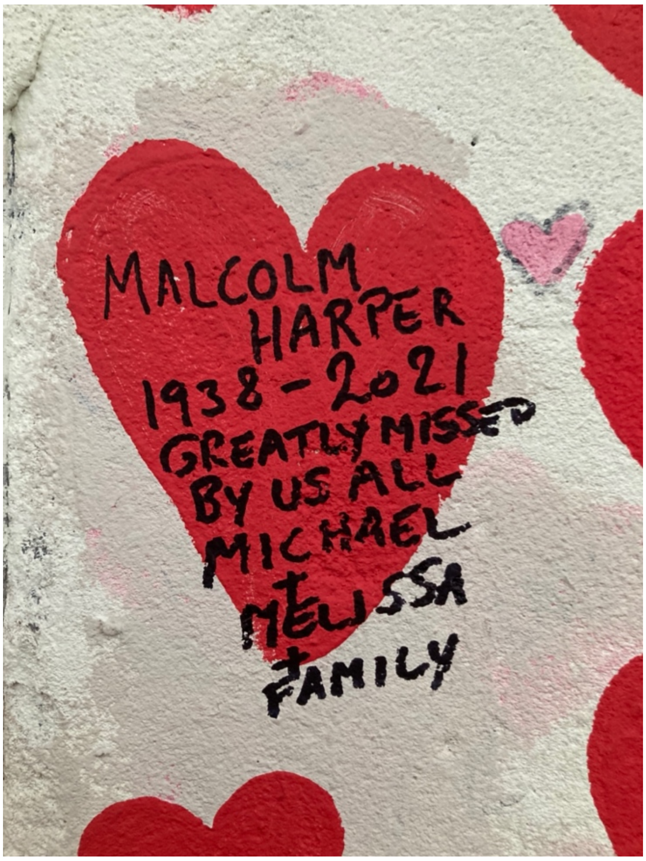

Figure 10 Remembering Malcolm. The National COVID Memorial, London.

Tronto stated that any ethic of care must be placed in its full moral and political context. From this perspective, she argues, care involves ‘particular acts of caring’ and a ‘general habit of mind’ that together inform all aspects of a practitioner’s moral life (Tronto, 1993: 5). I wonder how an ethic of care was exemplified here.

Almost one in four hospitalised COVID-19 cases caught the virus in hospital, it was reported during December 2020[55]. By January 2021, hospital acquired rates have trebled in some NHS trusts[56]. Indeed the hospital where Malcolm contracted the virus and subsequently died is name-checked by the media as one of the worst offending NHS trusts in England (Campbell and Barr, 2021). As David Oliver, an NHS

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[55] https://www.hsj.co.uk/patient-safety/covid-infections-caught-in-hospital-rise-by-a-third-in-one-week/7029211.article

[56] https://www.hsj.co.uk/patient-safety/covid-infections-caught-in-hospital-up-by-half-in-a-week/7029320.article

consultant writes[57], it is hard for healthcare staff to challenge their own practices when they are already so challenged by responding to the pandemic and an NHS service with endemic structural deficiencies. But challenge – and learn – they must.

Tronto (1998: 19) says caring should take place in such a way that all involved in caring contribute to the ongoing discussion of needs and how to meet them. No single actor in a care process should assert their own authority or knowledge in the process. Care ethics, it seems me though, favours the triumvirate of motivation, action, and impact in each dyad, reifying the skill and expertise of the care giver about what needs to be done (Kittay, 2011).

Responses to problems like COVID-19 are arguably predicated on a linear crisis management logic of detection, preparation/prevention, containment, recovery, and then learning (Branicki, 2020). In critiquing this approach from a feminist and care ethics stance, Layla Branicki (2020: 880) offers an alternative logic, where crises *“compound and confound each other within webs of relationships informed by care”.* Such a perspective enables a different perspective on temporality and boundedness, she opines, by drawing on a wider understanding of care, to include caring about, taking care, care giving, and care receiving. I am not sure I understand what she means *in practice*.

These aspects are like Tronto’s four elements of care (giving, receiving, caring about, and caring for), always seeing the work of care in its wider political context. I concur with Branicki that a different response calls for a different conception of temporality and boundedness. However, I find myself wondering whether care ethics – with its ontology of dualisms and theoretical orientation – can really contribute to different action in times of crisis, where learning and action are in ongoing interplay, what it means to be expert is fluid and situational rather than individual.

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[57] https://www.bmj.com/content/372/bmj.n70

Tronto (2015) expanded her model of care by '*caring with'* as a democratic practice, which carries the moral dimensions of plurality, communication, trust and respect; being open to recognise other people's care needs when your own needs are being met. Transformation to a caring democracy requires us to change not only the discourse about care or our daily concerns, but also to make political and social institutions more caring, Tronto argues. Do we really need to wait until our own needs are met before caring for others? This seems at odds with a more entangled and processual understanding of response-ability.

When I think about situation 4, COVID-19 can be considered as a wicked problem with long term consequences (Baltzersen, 2022). Collective learning at a system level has been important – in some healthcare systems, mostly outside of the UK – in responding to the pandemic, learning from past failures to inform preparation and future response (Baltzersen, 2022). In Scotland, following the first wave of the virus, the Government identified 'four harms'[58] – direct impact of COVID-19, other health impacts, societal impacts, and economic impacts – to guide risk assessment, decision-making and action. The principle behind the four harms was that there would not always be a 'right' or 'best' answer, but each tentative answer needed to be justified.

What I take from Addams is the connection between local, national, and even international progress through situated and participatory experimentation and learning. By situated doing, and its own internal logic (perhaps a logic of solidarity). In situation 4, the team fitting out and staffing the CAC were not thinking about the four harms, as they had not been developed, although there was a wider national context of maintaining access to health and social care for the population as well as

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[58] https://www.gov.scot/publications/covid-19-framework-decision-making-assessing-four-harms-crisis/pages/7/

providing a separate service for those with (or suspected to have) the virus. The team had less than two weeks to operationalise.

I think about healthcare professionals taking up new roles or performing roles when they did not have COVID-19 experience (no-one did at that point). I think about designing a service around patient experience in that building, rather than professional silos that the patient must orient themselves around, or how things might be done elsewhere. In a time of crisis, there was still space to think, to adapt, and to be creative. I think about the CAC operating on a 24x7 basis from when its doors first opened. How did they accomplish that? What is evident is that standard operating procedures changed daily. This became a source of confusion and frustration for some who returned to a shift after a break. I have also been told that many of those standard operating procedures were developed and amended by the staff themselves as those with the direct insight into what needed to be done for the CAC. This suggests a focus on immediate performance and wider learning, and by people who were no longer in familiar teams.

“One of the few consolations of this pandemic is its grim camaraderie, a new fellowship among the fear” (Francis, 2021: 76). This certainly reflects what my participants tell me about the level of cooperation during the pandemic, from the setting up of WhatsApp groups for cluster leads, to volunteering to staff the CACs, a different – response-able – ethos is emerging, sometimes mediated by technology.

I return to the relationship between care and action. Dewey opined that ethics should be understood as the art of helping people to live richer, more responsive, and more emotionally engaged lives (Fesmire, 2003). The delivery of healthcare *is* inextricably tied to questions of politics, power and equity (Tronto, 2010). I acknowledge role, status, gender, ethnicity, and social class are part of the ‘situation’ in my inquiry into practising caring. The “Glasgow effect” – excess mortality in the city that cannot be accounted for by poverty and deprivation alone

– is a phenomenon under study[59], as I discussed in chapter 3. While doctors' surgeries can attempt to ameliorate some of the health and wellbeing effects of deprivation, the underlying causes of chronic illness prevail. This is the day-to-day for Dr Gail in situation 5.

I am also reminded of Mol's comments about the caring role of the printer, technology that helped to show these staff they are being compensated for their work, and for the children that the doctor has treated them. That the most important task for the surgery manager on the day before her holiday is to print. The most prosaic of sociomaterial actions – a sticker, a hug, a lecture – involving the whole team is consequential insofar as there was (mutual?) healing in the encounter, as well as enhancing the clinicians' capacity to wit(h)ness their patients… curing as well as caring, as Mol puts it (2008), where care is not just about clinical diagnostics and interventions.

The language of wicked problems and grand challenges – while highlighting the complexity of issues such as poverty, disease, and climate change – can potentially obscure from the potential in everyday situations and encounters to become consequential, even emancipatory (Duran, 1993; Haraway, 1997; Seigfried, 1993), through a logic of solidarity. In proposing a new theory for a pragmatist approach to dealing with such problems, involving experimentation and participation, it is notable that Fabrizio Ferraro, Dror Etzion, and Joel Gehman (2015) make no mention of Jane Addams. Arguably she had more direct and sustained experience of addressing wicked problems than her male contemporaries (whom are feted for their contributions to pragmatism in a way that Addams and Follett have not been to the same extent, although this is slowly changing (Ladkin, 2020; Morlacchi, 2021; Skorburg, 2018)). Her philosophical work and social activism responded to the social and economic concerns of the day, within neighbourhoods and beyond, to issues of

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[59] https://www.theguardian.com/cities/2016/jun/10/glasgow-effect-die-young-high-risk-premature-death

war and peace[60]. It was situated, distributed, and processual. In the sections that follow, I develop these themes of experimentation and participation, by drawing on feminist pragmatism, as well as more diverse and global feminist voices.

Progressive experimentation

In this sub section I suggest that progressive experimentation is more than tinkering, but a resonant process of learning and mattering. Banerjee (2022) says we should re-imagine Addams' social ethics as an invitation to view moral agency as social as much as individualistic, and in the pursuit of social progress. This approach enables us to move from cognitive understandings of care as abstract principles to a performative understanding of caring as situated in social situations. It is this move to caring collaborative action that I now explore.

If we think of organisations and organising as dynamic sociomaterial practising, then this implies continuous change. Pragmatism is not grounded in a conception of knowledge as absolute truth, there is a recognition that various methods of inquiry can lead to different understandings (Hamington, 2004). Knowledge is neither static nor monolithic, rather comprising experience – emotional, aesthetic, situational, and relational (Dewey, 1934). From a pragmatist perspective, such change, in attending to problematic situations, offers possibilities for learning in and through action. This could be thought of as progressive experimentation – progressive in both senses of the word: developing incrementally and oriented towards social reform. Progressive experimentation as a form of collaborative inquiry also comes with uncertainty about outcomes, but it is not random in its practice. Arguably, Addams' experimental work was scientific (Skorburg, 2018) in its methods of data collection, observation, and collaboration. These have continued relevance as a way of progressing social change, as a participatory and evidence-based process.

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[60] https://www.nobelprize.org/prizes/peace/1931/addams/biographical/

Matthias Gross (2009) highlights Addams' 'experimental method' at Hull House as an attempt to lay the ground for the public acceptance of collective learning processes. Indeed, Addams' work at Hull House can be seen as a succession of collaborations and experiments, some catalysed by Addams', but most emerging from local communities and groups. Lake (2014) sees Hull House as providing a relatively stable, yet flexible space from which work emerges bridging institutional, political, educational, and moral divides. From this space, Lake (2014) continues, Addams developed a practical methodology for tackling dynamically complex and ill-structured issues where there are no final resolutions, where stakeholders have divergent interests, needs, and values.

Amrita Banerjee (2022) thinks of the creative experimentation within Hull House (and even Hull House itself) as a 'liminal space', one that does not settle down and refuses to give in to an either/or dichotomy. While a liminal space is seemingly chaotic, she continues, it only appears to be so from the point of view of a binary ordering of the world. It is such spaces that a fertile for participatory inquiry, in the case of Hull House, to advance social wellbeing and democracy. This is worldmaking inquiry in practice.

I think about Grace, Abi, and all the participants in the two vignettes above. While some experimentation may seem more familiar – the updating of standard operating procedures – there is world making (as well as a precedence, although I am sure procurement would say a dangerous one) in fitting out your own care facility with equipment and materials. Perhaps there is less choice with found objects – you take what can be spared – but alternatively there might be more discretion, to know what works and re-appropriate it. There was an element of necessity in taking furniture – not least the required speed of opening the CAC, perhaps itself a liminal space in its creative adaptations – but it also strikes me as a deliberate and creative act.

I am reminded that action happens in sociomaterial situations. My study is not a critical exploration of power, economic and social injustice but it would also be remiss of me to overlook this, particularly when so influenced by Addams' ideas and activism. Her 'experimental philosophy' (Skorburg, 2018) was situated in lived experience in Chicago neighbourhoods with their lack of sanitation, sweat-shop working conditions, undocumented industrial accidents, disease, infant mortality, and child labour, among others. Caring in a broader sense of caring for the environment, caring about poverty, and injustice, is still far from being a central cultural and economic concern (Nelson, 2001: 138). The learning for my study is *how* Addams' social ethics contributed (and still resonate (Lake, 2021)) in advancing social progress, for progress *was* made in this 'Progressive Era' in US history.

Consequential mattering

In this sub section I look beyond the ongoingness of care, as a process of tinkering, to see how caring becomes consequential.

During the pandemic, wearing a face mask and washing our hands was – for some – more than protecting loved ones, but an act of societal responsibility[61]. Even in situations when we are attending to the needs and requests of known others, we are in a wider caring constellation of intra-relations and situations, where others might attend to us, or the effect of our coattending is entangled across time and space. This entanglement, I suggest, calls on us to consider our accountabilities, not to reify the actors, but to attend to the effect of our intra-actions as a practice of solidarity.

For Barad (2003, 2012, 2014), mattering is not a thing but an ethical and agentic doing, of what/who comes to matter and what/who doesn't within an infinity of possibilities. Mattering is consequential, inviting us to consider our accountabilities

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[61] https://www.telegraph.co.uk/global-health/science-and-disease/wearing-face-mask-act-solidarity-chief-says/

to our selves, others, and the worldings our choices enact. I mentioned in chapter 3 that for Watson (2010) love and caring come together, extending to ourselves, others, nature, and the larger universe. Practising caring offers the potential to emphasise dynamic and agentic morality *between* people, and their environments, evident in ancestral, spiritual and indigenous traditions, such as *Ubuntu* in Southern African philosophy (Chisale, 2018; Gouws and van Zyl, 2015; Hall et al., 2013), *Confucianism* (Li, 1994; Rynes et al., 2012; Sander-Staudt, 2015), compassionate action in *Buddhism* (Fow, 2003), concepts of Kaitiakitanga (guardianship), Manaakitanga (caring) and Whanaungatanga (interdependence) in *Māori* culture (Barnes, 2012; Brannelly and Boulton, 2017; Love, 2020; Ruwhiu and Elkin, 2016; Spiller, Pio, et al., 2011; Wolfgramm et al., 2016); extending to caring interdependence and stewardship with non-human (and ancestral) kin.

I respectfully acknowledge knowing in Indigenous traditions, but it is not appropriate for me to *appropriate* others' wisdom, no matter how much I might appreciate it, which is why I have not developed these ideas further. However, it challenges me to look beyond the boundaries of organisation studies, and perhaps even Social Sciences, to find sympathetic scholarship that exemplifies an attention to caring as a practical, situational, and social ethos, such as in Haraway's concept of multispecies kinship (2016b).

Hamington and Sander-Staudt (2011: xi) highlight how care ethics is concerned about sustainability, as care is focussed on maintaining life, which includes being responsible for the well-being of future generations, they argue. Posthumanists such as Haraway (2016b) who write about 'odd-kin' relations, becoming with human and non-human, might also argue for our responsibilities to our ancestors and fellow earth dwellers, as well as those to come. Held (2006) and Barnes (2012) develop an ethic of care in a global context, beyond strangers with whom we might come into contact, but in unknown situations. While Noddings might counter argue that none of these comprise an ethic of care (Noddings, 2012), going further to say that these examples devalue the very idea of care as she intended it (2015), I go back to Mayeroff (1965) for whom caring combines an awareness of difference and oneness, with an autonomous yet specific other, whether the other is a person, an idea, a community, or the environment. In this context (1971: 28), not every action we take may result directly in the other's growth, but that actions taken as a whole must help growth.

Caring, as Mayeroff explains it, has resonance with Addams' perspective of democracy as a way of living, more than institutions of 'Democracy'. Committing to democracy calls upon us all to share responsibility for the consequences of processes to which we are connected. In today's context, Nora Hanagan (2013) says, from climate change to failing infrastructure, collective action is called for to effect change.

"Caring itself can be considered to be responsible behaviour. This is not responsibility in terms of liability, but rather it is in terms of responsiveness to the growth of the other" (Mayeroff, 1965: 472). I am reminded of the concepts of response-ability, entanglement, and intra-action. Rather than taking separateness and intersubjectivity as a basis for action, what if – as Barad (2007) and Haraway (2016b) tell me – we are already entangled in our social relations and actions? Entanglements, Barad (2011b: 150) says, are not another name for the interconnectedness of all beings as one but are *ethical relations*, of being agentically bound with others in the actions we take.

Leslie Oakes and Joni Young (2008) write that contemporary notions of accountability tend to emphasise the construction and reporting of fixed output measures. They contrast this normative view with Addams' practice of accountability as a process, manifest in her writing. Accountability was not solely a report of actions taken or goals met, but explaining the choices made and justifying the rationale for these choices (Oakes and Young, 2008: 786). Noting that Hull

House did not have any fixed goals, Oakes and Young focus on Addams' accountability through narrative practice, as a method of interpretation and explanation of the decisions made by Addams' and other Hull House residents.

Noddings (2010: 12) maintains that caring demands completion, some response from the cared-for, which is often absent in attempts to care for strangers at a distance. For that reason, she says, we cannot care for unknown others no matter how much we may empathise. This contrasts with Mayeroff (1971), who argues that in caring as a process, we should look beyond an individual encounter to determines its efficacy, focusing on an ongoing orientation towards growth.

Is this what accountability might mean? To be(come) entangled, and with a collective emphasis more on response-ability than individual responsibility in our co-attendings?

Theorising potential – coattending as an aspect of a caring ethos

In this section I move to theorise coattending. If care is fundamentally concerned with making change as Barnes (2015) suggests, appealing to Fisher's and Tronto's original definition of care that emphasised interdependence, then it offers the potential to ask how caring might also favour justice and well-being, to engage with issues of presence/distance and degrees of intimacy within caring encounters, and the significance of time and our collective responsibilities for past wrongs and future needs. This makes possible a very different form of attending.

In making this claim, I refer to the work of nursing theorists who opine that caring is a more entangled relationship of 'mobilising transcendence', oriented towards mutual becoming (Parse, 1992), offering a more processual view on temporality and boundedness. What I take this to emphasise is change-full potential within each encounter, not solely to alleviate or intervene in the here and now, to transform sociological, spiritual, and environmental possibilities, taking entanglement as the social condition.

In chapter 4, I discussed how *attuning* invites a different way of seeing and experiencing how and what we feel, to see them not only as part of our entanglement, but also to acknowledge their ethical and generative potential. In inquiring into what we feel in a situation, it becomes a world-making act, we make choices favouring a course of action. In exploring how sympathetic engagement, and love and its caring affects comprise differences in how our embodied awareness of perplexity, difference, or troubling,

In chapter 5, I explored how I arrived at *inquiring* – as a verb, or process – as an aspect of a caring ethos oriented towards mutual flourishing, while we attend to others who may need our involvement, as we too need others. In exploring how pluralistic inquiry and flourishing relations as different – and response-able – participation in morally problematic situations, I see beyond dialogical accomplishments or organisational competence.

Of all the chapters I have written, I am finding this one the most difficult. It seems easier to focus on what care work these teams are doing – in taking collaborative action – and whether it meets the instrumental needs of the situation. Whether that is minimising the time a patient spends in a COVID-19 service or sending a child off with a sticker when pharmaceutical medicine is not the cure. Perhaps this is the challenge in organisations and organising, to become preoccupied with doing, and doing in a way that makes 'best' use of resources, rather than attending to how as well as the what and why.

This focus on care as practice perhaps obscures more speculative questions about how each individual act comprises an intervention, and with a caring orientation, but with wider societal resonances. Nurturing response-ability. How, giving a child a sticker is an affective sociomaterial practice, that this child shows the sticker to their friends, that this might allay any fears or uncertainties another child might have about visiting the doctor. Perhaps the ripple effect of giving a child a sticker is that more children are seen by a health professional, and even if there is no cure for their life situation which is causing ill health, there is a growing sense that Primary Care might offer some social benefit.

"Care requires responsibility for the future" (Barnes, 2015). In this chapter, and thinking with Addams, I return to the ongoingness of inquiring, as a process of trial and error, learning and growth, with local and sociomaterial resonances. More than before, I am going to be speculative in my theorising.

I understand *coattending* to mean participating in consequential action. In this context, participating calls for 'entangled' (Barad, as explained in chapter 2) and 'coactive' relations (Follett, as discussed in chapter 5), where individual differences (such as skill, experience, and role) and human and beyond human participants work dynamically and in solidarity. An aspect of consequentiality is our capacity to learn from others and the experience (Hamington, 2009).

Consequential means to change relations and the 'situation', calling into question boundaries and temporality. I suggest that in coattending, we are responding not only to the situation we find ourselves in, but also its sociomaterial context, and where the unintended effects of our actions will resonate. This reminds me of Haraway's idea of 'troubling' that I discussed in chapter 4. Troubling calls us to be with different others (human and beyond human) in the 'thick present' (2016b: 1), as a practice of response-ability; and where our accountabilities invoke questions of custodianship and reciprocity.

Chapter summary

Fisher and Tronto (1990: 40) define care as all that we do to maintain, continue and repair our world. Such care is interwoven *"in a complex life-sustaining web",* which includes social, material, and affective worlds (Ryan et al., 2023). What makes the ethic(s) of care different from other moral theories are its emphasis on action (Monchinski, 2010). I have previously critiqued this view, but not because I disagree with the imperative to act. From the perspective of a relational ontology – which I have argued elsewhere underpins most care theories – action is normative: was it good care, given to proximate others, did it ameliorate suffering in some way.

In this chapter, I have developed a wider and multidimensional perspective on action, informed by a processual ontology that foregrounds our entanglement and 'modes of association' (Follett, 1919). Community, and consequential action, is performative, bringing alternative worldings into being in the here and now.

This perspective shifts my understanding of situated action – it is more than the personal and the quotidian, also resonating to making a wider societal difference. When I think about the vignettes, and my participants, they were making interventions in the lives of their patients, and arguably in doing so challenging in small ways the forces that perpetuate inequality. These small acts – such as giving a child a sticker, or buying hand cream – are still small acts, as well as being ethical in their affects. We do not necessarily know which action and response may become consequential, and how, when we make them. A processual stance suggests that the immediate situation is always changed and has ongoing import. One such import is the nurturing of solidarity and reciprocity at local and lateral levels (Hodge et al., 2020; Montes and Paris Pombo, 2019), beyond organisational and societal boundaries, across sociomaterialities, even across time and space. It can be enacted in the simple gestures of feeding a stranger, giving a sticker, amending a procedure. In relating consequential action with attuning, and inquiring, all action is ethical.

In the next chapter, I move to theorise an ethos of caring, building on the social dynamics I have developed in chapters 4, 5 and here in chapter 6.

Chapter 7 – theorising an ethos of caring

Introduction

“Those who first invented and then named the constellations were storytellers. Tracing an imaginary line between a cluster of stars gave them an image and an identity. The stars threaded on that line were like events threaded on a narrative. Imagining the constellations did not of course change the stars, nor did it change the black emptiness that surrounds them. What it changed was the way people read the night sky.” (Berger, 1984: 35)

There are so many ideas in this study as I draw on diverse literatures, ways of seeing, and experiences, to create something different and distinctive in bringing together a processual ontology, diffraction, and caring. In chapter 1, I suggested three alternative criteria with which to engage with my study: congruence to a processual logic, fidelity to a multiplicity of unfolding experiences, and generativity as a stimulus for action and ongoing discussion. I would argue that congruence can be found in each chapter, rooted in my explanation of my inquiry logic in chapter 2. Fidelity can be found in the five vignettes, and in reading these through resonant experiences, in chapters 4, 5, and 6; as well as in situating the entire study in health care in chapter 3. In this chapter, and in chapter 8, I foreground generativity.

Along the way, I have raised many perplexities about practising caring. In troubling care ethics, I wonder about caring (as a verb) and how this makes a difference. In chapter 3, I discussed whether care and justice can co-exist in one moral theory, an ongoing debate among ethicists. Instead of taking a theory-led approach I counter argue that we might theorise from experience, cut through with pragmatism and feminist technoscience. These ways of knowing tell me to notice the emancipatory potential in everyday experience.

Love and kindness are vexatious, do such affects devalue moral theory by turning ethics into sentimentality? Again, from pragmatism and feminist technoscience I see that we cannot be caring without kindness as a practice of solidarity. Thinking about my empirical sites, while my investigation was not about the giving of care, I found myself experiencing situations that could not be separated from the structural changes, and persistent inequalities, in health and social care. All my participants wanted to change the way health is delivered, not just to cease the medicalisation of day to day living, or to provide a service with increasingly finite resources, but because they cared.

In this chapter I trace a line among the stars (ideas), to convey the point of my thesis (among many possible points that may remain unexplored), to outline an alternative constellation, a different reading of the night sky, as Berger might put it. They do not comprise findings or conclusions. The previous three chapters introduced caring dynamics and how they might be experienced processually. This chapter seeks to answer **how is caring theorised from a processual perspective**, by investigating a diffractive move from care to caring, and from ethics to ethos.

This motivation emerged during the early months of the pandemic as I reflected on my empirical experiences with GCHSCP professionals and moved with the public discourse around the (political) failings and (heroic) accomplishments of public care. I return to diffraction, a foundational aspect of my inquiry logic, to see how I have mobilised it in practice. I revisit the themes of chapters 4, 5, and 6 as I move from care as practice to practising caring, before theorising an ethos of caring and discussing its potency.

One of the many challenges for me has been around the word ‘theory’ and all that it connotes within the academy. I realise my study must make an original scholarly contribution – and I believe it does – but I am not sure this contribution comprises definitive ‘theory’ or ‘method’. I am guided by Cunliffe’s provocation for *theorising*, in offering “*unfinalised narratives that are open to re-interpreting and re-theorising by others for their own lives and circumstances”* (2022: 22) Following Cunliffe, and Pragmatists such as Dewey, I take theorising to mean speculative, mutable, fallible, and rooted in experience to guide insight and action; rather than definitive or universal. To that end, my argument is that practising caring calls for a more performative vocabulary and language, situated within an ontology of becoming.

For Mol and her colleagues, care comprises sociomaterial practising, manifesting in quotidian gestures involving people, contexts, and technology. My intent has been to explore this logic not from substantive perspectives of standard operating procedures, advanced medical technology and community health and care interventions, the economics and politics of health and care, the patient-doctor relationship, or normative concepts of good care – even though these comprised the empirical context of my field work – but in the day-to-day social dynamics of doing, relating, and organising. For rather than thinking of care solely as a commodity, in the context of a logic of choice, care is process (Tronto, 2010).

The encounters in chapters 4, 5, and 6 paid attention to social and situational dynamics unfolding within the everyday tasks of organising, activities and preoccupations that many organisational scholars eschew studying (Shields, 2006), and which form the basis of Addams’ informed observations and experiments about social progress, democracy and ethics (1902, 1911). From the perspective of care, we are always relational, and never autonomous, as we tinker in transforming collective material, relational and emotional dynamics; thereby opening up new opportunities for action (Winance, 2010).

In the previous three chapters, empirical vignettes were ‘cut through’ with my agentic involvement, care ethics, caring theory, and social ethics literatures to speculate how care as practice and in practice might be experientially theorised.

These chapters sought to answer the first part of my motivating question, about the doing of care from a processual perspective.

A return to diffraction

In this section I revisit the concept of diffraction – introduced in chapter 2 – to explore how practising diffraction unfolded along with the writing of my thesis. I revisit this before theorising caring because how I theorise is a diffractive move, not solely inquiring into what is different but also its affects.

The fluidity and dynamism of diffraction as a nascent inquiry logic is distinctive for my study. It has been a challenging concept for me to grasp and apply, in part because of my educational background in Humanities and Social Sciences. My understanding and use of diffraction is evolving. I am not alone in this fluid use. Following her analysis of 51 peer reviewed papers, Udén (2018) opines it is not evident how one might understand diffraction as a 'feminist concept', or how to communicate around it. Her analysis suggests it is a metaphor, and not necessarily one that has congruence with physics. The contribution of diffraction as a feminist practice (of metaphor and speculation, rather than representation) for Udén (2018), is what it brings to the table: difference, change, and history. As I think about how I have worked with it, these aspects make sense to me.

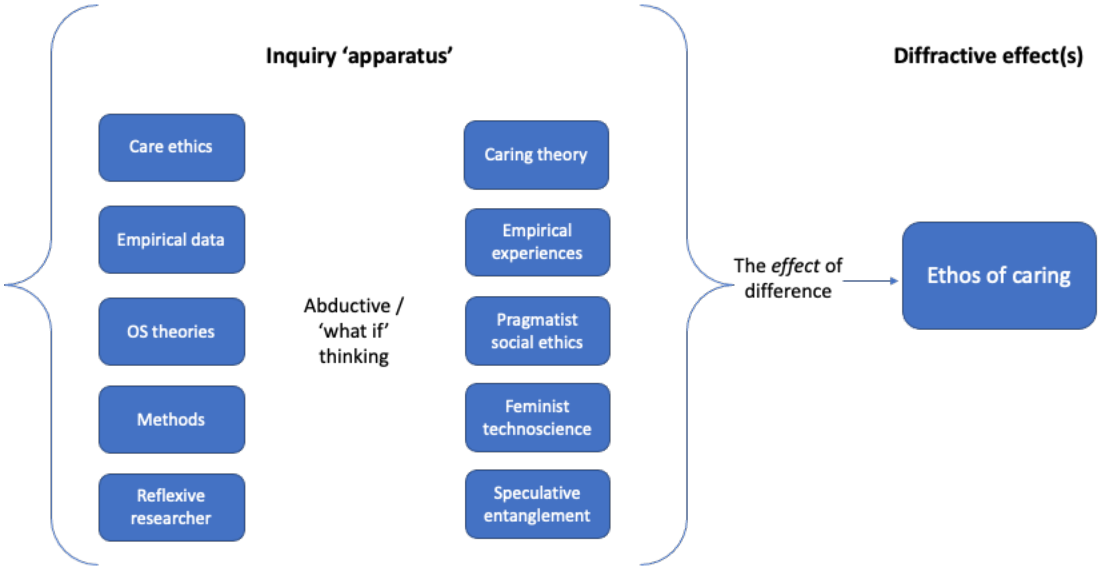

Figure 11 How I am using diffraction as a way of inquiring.

In chapter 2 I described diffractive inquiring (DI) as the logic underpinning my study. It was a post-hoc aspiration, although I did not know what that would mean, except for the use of vignettes and a sensitivity to emergence, partiality, and difference. Now that I approach the end of the study, figure 11 above captures what I think unfolded. The inquiry apparatus comprises not only the inputs – care ethics literatures, data, and my earlier ways of seeing – but also alternative stimuli. I am part of this apparatus, moved by an abductive or 'what if' perspective, which might also be thought of as troubling or perplexity.

My first task was re-experiencing past empirical situations as if they were live, by re-examining field notes that had been captured for a leadership study which was no longer tenable. These re-experiencings became vignettes. These vignettes became the basis for analysis, which I will discuss below. Before that, I knew my task was not just to notice difference / notice differently, but to discern the effects of these differences from a processual ontology and all that it affords. This is a wholly speculative endeavour. As I have said before, I had not been in the field to study care, and so the effects of what I had noticed are the results of my 'agential cuts', this is my construction of events, ideas, and affects into an ethos of caring. I am proposing a way of ethical practising and I am aware of the responsibility that comes with this, as well as its potential. These are not ‘findings’ I can verify, and yet I move to create possibility for organisations and organising.

Another use of diffraction in my study has been as an analytic practice, reading *“data from empirical research alongside other materials – including researchers’ perspectives, memories, experiences, and emotions – to provide novel insights on events”* (Fox and Alldred, 2021: 1). This was my approach in chapters 4, 5, and 6, with their singular thematic foci to notice empirical experience differently when speculatively cut through with different literatures, resonances, and from an ontology of becoming. Amba Sayal-Bennett (2018) opines that one of the strengths of diffractive analysis is how it can help us understand the role of bodily experience and affect in practice-based inquiring, where the researcher’s goal is less detached representation and more engaged partiality and situatedness.

For each of the dynamics chapters, I discussed the vignettes using care ethics and critical organisational literatures, highlighting how these literatures limited much of the caring affect in these experiences. Following this first analysis, I then moved to diffract my experiences and resonances from a more processual perspective. What followed was a perspective on how these vignettes exemplified practising caring when cut through with caring theory, classical pragmatism, and other literatures. I then offered a tentative articulation of what each dynamic might be doing in practice.

Figure 12 below shows how – using diffraction as an analytic practice – I was able to move from the relational insights that care ethics provided when thinking about what had been unfolding in the vignettes, to a more entangled perspective when cut through with different literatures and my own resonant experiences. I discerned three diffraction patterns – which were the basis of chapters 4, 5, and 6. The effect of these differences – or their diffractive effect – how response-ability is practised, which I call an ethos of caring. These patterns are less about specific interventions and practices – which would be of interested to more conventional research – and more about social processes, ways of seeing, and taking tentative yet consequential collaborative action.

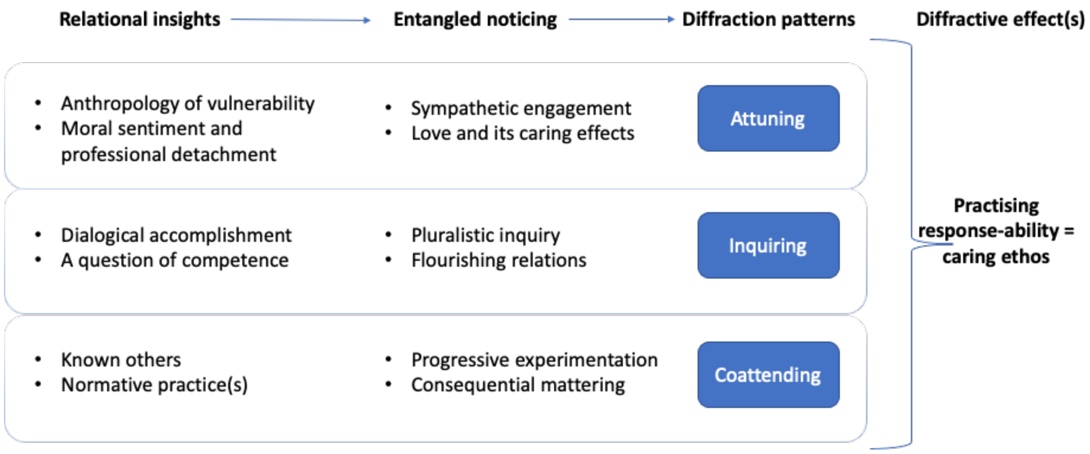

Figure 12 How I am using diffraction as analysis.

I understand the ‘situation’ to comprise the apparatus including theoretical insights, social dynamics, resonant experiences, and my partiality. In Deweyan terms, these situations are ‘problematic’, such that there is disturbance in the ongoing flow of practice, requiring collaborative attention and action. This does not necessarily mean dramatic points of crisis, but also prosaic interruptions within the everyday flows of doing. What makes a situation in Deweyan terms is indeterminacy – a course of action is uncertain. My (agential) task, as researcher, is to notice and move with unanticipated and still dynamic effects – for situations (and I) are not static but constantly on the move – previously beyond awareness.

The first effect of difference I noticed was the potency of practising caring as a line of inquiry that was already within my empirical re-experiencing. The second effect was in the interwoven and mobile processes of reading, thinking, talking, analysing, and writing about caring. The idea of caring as ethos emerged, I had not gone looking for it. As I approach the ending of my study theorising emerges, as I ask myself how an ethos of caring as response-able practising might be a difference that makes a difference in organisations and organising.

For Barad (2007: 170) such an approach is an ethical practice of 'mattering', a dynamic intra-active becoming that never sits still. Matter's dynamism is generative, engaging in ongoing reconfigurings of the world. Vivienne Bozalek and Michalinos Zembylas (2017b: 65) suggest that for Barad, mattering is a *"scholarly engagement with care, social justice and seeing oneself as part of a world".* This resonates with my inquiry into caring and my noticing of attuning, inquiring, and coattending as dynamic and entangled social processes. A question remains - so what?

One of the many questions for care ethicists is to address (potentially conflictual) concerns of what care and justice look like. They do this through ethical theories, albeit situational and relational. These theories imply norms and boundaries around what good care looks like. My approach to investigating care in practice comprised fidelity to experience, from which I derive my tentative theorisations. This situated perspective starts with what is unfolding, to see how caring is response-able practising.

For Barad (2003: 815) intra-action speaks to the idea that existence comprises processes of relating. We are never not entangled. In this context, I understand them to suggest diffraction is how researchers make visible entanglements and differences, where diffraction "*is not a set pattern, but rather an iterative (re)configuring of patterns of differentiating-entangling*" (2014: 168). To me, I understand Barad to say that diffraction is more than an analytic technique. Rather than speculating on the meaning of phenomena, as a reflexive exercise, diffraction focusses us on consequences (Bozalek and Zembylas, 2017a).

Udén's analysis, how I am experimenting with diffraction, and my use of DI for a chapter on doing process research (Augustine, 2022: 82), where I described it as “*both (verb) process (affect) and (noun) result (effect) in dynamic relation, rather than categorically separate*”, highlight to me how seductive it can be to extend the metaphor of difference. However, in doing so it is possible to lose sight of the potency of diffraction as Barad, Haraway, and Minh-ha introduced it, emphasising the mobility and dynamism of diffraction. It is not about novelty for its own sake or invoking diffraction solely because of difference. It is a provocation to *how* we gaze as much as where and at what (Fenwick and Doyle, 2018). Diffraction foregrounds entanglement, co-creation, and the relational dynamics of practising (Keevers and Treleaven, 2011).

Barad (2012) explains to me before caring can emerge, we need to rupture our *in-difference*. Diffractive inquiring invites me to participate anew in past experiences as still emergent and to notice differently: how are the dynamics in everyday encounters unfolding in ways that may have been hidden before, how are participants (me included) responding caringly, how is caring the difference that makes a difference within these situations?

I return to what I understand as first principles. Barad informs my understanding and practising (now) of diffraction as sensitivity to consequentiality, that is to say: *what is the effect of difference*? This strikes me as a challenging question to address, in part because effect is not static, nor singular (Barad, 2014), perhaps not yet known, and who gets to determine what the effects are, but this is the task I have set myself.

From ‘care as practice’ to ‘practising caring’

One of the potential limitations with chapters 4, 5 and 6 was singling out one caring dynamic to investigate in isolation. It could lead to a perception that there was nothing else going on in the various vignettes, that such dynamics do not interact, or that there were no other dynamics at play other than those I have focussed on. I now explore how attuning, inquiring, and coattending work together as practising caring. Their consequentiality, I suggest, is created through difference, although not a difference that can be predicted or repeated. In this section, I propose practising caring as a way of encapsulating the processual, generative, and performative of care in practice.

There is no neat, linear move from – for example – sympathetic engagement (chapter 4) to pluralistic inquiry (chapter 5), and then progressive experimentation (chapter 6), at the end of which caring 'happens'. Caring is not a process in those terms, but rather a *processual* making and remaking in social encounters where we act, develop bonds, anticipate, and respond to others' needs, learn, adapt, and react ongoingly. As I write this, I remember Barad's (2014: 183) queering of 'responsibility', which *"is not a calculation to be performed… It is an iterative (re)opening to, an enabling of responsiveness".* Instead, they (2012: 215) argue for *response-ability*, where *"each of 'us' is constituted in response-ability. Each of 'us' is constituted as responsible for the other, as the other."* This is less about the 'right' response, but inviting, welcoming and enabling the response of the other; and a *"differential responsiveness (as performatively articulated and accountable) to what matters"* (Barad, 2007: 380).

Mayeroff (1965, 1971), proposed a 'logic of effectiveness' within an ongoing relational process of caring. To care, Mayeroff said, is to help another grow, whether 'another' is a person, an ideal, idea, work of art or community. Thiele (2014) and Barad (2012) help me understand that inquiring into *caring* is less about calculating who is responsible and for which other – the pre-occupation of most critical and practitioner studies about *care* – but how we are collectively and ongoingly responding to and transforming problematic situations.

"[Caring] is not composed of the addition of three factors (someone who cares, a relation of caring, and someone cared for), it is within this more inclusive unit that

these factors may be discriminated out" (Mayeroff, 1965: 463). While Mayeroff did not use the language of entanglement or intra-action, I take this processual view of caring to go beyond intersubjectivity and the inter-action of independent others. His articulation of caring as a process connects me to the ideas and activism in Addams' social ethics. Her social ethics were to be lived, practised, and developed.

While the ethics of care 'movement' (Vosman, 2014, 2020) is around 40 years old, practical, situational, and relational morality is far older. It is in the work of Addams and other pragmatist philosophers, moral sentimentalists such as David Hume (Brugère, 2014a; Hamington, 2004; Held, 2006; Jaggar, 1989; Noddings, 2015), the 'Golden Rule' (a principle of compassion common to 'faith' systems) (Armstrong, 2011), and indigenous and western philosophy (Li, 1994; Näsman and Nyholm, 2021; Sander-Staudt, 2015; Spiller, Pio, et al., 2011).

Throughout this thesis I have engaged with the diverse care ethics literatures, and in particular the foundational ideas of Noddings, Gilligan, and Tronto. This triumvirate of scholarship – from philosophy, psychology, and politics – has influenced subsequent 'generations' of care ethics, as well as emerging critical scholarship in organisation studies (Fotaki et al., 2020a). In my readings, while Noddings (2012) and Tronto (1993) did use the language of caring, the dominant discourse, now influencing other disciplines such as organisation studies, is the focus on care as contested and gendered public work/practice(s).

Much research into the ethics of care is focussed on surfacing marginalisation (voices, experiences, and knowing) and the potential for transformation (Brannelly, 2018). Conradi (2020) opines that there are two distinct strands in care theorisations: ethico-political that asks how to better perform supportive interactions, and welfare-resourcing that asks who provides support and how performance is linked with society's unjust social structures. Most scholars theorise care ethics by extending its political philosophical scope, rather than exploring its application for practical action (Engster, 2015), that is to say the *conceptual* field is widened.

Vosman (2020: 41) suggests there are no perspectives about care ethics emerging from the perspective of and in response to various social problems, and the theorisations that might emerge from lived experience. However, this was the life work of Addams' and her social ethics, a point made by Hamington I which discussed previously. Additionally, care ethics is in conversation with social movements, such as the Patronas women in Mexico (Montes and Paris Pombo, 2019), how care ethics were mobilised in India during the COVID-19 pandemic (George and Greene, 2022), as well as its ecological resonances (Curtin, 1991). I concur with Raghuram (2016) in her critique of tacitly assuming that Anglo American / European care practices are somehow universal.

Hamington (2018) suggests that the time is right for a new social movement, infused with empathy and compassion as a challenge to today's neo liberalism. It would follow on from the Progressive Era when Pragmatism emerged and the countercultural movement and 'new left' of the 1960s. Care ethics as a heterogeneous, global, and interdisciplinary movement affirms our interconnected humanity, he writes. Nearly five years on since this invitation, it is this societal potential - unfolding within the microcosms of organisational and organising experiences, but resonating in our worldings - that my study also highlights.

When I write of organisations and organising, I refer not only to formal institutions – such as health and social care – but also grassroots and community organising, such as climate movements and 'decolonising allyship'. An example of this is a perspective on care, social, ecological and climate justice, and settler colonialism in Canada (James and Mack, 2020). Another example sees care as an act of justice within Black Lives Matter, getting into 'good trouble' through having empathy with Black and minoritised people in the US (Hodge et al., 2020). A further example proposes the Southern African philosophy of Ubuntu as a feminist and intersectional perspective on caring practice (as opposed to care theory) (Gouws and van Zyl, 2015). While these movements may take their cue from the feminist critiques of Gilligan, and others, there are also perspectives emerging from within indigenous and ancestral wisdoms, predating and even challenging the language, assumptions, and theories of care ethics. Three key tenets in much indigenous knowing comprise interdependence, guardianship (of place, community, and ancestors), and the integration of care and politics (Boulton and Brannelly, 2015).

In taking all these invitations seriously, and in diffracting care ethics with my own values, experiences, and other literatures (caring theory and moral philosophy most notably), I found myself focussing on caring, as a verb or activity, rather than care as a noun or object. This is explained below.

Diffracting care ethics

Hamington, Inge Nistelrooij, and Sander-Staudt (2022: xiv) counsel that not every activity given the label 'care' meets the 'moral standards of a caring act', or at least 'effective care', under the 'rubrics' of care ethics.

In chapters 4, 5, and 6 I diffracted empirical experience and care ethics to notice differently. This led me to see how feelings are social and a form of reasoning in problematic situations, they attune us to difference. That love is a social process, a doing more than a feeling. I also began to learn that expertise and agency is situated and fluid, rather than being solely the province of experts. This calls into question voice, and the performativity in dialogue, bringing new possibilities into being. Finally, I saw taking action as social habits, ways of being and doing together that foreground learning and growth through experimentation and participation.

Sander-Staudt valorises care's *"appeal to partiality, application to intimate relations, valuation of emotive components, and relevance to areas in moral life that have been traditionally neglected"* (2006: 23). My critique of care literatures is that this potential needs to be fully realised, in theory and in practice.

Following Mol (2002: vii), my move is away from epistemology and its concern with reference, of asking whether representations of reality are accurate. Inquiring from a processual ontology is one of the most striking departures in how I have studied care. It opens up alternative ways of noticing, of languaging, theorising and practising caring… not in binary opposition to prevailing care ethics but rather to realise the potential of caring to ongoingly make a difference, for ourselves, for others, and for the worlds we create.

A focus on how care is done – or enacted ongoingly as I consider in my own research – calls us to focus our gaze on caring *in practice*, whereas other theories and positions (even nursing theories, which I still draw on) elevate the roles and expertise of actors and groups; thereby perpetuating relations of dependency.

I return to Mayeroff (1965, 1971), who said that caring is an embodied and developmental experience (involving the whole person and not simply the mind or body, sense or reason) of becoming *in relationship* with (an)other(s) that develops and deepens over time. This other may be a person, or it could be an idea, an ideal, a community, or a living non-human entity. What is significant, is that this other is always specific, unique, and irreplaceable, and never a generalised other. In caring for another, I must be able to understand them and their world as if I were inside it. This may not always be possible – for example, I do not know how it is to be homeless and displaced due to conflict. What I learn is the importance of nurturing creativity and imagination in practising caring, by learning about the lives and situations of others quite different to me, and becoming mobilised to inquire about how to help (Addams, 1910; Dewey, 1934; Hamington, 2019a). In this caring inquiry, a generalised ‘other’ can become more specific, and mutual growth is possible. My HSCP participants did not live ‘shit lives’ in the way many of their patients did, and yet by living and working alongside their patients, hearing their stories, and witnessing their lives unfolding, practitioners held on to a collaborative capacity to be caring.

Mol and her colleagues state that *“the words coined for the public sphere [as a product in a market, such as healthcare] are ill suited for talking about care practices”* (2010a: 10). What has emerged for me is not only what we talk about but *how* we talk about care. Diffracting care ethics from a processual perspective calls for attention to language and vocabulary – for we need a different language to describe caring – despite the semantic traps of description and implication (we give something a name, it becomes fixed). I develop this point later in this chapter.

This thesis is situated within a processual ontology. In thinking with Pickering, Barad, Mayeroff, Simpson, and others, such a stance invites attention to and movement with situational flows. A processual perspective sees us as only ever fluidly entangled and agentic. Care ethics are typically oriented within relational ontologies, inviting attention to the intersubjective ‘between’ self and other, as objects reconfigure themselves.

In chapters 4 and 5, I wrote that Vosman asks whose knowledge counts as valid when considering care. This is an epistemological question, involving a focus on vulnerability and dyadic relations. In chapter 6, I suggest knowing and acting is a consequential process, challenging Vosman’s epistemological question. We are all in simultaneous and inter-dependent relationships of care, with human and non-human others. I am dependent on HRT to provide the hormones my body can no longer produce to regulate emotional, psychological, and cognitive function so that I can imagine, think, and write this thesis. I have the agency to tinker with my dosage, and to *think with* my GP (a logic of effectiveness in action), and my bodily responses, that perhaps the oestrogen dosage I had been on since prior to my hysterectomy is insufficient to maintain the good enough equilibrium I had found.

Rather than telling me my dosage is already too high (as I was told by the consultant who discharged me from hospital, which discouraged me from feeling as if I had any agency to alter my dose), my GP encourages me to make my own decision, that to increase my dosage is safe and appropriate. Thinking beyond my own health, what I see from a processual ontology is how care-full experience is felt knowing, aesthetic, practical, verbal, and more. I am not pursuing universal truths or principles, or definitive knowledge, my aims are rather more tentative, fallible, and mutable, but no less consequential in their potential impact.

A prevailing focus in care ethics literatures is on the actors (who) and practice(s) (what) that provide 'good' (as care ethicists see it) care. This care may be in homes or marketplaces, formal or informal, but they are normative and politically mediated, asking questions of power and status. From a processual perspective, informed by pragmatist philosophy and feminist technoscience, my focus is on situational dynamics, *how* care unfolds within the totality of a situation. This is a perspective that runs through chapters 4, 5 and 6.

Shifting our attention to the situation invites an emphasis on response-ability, a theme I developed in chapters 4, 5 and 6. Response-ability enables a different understanding of agency, less about expertise and responsibility and more about participation, about inquiry and community as process. Response-able power is coactive, rather than coercive, a point made in chapter 5. Care is perhaps also a diffractive practice – defined by attention to the effect of differences (Laugier, 2015: 226).

Returning to vulnerability. Rather than seeing care solely in terms of pain and suffering, response-ability orients us towards mutuality, growth, and flourishing.

This is an idea I developed in chapter 5, which moves the critical scholarship concern with what is wrong with care to a more generative perspective of the art of the possible, to see caring as ongoing, emerging in the quotidian of every day talk and action. It moves the discussion from normativity and 'local' acts of care for those who are physically proximate and known. In chapter 6 I highlight how caring actions have resonances, not just in the immediate human situation – which is always local, as well as socio-material – but that situations are microcosms of local, societal, and beyond (non-human, ancestral, even cosmological).

To see care in such temporal and transcendental terms is to understand that feelings are not an unhelpful by-product of doing 'emotional labour', or that certain feelings are more appropriate or useful in guiding 'good' decisions or actions, but that all felt experience – in all its complexity – is epistemologically indispensable.

This alternative, processual, language, coalesces into my assertion that rather than extending care ethics, as a theory led determination of what constitutes the practice(s) of care, it may be more helpful to follow how caring unfolds and to theorise from experience.

Why caring?

In this sub section I re-affirm how caring – rather than care – conveys a social *doing*.

Is 'care' a noun or a verb, and why might this be significant? Gherardi and Rodeschini suggest this distinction is central to understanding care as practice: *"While 'care' as a noun leads to the exploration of values and concerns about moral order and the understanding of good and bad, 'caring' as a verb leads to the exploration of the practices whereby care is performed and its value is asserted or contested in the context of practising"* (2016: 268).

There are – so far – few ready-made theories about *caring* either in the organisational literature or within the many developments of care ethics that can help me move from an understanding of care as a practice to care in practice, Gherardi and Rodeschini (2016) being a notable exception. Caring *is* one of nursing's 'grand theories'[62], described as *"responding to a call from a person, family, community, or humanity toward the purpose of nurturing well-being and more-being"* (Parker and Smith, 2010: 316). Caring, then, is more than about attending to vulnerability and ill-health, comprising a spiritual dimension oriented towards mutual (albeit human) flourishing. I have drawn on Roach's moral and philosophical caring theory throughout this thesis; indeed, she – along with Addams and Mayeroff – is a principal interlocutor in my thinking about caring.

Like bellows, the boundaries of the literatures I have drawn on to explore caring have expanded and contracted. There is a dearth of organisational literature developing 'care' and 'caring' – albeit a nascent conversation between care ethics and organisation studies – so I reviewed other literatures that focussed on 'compassion' and 'kindness' as potential proxies for how I was understanding caring. However, Monica Worline and Jane Dutton (2017), in defining compassion as a 'process unfolding in relation to suffering', make explicit how scholars use words such as compassion, kindness, and empathy. They go on to opine that if compassion relates to the 'darker side' of organisational life, then kindness, gratitude and happiness form the central concepts in positive psychology. This is not to say there is no place for compassion in organisational life, and Worline and Dutton make the case for the various personal benefits and competitive advantages in alleviating suffering. I have a different understanding of compassion however, as a way of be(com)ing in relation to human (and non-human) others, encapsulated in the 'Golden Rule' (Armstrong, 2011) and in Barad's (2012: 216) articulation of com-

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[62] "These nursing theories have the broadest scope for addressing a variety of concepts and propositions that nurses may encounter in the practice of care. They tend to be oriented around models and conceptual frameworks for defining practice in a variety of situations and care environments and ways of examining phenomena based on these perspectives." https://guides.library.uwm.edu/c.php?g=832418&p=5943165

passion as a rupturing of indifference. More than an ‘alleviatic’ response to another’s needs, it seems to me that in caring relations we are responding to a mutual desire for justice, growth, and change.

These contradictory definitions, the fact that what I think I mean by caring may not be what others intend in their choice of words, and the dualistic dark side and positive side, led me to limit my use of compassion literature. Focussing on care and caring in literatures has been problematic though, as I have explored in previous chapters. One further point to make about how I use caring relative to other scholarship (on caring and care) is that to me it is neither good nor bad, but rather just is, ongoingly and messily. Caring, for me, encompasses suffering, vulnerability, flourishing, love, and ambivalence, acting and holding back, an unceasing flow of feelings and bodily responses that mobilise us to inquire into and change the situations we find ourselves in, to see each small act in a broader context of future possibilities. Without this inquiry, I would have not seen caring in such processual terms, as a making rather than a made.

Why ethos?

In this sub section I explain why I favour the term ethos, and its practical relevance.

Ethics and ethos are etymologically linked[63], and both derive from the Greek word ‘ethos’. Ethos – as a rhetorical device – is typically associated with Aristotelian philosophy (Baumlin and Meyer, 2018). This rhetorical aspect can also be used to describe cultural narratives.

The contemporary difference between ethics and ethos is that ethics refers to a set of moral principles[64] that distinguish ‘good’ from ‘bad’, whereas ethos refers to

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[63] https://pediaa.com/what-is-the-difference-between-ethics-and-ethos/

[64] https://www.merriam-webster.com/dictionary/ethic

attitudes and values of a person, group, or institution[65]. This suggests to me that ethos is mutable, social, and performative, where *"[a]ttending to enactment rather than knowledge has an important effect: what we think of as a single object may appear to be more than one"* (Mol, 2002: vii). What I take this to mean is the multiplicity of actions, actors, and possible becomings, all of which with ethical potency, that are brought into being through action.

Arran Caza, Brianna Barker, and Kim Cameron (2004) opine that ethics are understood and implemented as duties and moral obligations, whereas ethos guides action in ambiguous situations. Organisations, they argue, need both: ethics to avoid harm, and ethos as a means of embracing and enabling potential. Furthermore, ethos, defined as virtuousness, is a collective phenomenon (Cameron and Caza, 2013). One such 'virtuous practice' was caring: people care for, are interested in, and maintain responsibility for one another as friends. I am not suggesting that ethics exist solely as mitigating practices, however the generativity of ethos resonates with my inquiry.

Gherardi and Rodeschini (2016: 280) want to change the place of care from the discussion of values, deontology, and moral development, to the talking and doing of ethics in context. I would suggest, then, that such practising is ethos, whereas ethic(s) comprises practice(s). In writing about care (in a nursing context), Bowden (2000: 39) refers to caring as *ethos* rather than ethic(s): *"What I want to underline by using the word 'ethos' is … conveying the broad characteristics of an ethical culture, rather than an alternative, self-sufficient and independent foundation for ethics, that competes with other moral theories."*

The language (and implied performativity) of ethos is also developed by Thiele (2014: 202) in exploring diffraction's potential for world making: *"theorising a*

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[65] https://www.merriam-webster.com/dictionary/ethos

different difference … leads to a thought-practice in which concepts are not an abstraction from the world, but an active force of this world".

I propose the word 'ethos' instead of 'ethic(s)' because caring is performatively ethical: we are making choices and taking actions that affect and effect the choices and actions of others. Because we make an impact. Because how we respond to the enactments of others alters the course of what happens next, where (feminist pragmatist) ethics embraces the social nature of morality (Seigfried, 1999). Because *"…research would entail making a stand for certain worlds and for certain ways of living on the planet, and taking responsibility for helping to make these worlds more likely and these ways of living more widespread"* (Gibson et al., 2015: 100).

I am not creating another dualism – of care/caring and ethic(s)/ethos – but rather highlighting a difference that might otherwise be lost if we do not pay closer attention to the words we use, their philosophical grounding, and how they create, alter, cancel, or reinforce what we believe to be. When we take an ontological approach to ethics, ethics becomes about *ethos*: a synthesis between values, culture and worldings that we co-create (Östman et al., 2019), and where ethos is made concrete through actions (Östman et al., 2019: 28). In doing so, my offer is for both/and, to see care as virtue and caring in practice, reconciling motivation and action (Engster, 2007; Slote, 2007). More than that, as a consequential process of mattering, where, rather than solely rational (normative) judgement, collaborative caring action is also mobilised by troubling *feelings* (Banerjee, 2022; Noddings, 1984), or 'perplexities' (Addams, 1902).

A practice-based view of ethics (and the word ethics was used rather than ethos) as a social concern was central to classical pragmatists (Culbertson, 2012; Fesmire, 2003; Hamington, 2001, 2004, 2015; Hanagan, 2013; James, 1891; Keith, 1999; Knight, 2009; Leffers, 1993; Pappas, 2009; Weinberg, 1923). In the glossary of terms at the beginning of this thesis, I cited Singer (2022) who defines ethics as dealing with issues of practical decision making, where its major concerns include the nature of ultimate value and the standards by which human actions can be judged morally right or wrong. It seems that this understanding of ethics forms the basis of how care ethics are formulated and extended. However, an alternative understanding of ethics – from pragmatist philosophy – has closer resonance to how I define and use ethos, and where all inquiring is ethical. Ethics from a pragmatist perspective attends to the potential for transforming life – whether individual, organisational, or societal – rather than merely judging it (Simpson and Hond, 2022: 140–141). This has consequences for participation in social processes, such as democracy, by which Addams means acceptance of and engagement in our social obligations, rather than 'democratic' institutions, or the machinery of Democracy (1902).

Practising caring, a different vocabulary

This section brings together the core argument of my thesis. The language of care ethics has arisen largely from women's experiences (Noddings, 2012). As my study now comes together, the argument I am wishing to make is that a processual perspective on care in practice, and theorising of caring, calls for an alternative language and vocabulary. It goes beyond replacing nouns with verbs, although this is one aspect.

There are several foundational terms in care ethics, informed by a relational ontology and a socio-political critical stance. I now contrast these ideas – summarised in figure 13 below – with ways of practising caring.

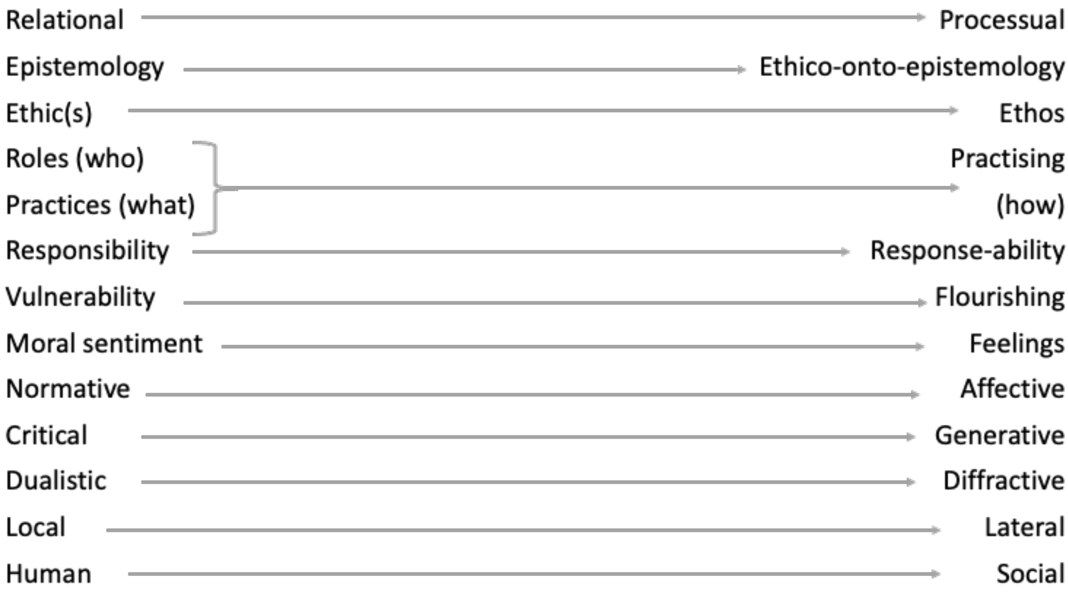

Figure 13 A more processual perspective on practising caring

A foundational principle in my inquiry and theorising is a processual ontology, in contrast to the relational ontologies that inform care ethics. This processual theme runs through my thesis – from the logic of my inquiry in chapter 2, to how I discern a difference between care and caring. A **relational** ontology – as developed by Gilligan, Kittay, Tronto, Held, Vosman, Barnes, and Hamington, among others – while foregrounding relationships also infers separateness as objects interact. A processual ontology, by contrast, foregrounds impermanence, ongoingness, and mutual becoming. I see a **processual** orientation in the works of Mayeroff, Addams, Mol, Shotter, Dewey, Follett, Roach, and Watson. It is from this processual stance, that the rest of the proposed language follows, language that is more performative, generative, and situated in experience. This processual orientation offers me a route to consider care *in practice*, as a doing, rather than a more conceptual development of care *as practice*. The implications of this for caring in practice are to see situated encounters as part of an ongoing process. For example, rather than evaluating each vignette in this thesis for the extent to which they might exemplify an ethic of care (or not), taken as an integrated whole, these vignettes might also say something about the dynamism of caring as a social process, where each encounter might be good, bad or ambivalent. Progressive experimentation becomes possible through a 'queering' of order and chaos, seeing situations as liminal spaces where alternative futures are shaped by diverse voices and needs.

In chapters 4 and 5 I discussed how Vosman raised the question of **epistemology**, whose knowledge counts as valid, and what counts as knowledge, when deciding what care work needs to be done. This knowledge also includes what the body knows and exhibits through habits and routines. An alternative perspective – albeit one not developed in this thesis – is Barad's '**ethico-onto-epistemology**' (2007: 185), which I introduced in chapter 2. It is an ethical process of 'mattering', through which we discern what is knowable to co-create what is to come. Such knowing is social, empirical, ethical, aesthetic, metaphysical, and affective. It moves knowledge from an individual (expert) to the totality of a situation, where such knowing is fallible, mutable, and yet still consequential. While they do not use the term ethico-onto-epistemology, I see the idea in the work of Haraway, Addams, Dewey, Follett, Boykin and Shoenhofer, Watson, Jaggar, and Eriksson. To see caring as ethico-onto-epistemology, it to take seriously our agential, world-making capacities in each encounter, no matter how seemingly mundane. The implications of this for caring in practice are to see the actions and decisions of all actors – administrators, printers, as well as medical experts – as sites of knowing and worldmaking. This is not just about the care work they do – making appropriate judgements about a patient or an item of correspondence – but also creating conditions where it is possible to learn, to make mistakes, and to take (calculated) risks (such as borrowing furniture). Pluralistic inquiry becomes possible.

Care **ethics** were developed in response to an ethic of justice at a time when a woman's perspective on moral reasoning was discounted for being too contextual and relational. This work by Gilligan has been expanded over successive 'waves', by Tronto who developed care as a political theory, and successive theorists who have aligned care with professional ethics – such as nursing – and other disciplines. As I have explained in this chapter and earlier in chapter 3, the emphasis is on developing ethics, arguably as frameworks or principles that define what good care looks like. By contrast, the language of **ethos** connotes a more performative and change-full practising, of being responsive and response-able. The potency of ethos I see in the works of Thiele, Mayeroff, Addams, and Hamington. The implications of this for caring in practice are to see caring as a way of being/acting in relation more than a set of rules to follow. Rules and protocols are needed – particularly in a healthcare context – and at the same time rules cannot account for how someone might respond to the unexpected and the quotidian. In adapting the correspondence workflow rollout at the surgery, the team exemplified a caring ethos through a process of inquiry. The situation was problematic, perspectives of all participants were brought to bear in hypothesising how to progress, and a course of action that was mutually beneficial was found.

A concern for care ethics are the **roles** (who) and **practices** (what) of doing care work. This concern calls attention to the precarity and contested nature of giving care, for women, people of colour, and minoritised others. In the context of care as a product in a market – as Tronto developed in her political theory – this means that care work is devalued and low paid. Within organisational literatures, care work is the province of leaders and managers, which I explored in chapter 5. Care work is typically performed as a politically and socially mediated practice. These ideas and critiques of care shape the work of Tronto, Barnes, Lawrence and Maitlis, Michael Kroth and Carolyn Keeler, Gabriel, Madeleine Bunting, Tronto, and many others. A processual ontology seeks to investigate how care is performed ongoingly. Rather than seeing care solely as practice(s), **practising** shifts the emphasis to situated social dynamics, and as a consequential multi-species activity, as I explained in chapter 6. I further develop the idea in this chapter, informed by Mol, Barad, Addams, Dewey, Gherardi, and others. The implications of this for caring in practice are to shift the emphasis from normative outcomes to a ‘tinkering’ mindset, where knowing and doing is fluid. The continual adaptation of standard operating procedures and the printing of stickers show this sociomateriality in practice.

Related to the question of who does the care work is **responsibility**. Responsibility and its relational ontological underpinning is dualistic in its distinction between those who know what needs to be done, and those who are the recipient of this expertise. It assumes a power differential, such as I discussed in chapter 5. Competence, attentiveness, and responsiveness is situated within the care giver(s). This is written about by Kittay, Tronto, Noddings, and Walker. Throughout the thesis, I have been arguing for **response-ability**. It is underpinned by ideas such as community as process, inquiry, collaboration, and entanglement. In making this argument, I am informed by Haraway, Follett, Addams, Roche, Watson, and Barad. The implications of this for caring in practice are to reimagine what we mean by accountability, from individual to social, bringing care and justice into generative interplay. This reminds me of the administrators, working together to implement a correspondence workflow process. Not all of them had concerns about their procedural inexperience and potential risks of miscoding, but the work to further their collective capacity to perform the tasks became a team effort. Individuality was maintained, drawing on the expertise of those with more experience, and for administrators to learn at their own pace.

Questions of responsibility also imply **vulnerability**, dependency, and even suffering. While care ethics acknowledge that we can all be care givers and receivers at various times, even simultaneously, they perpetuate the dualism of a care dyad. I explored these ideas in chapter 5, discussing the work of Engster, Brugère, Kittay, Held, Tronto, Vosman, and Bunting. A focus on vulnerability calls for amelioration. However, from a processual perspective, where caring is an ongoing social process, it becomes possible to consider mutual **flourishing** and an emphasis on the growth of all participants, even while attending to suffering. This alternative perspective is informed by Mayeroff, Addams, Murdoch, and Frankl, among others.

The implications of this for caring in practice is to see beyond making interventions in others' lives (patients, employees, dependent others) to shared agency and inquiry. I think of the security guard at Aldi, and all the small gestures that HSCP staff take to respond humanely in vexatious circumstances. I think of the Girls, and their menopausal distress. For all the anxiety and discomfort, these shared experiences also enabled the Girls to respond to each other – and me – differently. Finally, I think of all the ways that inattention to learning and growth impedes flourishing and can even be harmful. As I write this, I remember Malcolm and so many thousands of others whose death from COVID-19 was wholly avoidable.

In chapter 4 I discussed how **moral sentiment** is problematic in care ethics. What we feel might be seen as a by-product of doing care work, that perhaps some emotions need to be contained so that we can do the work, that while caring might be the human condition that is not enough for guiding care ethics, or that some emotions – such as compassion – are more morally appropriate in guiding good decisions or actions. Such ideas were put forward by Gabriel, Kahn, Slote, Engster, and Noddings. To suggest that some **feelings** are good or bad, desirable or undesirable, is to perpetuate a dualism that assigns judgement to what is typically a more complex and embodied response to difference. Feelings perhaps are a catalyst of sympathetic knowledge, kinship, entanglement, and wit(h)ness, which are epistemologically indispensable. In a perplexing situation, we might respond to what we feel, for our feelings are a social phenomenon. In making this claim, I draw on the ideas of Haraway, Addams, Barad, Roche, Shotter, hooks, Frankl, Murdoch, Jaggar, and Fromm. The implications of this for caring in practice are to restore our feelings as a source of reasoning and knowing. I think of Dr Gail and her stock prevention lectures, and the other ways she wants to help improve the lives of her patients, in developing social skills and encouraging a love life, for example.

If care ethics focusses on the what of care practice(s), these are typically **normative** in their orientation. Dowling, Bunting, and Tronto, among others, use the language of good care, implying a transactional relationship between care giver and care receiver, who confirms that an intervention has been successful. Indeed, Tronto maintains that there must be some form of conclusion for care to be ethical. This implies routines, habits, and interventions that are known and repeatable. By contrast, the vignettes in chapters 4, 5, and 6 highlight how caring manifests in and through everyday talk and actions. This attention to the quotidian is **affective**, and I develop the thinking of Gherardi, Mol, Stewart, Addams, and Conradi. The implications of this for caring in practice are to guide ethical considerations in experience as it experienced. I think of the hand cream in the staff room, of opening the window and turning off the radiator. That something as prosaic as being physically comfortable has ethical potency. There are wider resonances, in the small adaptations and innovations within the CAC, and how they have been gifted to other health services, perhaps now with more patient-centred practice.

Care ethics, since the work of Tronto could be seen as **critical** scholarship, in its interrogation of power, gender, politics, what is wrong a structural and systemic level. Fotaki, Kittay, Gilligan, and others rightly highlight the contested nature of care. From a processual perspective however, I focus on how tinkering, an attention to what is possible as well as what is, can be more **generative**. Mol, Addams, Mayeroff, and Hamington offer me a perspective where caring and knowledge production are inseparable and mutually motivating. I develop these ideas in chapters 5 and 6. The implications of this for caring in practice are to create alternative narratives and practices that nurture possibility in organisations and organising (Lawrence and Maitlis, 2012). Even in Cheryl's meeting, and with everything that was wrong with the allocation of pharmacotherapy resource, there was still a desire to meet the cluster's needs, and to see their needs in the wider context of the PCIP rollout.

In chapters 3, 4, 5, and 6 I highlight the **dualistic** thinking that informs care ethics, separating subject and object, care giver and care receiver, good care and bad care.

An underlying relational ontology – which sees us as separate intersubjective entities – reinforces epistemological distinctions. Not all differences are dualistic. Arguably, however, caring is a **diffractive** process in its attention to (making a) difference. Such a perspective perhaps creates room for experimentation, and for alternative (and beyond human) collaborations. In making this claim, I am guided by Minh-ha, Barad, Haraway, Addams, and Mayeroff. The implications of this for caring in practice are an improvisational capacity to work with what arises – such as in the daily (sometimes more than daily) amendments to standard operating procedures (which are normally static artefacts) as CAC staff learned more about how to mobilise and work together when attending to COVID-19 patients.

In chapter 6 I discussed how care ethics favours care as a direct and **local** act, with those who are physically proximate if not known. Tronto, Bunting, Engster, Noddings, Barnes, and Held, all debate the extent to which care ethics might extend beyond (geographic, organisational, and species) boundaries. This is a subject that divides care ethicists. However, when I read nursing theorists, indigenous scholarship, as well as Haraway, Addams, and Mayeroff, so I come to understand that each situation is a microcosm of local, societal, and beyond (non-human, ancestral, even cosmological). These **lateral** relations transcend physical bodies, time, and space in their acknowledgement of solidarity and interdependence. The implications of this for caring in practice are to see each patient encounter, or each amendment to a process, as having resonances beyond the patient consultation; particularly when those ways of working are gifted to other services.

Finally, care ethics is predicated on **human** relations, even if sometimes mediated through technology and other means. Only humans can be ethical, it is argued. Care ethics, as developed by Tronto, Gilligan, and Noddings are informed by – and depart from – natural maternal caring between a mother and child. Even Mayeroff developed this parental idea in his processual articulation of caring, even if the other was non-human. It is this beyond human – more **social** – processual potential that I develop in chapters 5 and 6 where caring comprises human and sociomaterial practising. This perspective is in the work of Mol, Gherardi, Bellacasa, and Haraway. The implications of this for caring in practice are perhaps to continue to innovate in the way health care is delivered, not just in terms of telehealth.

In outlining an alternative vocabulary, the question arises how it might inform a processual theorising of caring, and how is it different from care ethics and its extant language predicated on a relational ontology. I return to Haraway's quote on page iii. I am proposing a way of mattering and becoming with, by foregrounding performativity of language, shared understandings, and a processual ontology. This is such a divergent view of how the world is and when most language reinforces fixedness. I now employ some of these ideas to articulate an ethos of caring.

Speculatively 'theorising' an ethos of caring

I am only just beginning in my tentative articulation of an ethos of caring. In my reviews of care literatures, I began to identify other themes that offered a more nuanced perspective than dualistic, critical, and normative understandings. In chapter 2 I cited Haraway and all the troubling dualisms we might stumble over. In chapter 3, I highlighted how for Barad and Haraway, diffraction goes beyond binary thinking, to focus on the effects of difference, of both/and/+/-?

With this spirit, in this section, I now explore a more processual articulation of caring and how it might be different from other care ethics. I am mindful that Engster says care ethics continues to be developed as theory. My interest is to explore how caring in practice might lead to more performative inquiring and practising, giving those in organisations and organising the potential to focus on all the ways that caring unfolds on a day-to-day basis. It seems a more appreciative and co-creative line of inquiry for bringing about change (Cooperrider and Srivastva, 2017).

Drawing on the care ethics literature over a 30-year period, Thomas Hawk (2011) proposes an ethic of care as our primary 'ethical standard' in organisations and organising because it:

I. assumes the primacy of our *inter-connected* web of overlapping organisational and personal *relationships*, instead of independent and separated autonomy;
II. focusses on understanding the concrete *context* and particulars of a situation;
III. supports human *development* and well-being: that of the one or ones cared for, the ones caring, and the relationship;
IV. relies on the *whole person* for the processes of being attentive, responsive, competent, and responsible;
V. always leads to some concrete, empathically constructive act or *actions*;
VI. can encompass the full range of moral issues experienced by humans across the *private/public* continuum; and
VII. has moved *beyond* a *gendered* ethical framework that promotes a feminised ideal.

Hawk's articulation of care ethics seems congruent with Gilligan's practical, situational, and relational ethic; and seems to address the dualistic/binary notions of public/private, as well as gender. He suggests that care is learning-doing in its developmental focus. What Hawk does not do is make a connection between organisational and societal concern, thereby integrating wider discussions on care and justice. Nor does he extend beyond the human.

However, I would disagree with the normativity implied in Hawk's use of the term 'ethical standard', taking more comfort in his comment that such an ethic is value, practice, and process across the full scope of human activities (Hawk, 2011). This acknowledges that all situations where action must be taken have ethical characteristics, and that each ethical or moral situation is unique. In response(ability) we must call on our collective cognitive, affective, intuitive, physiological, and creative capacities to fully engage in each situation.

One of my contributions is novel insight to further discussion and research possibilities. My struggle – one of many – is how to name (and claim) this contribution, as I am not proposing a new theory or knowledge. Cunliffe (and so many others) inspires me to be passionate about inquiring, while acknowledging there is much I do not and cannot know. I use 'theorising', to mean *"creating spaces for dialogue and collaboration with others experiencing similar frustrations"* ((Cunliffe and Sadler-Smith, 2015: 4), cited in (Cunliffe, 2018: 19)). My theorising is invitational rather than an absolute and proven point of view. This has been another learning for me, an experiment in how one might theorise (rather than definite theory) from a processual perspective and how this bumps up against conventions and practicalities in doctoral research.

According to Laugier (2015: 224), the notion of care is best expressed not in the form of a theory, but as an activity: care as action (taking care, caring for) and as attention, concern (caring about). Addams (1902, 1911), Mayeroff (1965, 1971), Barad (2007, 2014), Haraway (2011, 2016), Shotter (2015, 2017), Follett (1919), and Dewey (1929, 1939), are helping me know care not only as contested practice(s), moral sentiment, or set of values, but as a *caring ethos*, transformative social dynamics we perform ongoingly and collaboratively, unlike most theories of *care ethics* which serve to extend contested concepts of practice(s).

My conceptual-practice focus is not about the doing of care as work – the practice and practices of formal (public) and informal (domestic) care, or caregiving organisations who do the work – but rather how:

AN ETHOS OF CARING - AS A CONSEQUENTIAL DYNAMIC OF ATTUNING, INQUIRING, AND COATTENDING TO THE ENTANGLED FLOURISHING OF OURSELVES, OTHERS, AND OUR WORLDINGS – IS EXPERIENCED IN EVERYDAY ENCOUNTERS.

I theorise an ethos of caring not in dualistic opposition to ethics of care, or even to extend care ethics, but to answer a different question: *how* care is practiced, ongoingly. What is important in this fidelity to experience is the processual and performative, the capacity for multi species flourishing, the centrality of feelings and relationships as a guide for consequential action, as well as other situational data, the ethical nature of our response-able entanglements as we *become with*.

The Merriam-Webster[66] dictionary states that the prefix *intra*- means ‘within’ (as in happening within a single thing), while the prefix *inter*- means ‘between’ (as in happening between two things). Intra-action (Barad, 2007) helps me reframe how we can discern social relationships, agency, and flourishing: by taking entanglement as the condition for existence (of all species, not only human. While my study foregrounds human relations with some engagement from non-humans, the potential for an ethos of caring is to extend across social relations). Foregrounding intra alters responsibility – as a dyadic duty or obligation to a dependent other – to response-ability as always a self and other intra-action. Both require us to be accountable, but in response-ability I discern a social ethos and future orientation.

The distinction between inter- and intra- is important, it moves ideas of care from a relational ontology to a processual ontology, of caring as an ongoing social phenomenon. This shift, Shotter (2013: 46) reminds me, reorients us: rather than beginning with theories in the conduct of our inquiries, we must start from *within the midst* of the complexity of our lives together. From experience. Care ethicists – Gilligan most notably – highlight the importance of context for guiding moral action,

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[66] https://www.merriam-webster.com/words-at-play/intra-and-inter-usage

but they see care as specific, normative, actions rather than a continuous flux of intra-relations and activity.

My theorisation, predicated on *intra*-relations rather than *inter*-relations, moves on from the foundational definition of care offered by Fisher and Tronto:

"On the most general level, we suggest that caring be viewed as 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, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web" (1990: 40).

While this definition has been criticised by some for being too expansive (Barnes, 2015), their definition of caring (rather than care) *is* oriented towards emergent and situational dynamics, making a difference, and where all participants are entangled and agentic. Tronto (1998: 16) later clarified what she and Fisher meant by 'species activity', suggesting how people care for one another is one of the features that makes people human.

It is noteworthy that as Tronto's ideas developed into a political theory of care as practice, so the idea of care (rather than caring) narrowed to focus on public acts of care. Tronto did use the language of caring in her articulation of the moral dimensions of care, but in doing so created a dualism between motivation and action where one need not have been. What – for me – is missing from Fisher and Tronto's definition is acknowledgement of the role feelings can play in caring actions. A sociomaterial and posthuman dimension – within which a life-sustaining web includes and is for the mutual flourishing of humans and non-humans – is not developed by these authors.

The practice dimension of care was also taken up by Held, who opines that an ethic of care combines practice and values – where “care” means the practices that take place and values by which these practices are evaluated, seemingly addressing the dualism inherent within the Fisher and Tronto definition:

“As a practice it shows us how to respond to needs and why we should. It builds trust and mutual concern and connectedness between persons … care is also a value. Caring persons and caring attitudes should be valued, and we can organise many evaluations of how persons are interrelated around a constellation of moral considerations associated with care or its absence” (2006: 42).

Held’s definition does emphasise that caring attitudes (caring as adjective) should be valued in the same way as caring actions, although she goes on to suggest that care is something that – in normative terms – is either present or absent. In doing this, she creates another dualism. As Roach (2002: 2) reminds me, caring is the human mode of being, expressed in ‘virtuous action and in habits acquired over time’. While moral inquiry may be a human endeavour, caring is not an exceptional human quality, nor the response of an exceptional species. Roach (2002) describes caring as the ‘human mode of being’: caring for human and non-human others (including the universe) as well as caring for self. Opportunities to care are not usually dramatic events, Roach continues, but come disguised in the simple, unobtrusive encounters of daily life – a smile, a helping hand, a word of encouragement, an expression of sympathy, or in caring enough to reprimand. Caring is something we practice, ongoingly, with others.

A more recent articulation of care – reimagined by Hamington and Ce Rosenow as a process of growth – acknowledges the ‘political’ dimension of care as a social ethic:

“Care describes an approach to personal and social morality that shifts ethical considerations to context, relationships, and affective knowledge in a manner that

can only be fully understood if its embodied [and performative] dimension is recognised. Care is committed to the flourishing and growth of individuals, yet acknowledges our interconnectedness and interdependence" (2019: 10).

Hamington's work on care ethics is influenced by Addams, as evidenced in the integration of personal and social concern, even though they emphasise an individualistic concern for flourishing. Like Addams, Hamington and Rosenow emphasise that such morality calls upon us to become attuned to our embodied (including felt) experience and to act. Like Mayeroff and Roach, there is an emphasis on flourishing and growth. Finally, while their definition of care *is* oriented towards emergent and situational dynamics, and making a difference, rather than seeing all participants as entangled and agentic, there is more of an intersubjective rather than intra-active focus.

In summary, I see several potential contributions in an ethos of caring. Firstly, our feelings, no matter how conflictual, comprise an ethical aspect of a caring ethos. I explored this in chapter 4, in my affective relations with the girls and how I came to see the worlds they bring into being in performing administrative tasks. I would not have experienced their world had I not paid attention to my conflictual feelings towards them and the emerging solidarity through shared menopausal experiences.

Secondly, it opens up processes of mattering within the consequential and emancipatory happenings of everyday lived experience (where, feminist scholars argue, change really happens (Duran, 1993; Haraway, 1997; Seigfried, 1993)). Printing stickers, borrowing furniture, buying hand cream, and opening a window may not in themselves constitute 'care' as care ethicists would define it. However, from a caring ethos these small gestures change situations: a patient feels seen, a healthcare service can function, and people can attend to their physical needs while performing their roles. These acts arguably nurture a climate of caring.

Thirdly, it invites human and beyond human collaboration (Visser and Davies, 2021). In that small surgery office, the printer was an agentic team member, an object with the capacity to generate ‘happiness’ (Gherardi and Cozza, 2022), or affective value. While the printing of payslips was a routine administrative task – confirming that someone had been paid – its role in the production of stickers for children helps to personalise ‘realistic medicine’ (Calderwood, 2018), a strategic aim for Scotland’s healthcare system. This means providing care that matters for the patient’s life and circumstances. Haraway would go further – and this is beyond the scope of my study – to suggest the realities of multispecies kinship (2016b).

Fourth, its future orientation enables us to focus on flourishing while attending to needs in the here and now. The meeting with Cheryl (the pharmacotherapist) did not go well and could be argued was not an example of a caring encounter. However, during the heat and antagonism in the meeting, the frustration that needs had not been met, there was still an intent to find a way forward. Resources were finite, and their allocation contested, and at the same time, a commitment was made to find a workable solution. This may not feel like flourishing, and it is very likely that COVID-19 transformed how pharmacotherapy services could be provided. Community pharmacies joined the front line of Primary Care during lockdown as GP surgeries moved online and with more resource constraints. Patients still needed prescriptions, receptionists still needed to mediate, and patients needed to be ‘seen’ for minor conditions that did not necessarily require a GP. The PCIP, which was due to run from 2018-21, is now in its second phase (2022-26)[67].

There is a continued priority to deliver enhanced pharmacotherapy services and a recognition of a lack of funding and appropriately qualified staff. GPs have reported an increase in patients’ health needs, with more mental health issues and patients with more developed conditions due to the delay in being seen and assessed

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[67] https://glasgowcity.hscp.scot/sites/default/files/publications/Draft%20PCIP%202022-25%20v4%20PDF.pdf

(GCHSCP, 2022). This does not look like flourishing. Health inequalities in Glasgow have exacerbated. Health and social care staff report compassion fatigue, direct, and vicarious trauma (Homes and Grandison, 2021; RCN Norfolk Branch, 2022; Scottish Government, 2020). Perhaps flourishing is an aspiration and a process, and a motivation to keep caring in the midst of everything else. I am reminded of Addams' reflections on the Settlement movement, that it was an ongoing social experiment to aid in the solution of social problems, and grounded on a philosophy of solidarity (Addams et al., 1893: 24). Not every initiative was successful, not every initiative had an intended outcome, not every initiative was collaborative, but they were imbued with a spirit of (data driven) experimentation (Skorburg, 2018).

Fifth, it challenges dualisms reinforced by a relational ontology. These binary oppositions create classifications such as subject / object, researcher / participant, reason / emotion, nature / culture, agent / patient, and theory / practice. They force hard epistemological distinctions (Simpson and Hond, 2022), and challenging them offers a very different way of practising and theorising caring. For example, are emotions or feelings a form of reasoning, or something other (and therefore unscientific)? Must a patient be a passive recipient of care, when arguably being a patient is agentic (for it is the patient who takes the medication, for example) (Mol, Moser and Pols, 2010b)? In caring, we learn through inquiry and action, forming working hypotheses about how to act. Theory and practice are mutually informing.

Sixth, the capacity for inquiry and change is predicated on an awareness of difference. My study began with an interest in 'arresting moments' (Cunliffe and Scaratti, 2017), disruptions to dialogic flows. In thinking with Haraway and Addams, the language of 'troubling' or 'perplexity' suggests dissonance within a situation. I think of the diffractive potential of difference, and how it affects. This reminds me of the administrators who were concerned about the impact of miscoding cancer patients. Their concern arose partly from fearing they had insufficient technical knowledge to perform the correspondence workflow task correctly. It could have been easy to focus in on this – and to have had a subsequent discussion about codes. However, the lead GP and surgery manager saw a different opportunity – to think and work collaboratively on how organisational and individual learning happened. This widened perspective facilitated a collective response – role taking, sharing information, and adapting the pace of change to meet individuals' needs while also achieving the intended goal. What was different in this perplexity was to see the situation in its totality.

Finally, as a social practice, caring nurtures response-ability (Haraway, 2016b), our capacity and practices of responding, acknowledging our entanglement. Thiele (2014) and Barad (2012) help me understand that inquiring into caring is less about calculating who is responsible and for which other, the pre-occupation of most critical and practitioner studies, but how we are collectively and ongoingly responding and transforming problematic situations; reconfiguring our entanglements (Lather, 2016: 126).

It seems to me that entangled social dynamics – such as attuning, inquiring, and coattending – nurture an ethical capacity of *"cultivating collective knowing and doing"* (Haraway, 2016: 34), which is how they define response-ability, as a multispecies, sociomaterial collaboration emerging through consequential actions within the realm of everyday experience. Practising caring, I suggest, is response-able practising. This is the effect of the difference that attuning, inquiring, and coattending bring about in social situations.

Response-ability invites making oneself open to respond to another without knowing ahead of time what attention is called for or how we should respond. In this availability, non-response is also a legitimate response. So, while response-ability is grounded in an ethos that affirms our intra-action with others, and with that an acceptance to be called beyond our immediate worlding, it is not a prescription to do so (Martin et al., 2015: 11).

This responsible practising is predicated on our intra-action: we are never separate from others, and as such we are always entangled within the always subjective process of becoming together. Iris Murdoch (1970), says that although scholars might talk of justice or freedom, they rarely talk of love, which is how we come to know others. Such a morality, Murdoch continues, is about movement, bringing about change in the world.

Chapter summary

In this chapter, I have moved to define an 'ethos of caring'. In doing so, I have also highlighted how a more processual view of caring – one that is performative, generative, and rooted in experience as it is experienced – calls for a different vocabulary and language. In reaching this point, I have discussed why ethos as a departure from ethics, and why caring as a departure from care. My perspective is that in inquiring into care in practice – rather than as practice – is less about extending care ethic(s), and more about practical and philosophical creativity.

In coming to caring, I am engaging with something so fundamentally (to me) central to how we are human(e), that is both natural and profoundly troublesome. That is, in our collective capacities to notice and be mobilised by caring feelings – love, compassion, anger, anxiety, disappointment, indifference, and ambivalence – in all their complexities and ambiguities. And for these – sometimes mutual, other times conflictual – feelings to become a source of knowing in vexatious situations, to inform our response-ability. We do not feel if we do not care, whatever feelings might be evoked… and I care very deeply about this inquiry.

In the next, and final, chapter, I discuss the implications of my study for theory and practice, and future inquiries. As I have said before, my theorisations are intended for others to take up as invitations. I then conclude the study by returning to my interwoven development as a processual researcher.

Chapter 8 – Outroduction

Opening thoughts

In this final chapter, I consider what might come next with a processual ethos of caring, as well as revisiting my continued development through this inquiry. Mindful of earlier critiques about reflective and reflexive practice, this is more about celebrating difference. I start by discussing the practical implications for organisations and organising, before moving on to consequences for theorisation. My intent is to show how this thesis is opening a conversation for others to participate in, both in terms of practising caring and in doing processual research.

Implications for practising caring

In this section I ask how practising caring might make a difference in practice, in organisations and organising.

Just before my fieldwork ended, I met Helen for coffee. She told me about feedback she received from some participants: that there was a feeling of pride they had been asked to take part in the research project. I changed the subject too quickly, before Helen had even finished telling me, and was immediately annoyed with myself. I had been so fixated on 'giving something back' that it had not occurred to me that for some participants, like the Girls (from chapter 4), being seen and their work valued enough to become part of a research study would be a contribution.

As lockdown continued, GCHSCP leaders told me how there was an increasing focus on creating a kind and compassionate culture as a way of mitigating compassion fatigue and (direct and vicarious) trauma among the Primary Care workforce. When I presented my 'findings' to a group of managers many months later, I was told that one of the most important contributions I had made for them was to remind them that the work they do *is* hard, and despite all the challenges of organisational change, interpersonal conflict, and the pandemic, the people I met did their very best for their patients and for each other; motivated by deeply held values of solidarity and public service. Given the high levels of exhaustion experienced by Primary Care staff, my seemingly inconsequential observation was experienced by some in the meeting as permissive: that someone outside of their world ‘got’ just how tough the work is, and that to find the work overwhelming sometimes was OK.

It could be very easy to overlook the importance of feeling seen, and your experience validated. I wondered what I could possibly tell this group of thoughtful, experienced, and informed practitioners about care and caring that they did not already know (and practice daily). I felt the pull to construct a framework of how to create a climate of caring, to be rolled out across the hundreds of GP Surgeries, health centres and other sites. It is a managerial ‘product’ and task that is familiar to me as an organisational consultant. But the truth is: I do not know, nor am I the right person to create such an instrument. While a framework may seem benign, and there are frameworks – produced by experts in compassion such as West, and Worline and Dutton – they can essentialise lived experience, focus less on what is and its participatory doings, and imply a top-down implementation rather than a collaborative and bottom-up capacity to work out what needs to be done and act.

While Martin Heidegger (1962) described ‘worlding’ as an intimate, compositional process of dwelling in spaces that gestates worlds, I take inspiration from Haraway (2016b), and the co-operative and conflictual ways of ‘world-making’ in which different species, technologies and forms of knowing interact. Worlding is an ethical and political ‘mattering’. This has implications for caring, in practice. I can co-create practising caring with Primary Care, but it cannot be created without entangled people and technologies. My role is at best facilitative or catalytic, suggesting attention to ongoing everyday experiences of attuning, inquiring, and co-attending.

Another significant implication about practising caring is its consequentiality. In chapter 4 I wrote that sympathetic knowledge – and love – is more than emotivism. Our feelings are ways of knowing that are ethical and world making in their potential to mobilise us to inquire into and act on what we find troubling. From the care perspective Held (2006: 1) states that moral inquiries that rely entirely on reason and rationalistic deductions or calculations are deficient. Sympathy, empathy, sensitivity, responsiveness, and even anger, enable morally concerned persons understand how they might respond. Fischer (2022: ll) notes that for Addams, *“feeling is central to an ethics based on cooperative inquiry, but ethics, more generally, needs to be informed by and in turn inform social action.”*

In chapter 5 I suggested that rather than focus on competence, and how it is dialogically accomplished, caring inquiry oriented towards flourishing has the capacity to become pluralistic and sociomaterial. An aspect of this is the capacity for learning. Hamington and Sander-Staudt (2011) argue that learning is inherent within a culture of care. This is because caring implies being empathetic toward others, and we cannot understand others effectively unless we are prepared to exercise our imaginations and are open to learning about others. This learning potential is emphasised by Mayeroff (1971), when he writes how caring as a process involves mutual development. In this context, a posthumanist practice approach to caring also has relevance to organisational change (Gherardi and Rodeschini, 2016).

In chapter 6 I asked how in acting together – no matter how seemingly mundane – our co-creative actions make certain worldings possible. This consequential orientation calls into question temporality and boundedness as we consider a social morality of mutual learning and growth. To that end, caring is more than tinkering, tinkering is a process of solidarity and mattering. This has consequences for our accountabilities, and response-abilities with known and unknown others. Even amid complex social problems – such as the pandemic – creativity, collaboration, and caring can still unfold, when we look at caring in practice processually.

Practising caring in organisations and organising may be a concern for those whose focus is on organisational development, which the Roffey Park Institute[68] (a charity that develops people who develop organisations) defines as *“the work of facilitating organisational success, by aligning structural, cultural and strategic realities of work to respond to the needs of an ever-evolving … climate”.* In a health and social care context, much work has been done by Michael West and others (2020; West et al., 2015, 2020) on the role of compassionate cultures and compassionate leadership in facilitating increased innovation, collaboration, resilience, and high quality patient care. Worline, Dutton, and others (2008, 2011; 2017), write that compassion is a process to be embedded in organisational culture, which involves noticing, understanding, feeling empathy, and taking action, in order to alleviate suffering and improve organisational performance.

In my quest for contributions, I have wondered about the ‘so what’ aspect of practising caring – what measurable and meaningful difference would it make in practice, how might that be ‘rolled out’ as an organisational initiative. Indeed, in conversations with academic colleagues, I have been asked these questions. This may be future research, most certainly for others. Worline and Dutton make claims for the practice of compassion. Cameron and colleagues make claims for the practice of virtuousness. My claims about practising caring are speculative.

What my contribution comprises, is the invitation to look more closely at how caring is already unfolding in the day to day of organisational life, rather than to assume that there is a caring deficit. Both can be possible, although Critical inquiries might favour a deficit approach. A processual perspective centres on the specifics of the situation as experienced as the basis of inquiry into what needs to change and

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[68] https://www.roffeypark.ac.uk/knowledge-and-learning-resources-hub/what-is-organisational-development/

how, rather than more abstract frameworks and principles to be ‘rolled out’ as part of an organisation-wide initiative. This is not to say there is no place for organisational development initiatives, but rather than something top down and normative, to reimagine organisational change, innovation, and learning, as an ongoing and participatory process involving the quotidian and the deliberate. Organisations are constantly changing, on a momentary basis, as people, process and technologies interact. How much more effective might organisational initiatives be(come) if they moved with the ebb and flow rather than washing over it?

Implications for theorising caring

In this section I explore how an ethos of caring, as an experience informed theorisation, might inform further discussion, particularly with a more processual vocabulary and language with which to practice and theorise caring.

The consideration of care as an organisational phenomenon is nascent (Fotaki et al., 2020b), with care and caring used interchangeably to refer to ‘care’. For example, the economic field aims to propose an alternative of ethics of management and organisational behaviour that favour actors’ well-being (Le Loarne-Lemaire and Noel-Lemaitre, 2020). This can be contrasted with organisational care literature that stresses questions of *“how people attend to each other at work, how they feel treated by others, and the quality of their relationships”* (Lawrence and Maitlis, 2012: 641). While these approaches consider caring in practice terms, following Tronto (Olthuis et al., 2014; Tronto, 1993) and Held (2006, 2015), they perpetuate the dualism of care as individual and role-based, and within dependent relations.

From a theorising process perspective, there is growing interest in what we may discern differently about organisations and organising as a socio-material practice, and from an ontologically processual perspective (Braidotti, 2006; Pallesen, 2017; Revsbæk, 2018; Revsbæk and Simpson, 2022; Simpson and Hond, 2022). In writing about her doctoral experience, Anna Brown (2021) notes that in tilting the emphasis towards the processes that bring things into being, rather than the objects that are produced, she experienced a 'simultaneous becoming of researcher and research'. I have taken up a similar invitation, to perform my doctoral research processually. Reflecting on Brown's learnings, from a theorising perspective, the dualism between researcher and researched needs to be 'queered' (in both senses of the word). What I have found, as I discussed in the previous chapter, is a different vocabulary and language with which to practice and theorise caring.

In attempting to allow practice to inform theory (rather than theory inform practice), Mauro Turrini (Mol, Moser, Piras, et al., 2010: 74) interprets Mol et al as stating that *'good'* care is tinkering in a world full of complex ambivalence and shifting tensions (Mol, Moser, Piras, et al., 2010: 84). Despite the normativity Turrini implied in 'good' care, which the authors challenge elsewhere (2010b: 13), a more open definition enables the practice of care to be explored empirically.

While my inquiry into caring emerges as a conversation about my empirical experiences, care and caring were not my intended focus in the field. Studies into care in practice do exist (Gherardi and Rodeschini, 2016; Martela, 2012), informed by pragmatist and posthuman ideas. In developing the provocation for more of such studies in organisations and organising (Simpson and Revsbæk, 2022), and indeed in furthering my own contribution to this discussion (Augustine, 2022), I see potential for more practical, processual, and sociomaterial theorisations of caring, emerging from practice and for consequential practice in transforming organisations and more than human communities. I am reminded of Haraway, who says our task is *"to make trouble, to stir up potent response to devastating events, as well as to settle troubled waters and rebuild quiet places"* (2016b: 1).

Summarising my contributions

Barad, Haraway, and Puig de la Bellacasa remind me that the agential choices I make are ethical as I favour this worlding over many others. One contribution then is greater transparency about the choices (or partiality) I have made, because we do make them, as STS scholars (among others) have been telling us (Haraway, 1988; Latour and Woolgar, 1986). Another contribution is to acknowledge that as our research develops, so do we, and that this can become an entangled process of becoming. My understandings of care, diffraction, and inquiry are evolving as I move from knowing who wrote what to living those ideas. This was an invitation from St. Pierre (2018, 2021).

My first understanding of diffraction comprised how it is being used as an analytic practice. As I tried to integrate the potential of diffraction into my research methodology, so I began to understand its methodological potential. Seeing this, helped me understanding the ethical dimensions of diffraction. Understanding diffraction as a consequential way of seeing – called for me to live diffraction, not just as something to do, as practice(s), but as a process. For me, diffraction is both noun and verb, and in this integration, I find it hard to always know which I am favouring at any one time; and in which ways I am extending diffraction as a metaphor rather than a closer facsimile of its meaning in physics.

I believe my thesis makes several novel contributions, which I now summarise. Firstly, in chapters 4, 5, and 6, I extend an invitation to look more closely at how caring – as a social dynamic – is continuously unfolding in the day-to-day of organisational life. Secondly, in chapter 7, I propose a vocabulary and language of caring, informed by a processual rather than relational ontology and drawing on pragmatism and feminist technoscience, which conveys the ongoingness of care in practice. My third contribution, in chapter 7, is to suggest that ‘ethos’ – rather than ‘ethics’ – more accurately conveys how caring is performed in practice, and that this ethical practising is consistent with pragmatist inquiry. Throughout this thesis, a further contribution is in showing how ontologically processual inquiries may generate insights that epistemological studies miss or discount; as well as foregrounding entangled and co-creative relations between researcher, participants, ideas, and situations, and the ethical mattering of crafting doctoral output. A final contribution, again running through this thesis, is experimentation with diffraction as inquiry logic, first introduced in chapter 2, as a way of surfacing seemingly inconsequential and yet catalytic differences in day-to-day organising, relating, and doing.

Where next?

I wrote earlier that my many possible studies were whittled away, as my study took shape. So, as with every doctoral thesis, some ideas needed to remain un(der)explored. There are several areas for continued development arising from my study. This section explores some of these possibilities for the future.

Addams' caring motifs

Addams' emotionally engaged, participatory, experimental, and situated social ethics have long influenced the domains of social policy and work. More recent reappraisals of her written and experiential activism suggest she was practising an 'ethic of care' decades before the term was coined (Banerjee, 2022; Hamington, 2004: 93). Addams extended care ethics to the public realm (Hamington, 2019b) by challenging the parochial and familial mores that guided domestic life as being applicable in workplaces, neighbourhoods, and public institutions. Her ethics – combining empathy and collaborative action – are also beginning to inform understandings of human relations and care in organisations and organising (Hamington, 2004; Ladkin, 2020). In contrast to the contemporary, critical, ideas about care as a relationship of power (Tomkins, 2020), caring is what Addams advocates (and practices) for democracy and its various institutions. For Addams (1910), care (as emotional engagement) results in (intra)action.

Tronto (1993) mentions Addams twice, both times to state how she ‘lost’ moral authority through her continued commitment to pacifism during World War l (even if Addams did go on to win a Nobel Peace Prize, the first US woman to achieve this honour). This absence of even a mention of pragmatist ideas of democracy, social change, and concepts of ‘power with’ even if to reject them in developing her own argument, I believe, is a significant omission (particularly given Tronto’s liberal and progressive views as a political scholar and activist) in care ethics.

A future inquiry, for myself and/or others, might be to reappraise Addams’ social ethics – practiced from a human-centric perspective – re-read as moving towards a more holistic posthuman and associative take. This would extend the conception of practising care my thesis outlines. In thinking with Addams (1896, 1902, 1910, 1911, 1912), I discern several potential caring themes in her social philosophy i) emotional engagement, ii) progressive experimentation, iii) constituent storytelling, iv) pluralistic inquiry, and v) relational accountability.

Another inquiry might be to diffract posthumanist and pragmatist social ethics, to extend the concept of caring as ongoing, non-binary, human**e** and beyond human response-ability; and whose urgent provocations to ‘think with care’ (Puig de la Bellacasa, 2012) are sympatico with Addams (and other pragmatists, notably Follett and Dewey). This would involve thinking more deeply with Barad and Haraway, as well as Braidotti and others who critically engage with anthropocentric discourses, to consider an ecological and social ethos of caring.

Social ethics, pragmatism and posthumanism

I imagine further development of a pragmatist-informed posthuman/post qualitative way of seeing/doing consequential inquiries. A recently published edited collection on doing ontologically processual inquiries has started this conversation within organisation studies (Simpson and Revsbæk, 2022). Much feminist technoscience thought looks to Derrida, and Deleuze and Guatarri, and an ontology of immanence. How would it be to build on the ideas of Addams, Dewey, Peirce, Follett, and others, ontologically processual and rooted in lived experience as it is experienced? That would matter because it would afford a stronger practice/experience orientation to the performing and theorising of inquiries. There is limited scholarship exploring potential synergies between pragmatism and posthumanism, for example relating Dewey's concept of experience with the bodily ability to make new environments (Guernsey, 2017), or Peirce's articulations of semiotics and the immanence of feeling in order to call attention to what remains unseen (White, 2015), but the contributions of women pragmatists to this discussion are so far overlooked.

Inspired by Seigfried (1996), I suggest that what connects the pragmatism of Addams, Follett and Dewey with feminist technoscience and posthumanism is a focus on the emancipatory potential of everyday experience made possible through a 'feminist' sensitivity to collective action (Haraway, 1997), as well as a shared interest in how 'scientific' methods inform experiment and inquiry. Pragmatism and feminism share a practical view of philosophy that emphasises pluralism, experience, and public engagement to address the complexities of lived experience across diverse spaces (Kaag, 2011; Lake and Whipps, 2021), valuing the embodied and relational nature of personal and social change. As Barad reminds me, practices of knowing, such as research *"are specific material engagements that participate in (re)configuring the world"* (2007: 91).

Caring and collaborative leadership

Within organisational and organising literature, an ethic of care has been taken up in the context of race and intersectionality (Bass, 2009, 2012; Stanley, 2009), gender (Fine, 2009; Inal, 2017; Johansson and Edwards, 2021; Kropiewnicki and Shapiro, 2001), Māori leadership and management (Kahungunu et al., 2010; Ruwhiu and Elkin, 2016; Spiller, Erakovic, et al., 2011), business practice(s) (Hamington and Sander-Staudt, 2011), authenticity (Atwijuka and Caldwell, 2017; Faircloth, 2017), transformational leadership (Simola et al., 2010, 2012), civic leadership (Sun and Anderson, 2012), human resource management (Armitage, 2018; Islam, 2013; McGuire et al., 2021), leadership in educational contexts (Ehrich et al., 2015; Frick and Frick, 2010; Langlois and Lapointe, 2007; Owens and Ennis, 2005; Smit and Scherman, 2016), leadership and nursing (Bowden, 2000; Chamberlain et al., 2016; Edwards, 2009; Green, 2012; Lord et al., 2013; Woods, 2011), relational leadership (Binns, 2008; Henry and Wolfgramm, 2016, 2018), indigenous leadership (Chamberlain et al., 2016; Faircloth, 2017; Wolfgramm et al., 2016), reflexivity (Cunliffe and Ivaldi, 2021), leader-follower relations (Gabriel, 2009, 2015; Hawk, 2011), business ethics and codes of conduct (Fotaki et al., 2020a), employee satisfaction and wellbeing (Kroth and Keeler, 2009), employee involvement in sustainability (Carmeli et al., 2017), stakeholder theory (Engster, 2011), management strategy (Kroth and Keeler, 2009), management learning (Heath et al., 2019; Smith and Kempster, 2019), and leadership for sustainability (Nicholson and Kurucz, 2019).

My original study was focussed on collaborative leadership. A future line of inquiry might be to explore how caring comprises an aspect of practising leadership. This goes beyond conceptualising care as managerial activity (Kroth and Keeler, 2009), or moral duty / caregiving towards followers (Ciulla, 2009; Gabriel, 2009, 2015; Tomkins and Simpson, 2018). These literatures are shaped by a critical stance that views relational leadership in terms of power relations, where the task of the leader is to ‘moderate’ their power and view of the other in their relations. They hold a dualistic perspective that sees care and duty in opposition.

Instead, I see a potential to explore how practising caring enables collaborative agency, which Simpson (2016b) argues, comprises ‘leadership’. Such a perspective can be seen in theorisations on caring and leadership emerging from Indigenous scholarship, where leadership is intertwined and sustained through mutual reciprocal relationships, as a moral aspect of collectivist forms of leading (Chamberlain et al., 2016; Henry and Wolfgramm, 2018; Ruwhiu and Elkin, 2016).

Practice, practices, and sociomaterial practising

While Mol and her fellow authors are criticised by Maria Piras and Alberto Zanutto (Mol, Moser, Piras, et al., 2010) for a broad definition – persistent tinkering – that might render caring as a ‘style’ rather than ‘practice’, Mol responds that such an assemblage of modes and modalities (or styles) enables the researcher to ask ‘how’ questions (how is care being done in this place at this time with these human and non-human actors?), rather than what or where questions, which she suggests is arguably the goal of practice-based research.

Practising is infused in this study, although I hesitate to call this a practice study. Simpson (2011; 2009, 2018) previously described Pragmatism as a ‘philosophy of practice’; claiming its place alongside theorists such as Pierre Bourdieu, Anthony Giddens, and Theodore Schatzki. Gherardi (2012) highlights the pragmatic stance of a practice-based approach, where practical knowledge is directed towards doing, is anchored in discursive practices, and knowledge (rather than knowing) emerges from situated action.

However it appears that the goal of many practice studies is to capture the procedures, methods or techniques performed by social actors; where knowledge is a form of mastery (Nicolini, 2012). This focus on practice as things (nouns) – routines, roles, mastery – is at odds with my interest in the performative social dynamics involved in practising (doing). In this context, practices are understood as fallible predispositions to certain actions, ongoingly learned and relearned in the continuous processes of selves and contexts creating each other (Simpson and Hond, 2022: 136). There is an important distinction (Nicolini, 2012; Simpson, 2016a), illustrated in Dewey's reminder that there is no absolute end to inquiry *"as every new settlement introduces the conditions of a new unsettling"* (1939: 35).

There is a nascent conversation about posthumanist practising (as a verb), as knowing 'between multiple human, discursive, and material components and the vital forces that emerge from their encounters' (Gherardi, 2019a; Gherardi and Laasch, 2022). I am arriving at posthumanism from this conversation between pragmatism and feminist technoscience, and what Seigfried (1996) and Jane Duran (1993) describe as the consequential and emancipatory potential of everyday experience made possible through a 'feminist' sensitivity to collective action (Haraway, 1997). This is a different entry point to scholars arriving at posthumanism from science and technology studies and elsewhere.

Valorising self-care

Engster (2007) sets out a hierarchy of caring obligations based in the degree of intimacy and physical connection between those in need and those giving care. Our first level of responsibility is care for ourselves. For Mayeroff, caring is also self-realisation through the growth of others, although Noddings (1984) states that 'brief' caring encounters need not involve such a 'grand objective'. Thinking with Haraway's idea of becoming-with, and Barad's notions of entanglement and intra-action, Mayeroff's point would make sense.

My theorising of caring invites a focus on caring for the self, and yet this is not a point I develop in the thesis. Caring for 'ourselves' forms part of the foundational definition of care outlined by Tronto and Fisher (1990). *"We are care receivers, all"* Tronto (2013a: 146) writes, inviting us all to consider our own vulnerabilities and needs, and in doing to recognising that others have needs too. This goes beyond ideas of patient empowerment and choice within a care marketplace (Mol, 2008; Ward, 2015), or in a commodified form such as going on wellbeing retreats. It has been suggested that this type of self-care connotes individualistic behaviour tied together with neoliberal themes of wellbeing and personal growth (Molinier, 2021).

During lockdown we practiced newer forms of self-care: self-isolation and social distancing (Chatzidakis et al., 2020: 2), individual acts with social consequences. In further developing self-care in a context of intra-action (feminist technoscience) where we are inherently social selves (classical pragmatism), I would also look to Latin American perspectives, where, in identifying with their peers, women experience a process of self-care that has a therapeutic value and comprises a step in the direction of engaging themselves in social activism (Molinier, 2021). If we live in our world feeling/perceiving ourselves to be connected-in-general, our experience of social problems will be very different from the experience we have when we feel/perceive ourselves to be unconnected-in-general (Leffers, 1993: 74). It is this membership of a social whole, Dewey (1998: 349) argues, that compels us to take responsibility for our own wellbeing growth, for without this there can be no effective social interest. What then, might wellbeing look like as an aspect of a caring ethos?

Becoming a processual researcher: redux

In this section, I revisit some of the themes and aspirations from chapter 1, about undertaking doctoral research processually, and the interweaving of theory, practice; and my own development in acting out an ontology of becoming.

This has been an ambitious, experimental, and uncertain journey, which began in response to a series of breakdowns in my doctoral plans. Continuing with my original study – even accounting for the disruptions of lockdown – would have been satisfying. However, I suspect that the mix of feelings I have now – anticipation about how this might be received, pride that I have accomplished something different, and relief that I can soon move on – would not be so charged. If nothing else, this thesis is a testament to what can be produced when faced with a challenge: to turn an inquiry in crisis into a novel insight with fidelity to experience.

I am learning to become a researcher through the process of undertaking my research. It is a performative process, it changes me, which then changes my practice in the field, in my imagination, in my peer relations, and on the page. And I am changed again. My development as a researcher is central to how I now theorise, this document is more than instrumental output: it tells the story of who I am becoming for the last few years.

As Massumi (2013: xi) says, *“processually speaking, a making is always bigger than the made”.* At times, it has been difficult to draw boundaries around my research as an academic inquiry, my identity, values, and purpose. They have frequently blurred such that my inquiry has been more than an intellectual endeavour, but a journey of self-discovery through practising caring. It has been all consuming at times, which is perhaps not ideal in terms of self-care.

‘If I had known at the beginning what I know now…’ is a typical refrain of hindsight, the consequentiality of certain decision points, and what – in the grand scheme of things – was not as material as it seemed at the time. Perhaps I could have persisted with a leadership study, even during the lockdown, with a changed method(ology), of online interviews and shadowing meetings, tracking the unfolding of collaborative leadership in Primary Care in its response to the changing priorities of

Primary Care. It *would* have been a distinctive and interesting contribution, both to the health and social care organisation and to the literatures on how collaborative public leadership happens in practice during one of the most significant global events of this century (so far).

I stand by my choice to follow caring, catalysed by my supervisor to look again at my data and how I reexperienced it, and to 'act out an ontology of becoming' (after Pickering). And because it matters to me. In chapter 2, I explained that Pickering's invitation informed my understanding of how one becomes a processual researcher: upholding fidelity to experience, and in doing so moving from practising research as a replicable process of representation, to processually and tentatively crafting one worlding from a multitude of possible becomings (Pallesen, 2017). Researching when theory, method, and experience is entangled, fluid, messy and partial (in both senses of the word – incomplete and biased).

This is what it means to me to undertake an ontologically processual inquiry. The argument I make here, therefore, is not one of a proven/unproven hypothesis upon which to develop a novel insight, but how I research, analyse, theorise, and write linearly, disjointedly, and all at once so that a coherent – albeit ephemeral – perspective takes form. To performatively demonstrate how research might be done differently, and still yield novelty of merit for practice and the academy.

I have attempted to be discerning in the development of a persuasive narrative about this experiment in fidelity to experience. Ideas, theories, experiences, and resonances have been whittled away. Some were harder to let go of than others. These comprise the possibilities I discussed above.

This has been the most challenging writing process I have encountered, mainly because I would have liked to write each chapter concurrently, better still to have structured a different thesis. It was only when I began writing that the inquiry really began, trying to hold in my head conflictual logics, questions, and ideas of all the possible theses I could have written as it became *this*. A post structuralist scholar might suggest I be more ‘rhizomatic’ – a non-hierarchical approach connecting any point to any other point (an approach used by Ruth Weatherall in her doctoral thesis (2019)). Had I engaged with Deleuze and Guatarri and their ontology of immanence, this would have been an entirely different study.

Similarly, I acknowledge the untapped potential of ‘agencement’, as Gherardi (2016, 2019a) explains it, to help me capture and convey the dynamism, processes of connecting, and open-endedness in my inquiry. By agencement Gherardi means processes of connecting with, practising (as a verb) rather than practice (as a noun). I believe my study does this, although drawing on different ideas, informed by pragmatism and feminist technoscience.

At heart, I am a storyteller – albeit one influenced by Addams, Berger, and Haraway, who all see stories as epistemological instruments of inquiry and transformation – where the (ethical) responsibility of storytellers is to enlarge and enliven our understanding of experience. To invite (or should that be incite?) change. Berger (1972) helps me understand how thinking arises from our capacity to notice differently. Haraway teaches me that storytelling is care-full thinking (Terranova, 2016). And, I am inspired by Addams’ conversational and candid writing style as a form of ‘ethical activism’ (Fischer, 2019).

Addams, Berger, and Haraway give me courage as I embrace the possibility that noticing, talking, thinking, re-experiencing, and writing, comprise analytic mutually informing and performative practices (as noun and verb) (Braidotti, 2014; Brinkmann, 2014; Cunliffe, 2018; Gergen and Gergen, 2018; Gilmore et al., 2019; Howard-Grenville, 2021; Jackson and Mazzei, 2017; Jegatheesan, 2005; Katila, 2019; Revsbæk, 2018; Revsbæk and Tanggaard, 2015; Richardson and St. Pierre, 2017; Ronai, 1992, 1995; Shotter and Katz, 1996; St. Pierre, 2018; Weatherall, 2019). So many established and emerging scholars are inciting me to care, to experiment, to make trouble (Haraway, 2016b). I only need to be asked once, especially when my supervisor encourages me to 'be more brazen' in flowing against the tide.

I understand that doctoral research is supposed to be challenging and rewarding. I had not anticipated that I would also undergo emergency and life altering surgery; a menopausal transition with attendant impacts on my mental, physical, intellectual, social, and emotional health; and a global pandemic that touched millions of lives, including our family and the tragic loss of my father-in-law. It has been hard to hold on to my focus at times. At other times I have become so entangled in my inquiring that past, present, and imagined future, experience as lived, and a multiplicity of possible becomings, have all seemed alive and vibrant in the here and now. I do not know that I could describe *how* that happened. I recall a point – discussed in chapter 2 – made by St. Pierre (2018: 604) about the 'long preparation': reading, thinking, writing, and living with theory while in contact with experience. I am not sure I really got what she was saying when I first read that – beyond referencing the brevity of thinking time when doing doctoral research, in the rush to methodology.

A further learning has been about the shifting logic that underpins this study. My original logic comprised performative, intersubjective, and processual leitmotifs. In chapter 2 I updated these to abduction, empiricism, and diffraction. As I reflect on the process of analysing-writing, and how each chapter is taking shape in support of my theorising, what makes more sense now are guiding principles of diffraction, empiricism, and affect, and rooted in process. This is more congruent with the alternative evaluation criteria I proposed in chapter 1 and revisited in chapter 7. What has been constant has been my commitment to follow unfolding experience.

I return to counsel from St. Pierre, that *"inquiry should begin with the too strange and the too much. The rest is what everyone knows, what everyone does, the ordinary, repetition"* (2018: 607). What I understand now, is that inquiry is more than literature reviews, research design, weeks spent in the field, analysing data, and the pursuit of novel insights. Inquiry is also rupturing and reconfiguring (rather than ‘repair’, as discussed in chapter 5) in supervisory relationships, bursting with glee at the discovery of a new idea and its potential (remembering the first time I read Mol, and Haraway, as I write this), reading William James as an undergraduate (nearly 40 years ago), forgetting, and the joy of connecting him with his community of Pragmatists, James introducing me to Dewey, Addams, and Follett, laughing out loud when reading Jane Addams, relishing in her turn of phrase, exceptional candour, and timeless social commentary, researcher becoming in-patient, having to start my inquiry again midway, and learning not to rescue my participants by offering help they did not need, and still be making a contribution.

I have asked myself whether this study might be received as a naïve and idealistic treatise, calling for a practising of response-able kinship – even love – that runs counter to the toxic, power-laden, and conflictual realities in organisations and organising. Regardless of all the ways that care might be problematic, in my experiencing caring also exists. It exists as a social dynamic, in the mundane and the everyday, between people, non-humans, and technologies, and this to me is a source of hope and comfort. I am reminded of Minh-ha’s (1998) critique of binaries and dualisms, instead seeing difference as an act of potent creativity rather than separatism. My study, then, is a modest appreciation of what is, and what might be, rather than critically engaging with what is not.

Massumi (2015) refers to a ‘margin of manoeuvrability’: hope and potential in what comes next rather than a wished-for utopian end state or big picture. This hope is what he calls affect: the dynamic capacity to affect or be affected where *“emotion is how that ongoing experience registers at a given moment*” (2015: 4). Hope, or affect, is to be experienced in the present tense, he writes. Rather than being passive, I see my hope and appreciation of what is in this study as provocative.

Finally, I ask myself how I have changed, what is it that I might do differently in the field and on the page because of this study; beyond all the theories and concepts I have engaged with that are expanding my academic knowing. While there may be many practical and conceptual changes – around participation, logic, and emergence – to meet the needs of a different inquiry, it is my growing courage to inquire differently that stands out for me as significant. For me, all this learning is about being present with what is, with whom and how, beyond design, language or gesture, care-full and multi-sensual experiencing, 'meeting' others as entangled rather than intersubjective kin. Placing trust in the process and to keep moving.

Closing thanks

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Over and above the contribution my inquiring makes to practising caring and organisation studies, I hope that future researchers might be(come) emboldened to bring their whole and partial selves to their inquiring, to take seriously our ethical response-abilities when making knowledge claims, and to theorise like our entangled futures depended on it.

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