Fallacies of care – A short introduction

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Sophie, a Montreal artist who has been in a wheelchair since she was nine years old, and who therefore is continually involved with the Québec health care system, once told Annette that she had never met a kind nurse, or one who handled her fragile body with care. This angry statement, made at a moment when Annette had just started, as an anthropologist, her new position at the University of Montreal's Faculty of Nursing, seemed difficult to reconcile with the Faculty's official paradigm that defined care as action grounded in emotional work: "attitudes of compassion, listening, comprehension, support, reciprocity, collaboration, openness regarding continued education, proactivity, creativity and commitment" one can read on its website (FSI, n.d.). How does Sophie's lived experience and the undeniably positive aims of nurses as envisioned by the Faculty occur in the same health care environment? Or, put slightly differently, how do noble aspirations, good intentions and even good actions, paradoxically result in harm?

The authors of this special issue try to answer the latter question; more specifically we focus on elder care from a perspective we call "fallacies of care." This central notion we define in a general way as "when care motivated by good intentions inadvertently does harm" (see Leibing, 2010, 2018, forthcoming). Each of the following four papers specifies and defines "fallacies of care" in a slightly different way, and we hope that, through multiple perspectives, consciousness can be raised regarding the multifactorial, complex, and not easily explained proximity between harm in the widest sense and ideologies of care.

Of course, ideas of care have been interrogated and put into new perspective before by social scientists: For instance, feminist perspectives conceive of caring as gendered work (e.g., Tronto, 2010); emotional work in care can become a commodity (e.g., Hendersen & Petersen, 2002); and care itself – commonly defined as giving and receiving – is a culture-bound concept with situated logics and normativities (e.g., Aulino, 2010; Garcia, 2010; Mol, 2008; Stevenson, 2014). Further, a lot has been written about access to care, deservingness and governance of care (e.g., Castañeda, 2009, Nguyen 2010, Han, 2012, Giordano, 2014); care in humanitarism often reduces people to partial citizens (Fassin, 2012; Ticktin, 2011); there is a lack of concern with materialities of care (Buse, Martin, & Nettleton, 2018); and practices defined as 'unusual' in common Western definitions of care are often overlooked, such things as waiting or illicit drug-consumption as care

(Han, 2012; Meyers, 2013). And then there is, of course, the absence of care, abandonment (Agamben, 1998; Biehl, 2013). These different perspectives can all be ways of throwing a critical light on care practices and its diversity demonstrates that care is a complex matter that merits ongoing discussion.

The specific subject of aging in critical discussions of care has been beautifully summarized by Elana Buch (2015). A number of issues are at stake and although such issues overlap with preoccupations found in care practices for younger people, the greater closeness to the end of life (see Biggs, 2017), the inevitable decline of the aging body, but also aging-specific normativities, prescriptions and dichotomies, such as normal and pathological (Katz, 1996; Lamb, 2017), successful and unsuccessful (Minkler & Fadem, 2002), and active and non-active aging (WHO, 2002; Katz, 2000), as well as third and fourth age (Gilleard & Higgs, 2010), structure care practices and capacities of caring for older people.

"Fallacies of care" is more specific in that it looks, critically, at the highly complex issue of goodness – doing good - in care, and here in elder care. And although we talk about fallacies, our intention is not to deconstruct or debunk care or to equate it with harm. Our intention is to provoke discussions and, hopefully, a greater awareness of such issues among health professionals, especially those working with older people, but also among social scientists. Greater awareness might be gained through changing and challenging perspectives: Ulrich Beck (2015) argued in one of his last articles, referring to climate change and risk, that talking about the bad – fallacies – can actually have good results. The discussion does not have to stay in a state of criticism, he argues - discussions of fallacies can lead to "social catharsis", but only when "…the past is reproblematized through the imagination of a threatening future." (p. 83).

All four articles in this special issue challenge something that is generally taken for granted in elder care. They have in common that the authors show that when ideology gets disconnected from concrete practices and socio-political contexts, good intentions become problematic. Questioning assumptions of the good, the anthropological approach taken by the authors underlines that care in practice is often more complex and negotiated than ideals of care would make it seem.

Lemos Dekker's article eloquently reminds us (in line with Mol's statement [2010], that in care the good and bad easily get intertwined),

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that harm within fallacies of care is not always a clear and straight-forward issue, but rather a prism through which good and bad some-times becomes ambivalent: her case study in a nursing home in The Netherlands shows how care in the context of an unexpected death involved co-occuring but different perceptions of what is good care, and led to conflict between the intended actions resulting from protocols and care practices. Fallacies of care, she elaborates, can emerge not only when good intentions have bad outcomes, but also from the fric-tion between multiple and competing goods.

In Beck's description of social catharsis, fallacies need to be linked to norms in the past in order to change the future. Leibing adopts such an approach when she describes central values – many of them steeped in humanism – that persist over time in (international) geriatric dis-courses. These values, she argues, can become fallacies when they result in ideals and abstractions that are disconnected from actual regimes of care. Her fieldwork in a Brazilian geriatric clinic shows that the way interviewees articulate geriatric care not only mirrors international and longstanding values in this relatively marginal medical discipline, but also that the application of ideals is especially difficult in a context of scarce resources.

In the third article Seaman, Robbins, and Buch criticize what they call the "evaluative approach" in studies on care – those studies that assess care in terms of categorizing the good and applying these in interventions for improvement. They unveil the implicit assumption that care can be made predictable by building on extensive fieldwork in home care organizations, long-term care institutions, and memory clinics and support groups in the United States and Poland. The authors argue that the implicit link between good care and predictability highlights a fallacy in the predominant evaluative understandings of care in many societies and argue precisely for an attunement to the unpredictability of care and its contextual embedding in historical and social complexities.

The fourth article is the result of a collaborative writing project between an anthropologist and a psychologist. Pinto and Pinto draw attention to the relationality between clinician and client in psy-chotherapy. This relation, and with it, good treatment, they highlight, is often premised on particular and limited understandings of empathy as emotional and cognitive alignment. Through an auto-ethnography of psychotherapeutic practice in the United States, in which an imprisoned older woman needs to come to terms with guilt and aging as limited lifetime, they argue that equating empathy with alignment becomes a fallacy of care in that it risks jeopardizing the treatment itself. Alternatively, they propose a conceptualization of empathy that allows space for the psychotherapist to navigate both alignment and incon-gruence.

Together, these four contributions assess assumptions of the "good" in elder care. Exposing such assumptions, through the concept of fal-lacies of care, is not to undo the good itself, but aims at unravelling its layers and implications. With this, we hope to open up space for re-flection, both in academic work and in care practices.

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