Record of the conference 'Who is rendered responsible?'

Opening by prof. Dr. Gerty Lensvelt-Mulders

We live in a period that asks our attention since the healthcare system is rapidly changing. Professors and scholars reflect on this issue which poses us for possible obstacles in the future. Who is responsible, is the question? Citizens? The government? The governmental rhetoric regarding this question is based on certain assumptions that mark the shifting of responsibilities in the healthcare system and on a broader societal level. One assumption is that people are capable to take more care of each other and are able to lean on each other. But what if people are not part of a network or able to articulate their needs?

These questions will be subject of today's conference. The approach is interdisciplinary since you can break 'small walls' by linking the various sciences.

Carlo Leget introducing Thomas Biebricher

Keynote by Dr. Thomas Biebricher 'The Welfare State and the subject of Neoliberalism'

Biebricher is a political theorist, so he starts with a disclaimer. It might be abstract, but he is confident that we, his audience and most of them empirical researchers, can bridge the gap with practice.

First he outlines his presentation. His thesis is that de citizen is holded responsible by a neo-liberal govern mentality.

<u>Theoretical background</u>:
Foucault's govern mentality lectures power is not centered in one place, but is rooted in practice and procures subjects, and consequently: identities.

Why power shifted to govern mentality? The history of govern mentality is not about how it's done, but in what discourse; what is it that should be governed, for what problems, and how (economically, etc. So it is a govern mentality of reflected practices. Govern mentality is the conduct of conduct.

Governing in this perspective is about governing rationalities. The object of govern is 'territory'. This new dimension in political governing arised due to a growing population in the cities that had to be governed. Cities consist of a population of 'living bodies, entities'. How to govern this population of living bodies is at the heart of political problematic.

The availability of technology structures governing rationalities. Statistical means determine what is possible to talk about the population. So there is a close link between rationality and how you think about the population.

How do you govern the 'living bodies'? You incentilize them! That means that govern technologies are applied. There is a link between rationalities and the conduct of the self. The assumption is that 'rationalities' and behavior are related to each other. If this assumption

applied, it will be reflected in inefficient governing. So here we see a liberal political perspective which could be framed as ‘through the freedom of those you govern. In short it is the attempt to shape people according to rationalities.

The Rise of the Welfare State

There are different stories about the rise of the welfare state

Some say:

-progressivism/pragmatism (*this point is incomplete)*

-is the result of revolutionary pressures out of population (christen democratic view)

-as necessary construction to feed capitalism. Namely

- by stabilizing state power

-since the state always has to arrange itself with capitalism

-insurance technology make people objects of governing: creating subjects (risk calculation)

-by establishing norms normalization.

Normalization

The process of normalization evolves by gathering knowledge and data, for example: how long do people live, how long can they be expected to work? And then practicing power by these norms.

Effect of power: if you don’t live up to the norms and descriptive assumptions you drop out, for example in case of non-representive biographical lives (in case of women). It becomes prescriptive: propagating /inculcating norms. A link with practice: social workers also practice power by reasoning according norms.

What is neo-liberalism and what are the two neoliberal critiques of the Welfare State?

1) there is a moral hazard: maximizing ‘surface’ power over individual and by this making people to calculating subjects, for example: reckless skiing, since he has insurance anyways. Of course the calculating happens according to wrong incentive, with no responsibility.

2) incompetence/dependence: people loose ability to take care of their lives. The welfare state creates dependence relying on provision of the state. Not *pursuing* is the opposite of the neoliberal vision because that vision is an enterprise society, which is led by entrepreneurs the neo-liberal subject. The subject as entrepreneur of the self.

The imperatives of this neo-liberal subject are as follows:

Free: nothing stands in the way of our success, accept for our own passivity. So be..

Active: do something, create opportunity, and make the best of yourself.

Entrepreneurial: but you weight risks and chances against each other. You can't become gamblers, you should stay…

Prudent: get back on your feet and remain responsible individual responsibility

'able to take care of yourself, be autonomous' is part of human dignity. There is a lot to say for this. We should rely on our selves, not only for ourselves, but not to be a burden for a society. We have social responsibility.

"Society doesn't owe you anything, but you owe to society, not to be a burden."

Two examples:

-labor market and poor relief. VS mid-nineties, Germany 2000: provision became conditional, like in more cases of receiving benefits. First proof your responsibilities. This state a shift from welfare to work (for it).

-health care: the preventive paradigm and the power of knowledge. 'I don't want to know about this!' becomes more difficult, while more and more knowledge is generated about causal correlations in all kind of life domains and correlating risks. This intensifies the conduct of the responsible self. Lack of responsibility only falls into your own disadvantage. This is also connected to practice for example with insurance. No implausible scenario is that activity A, B or C are not allowed, since your insurance tells you so.

So the welfare state needs to be changed conform neoliberal logic in order to conduct people according to neoliberal rationality.

Question from the audience: what is the relation of being a burden in society and adding something to society? Answer: In the power relation the negative dimension of people is pointed out.

Prof. Dr. Tineke Abma (VU MEdical Center Amsterdam) on: 'Care for the elderly'. (11.30-12.00)

The tragedy of the transition; what does the transition mean in the Netherlands? It works out as a tragedy; it's mainly the voices of the stakeholders. Decentralization (WMO as per 1-1-3015) should show examples of government versus municipality participation = retreat of the government, this should give better municipalities. The idea is that it will lead to 'self-sufficient'citizens and 'self-reliant'municipalities. But does it? Underlying is a 25% cut back on healthcare; So is it a moral input or just an ordinary cutback? The welfare state affects peoples' lives: the public sphere enters the private life. There is the lifeworld and the systemworld: the lifeworld consists of the symbolic and the cultural order and is led by dialogue, solidarity, friendship and love; the systemworld is the communication of the welfare state. System- and lifeworld are separated: the systemworld has become over-important, the importance of the lifeworld becoming smaller and smaller. We rely on knowledge for control. Solidarity is decreasing; bureaucracy is the new solidarity, because it fits the system.

The transition is sold as a recipe for a solidarity-society: but is it? There has been a pilot in Maastricht, called 'wijkkracht' (similar to keyring concept in London); but the outcome wasn't altogether positive because:

- All workers had strategic actions/hidden agenda's
- There was a focus on output, pressure to deliver, success
- Workers wrestled with complex moral issues, had to balance between helping/letting go.

Not everybody is or can be self-sufficient, and workers are there to listen too, not only to act.

We see that the transition is implemented in the way the system works; not on how people encounter their world. Results are amongst others:

- Alienation from moral responsibilities (by the workers); ex: 'we have an intake-form' instead of a conversation;
- It creates demotivation and demoralization with the careworkers;
- Money politics rule the way we help now.

References are made to Foucault's idea of the self-sufficient citizen, which seems unrealistic and paradoxical. You are not just free consumer, but a norm that needs to be obeyed; productivity is the norm. We are having a discourse with disciplinary effects: "if not, then…" The transition has led to resistance among workers and volunteers; this in turn was labeled as undesirable, 'insubordination', and the responses were seen as critique (rather than positive feedback).

There is always a moral appeal of 'the other'; and the other can be the 'indiscrete face' of the widow, or the migrant woman who makes a moral appeal to us. I.e.: when a migrant woman was 'forced' to participate with her neighbors, it didn't work; she didn't know her neighbors, didn't want to 'empower'; and once the social workers stopped pressing, and were just there, the contact improved, unrest disappeared. Now she could accept the woman for what she was, and let go of the idea of representation.

Panel Discussion
By prof. Dr. Tineke Abma, Dr. Thomas Biebricher and prof. Dr. Joachim Duyndam.

Biebricher said in reaction to Abma's speech, that he thought it was very well done in complementing what he had said. The empirical descriptions were interesting, especially about the care workers and whoever it is of marginalized population. The systematic point was also interesting about Habermas and his critique on the welfare state. And the term 'tragedy' is well chosen: it is the same kind of bureaucratic; there hasn't really been a break with that. The transition in the welfare state is more of the same.

Duyndam: I would stress the military context. It is not neutral. It is about participation and responsibility. According to Levinas, war suspends morality. And dramatically, morality

always takes the outside position. But morality should take the inside perspective. So, reframe them, and fight back! Take the inside position to reform the things that are at stake. Responsibility derives from freedom, but Levinas changed this: freedom derives from responsibility. According to Nietzsche, morality is the weapon of the weak.

Abma: I call it a tragedy because it is a repetition of a system logic which we don't like: we don't like the bureaucracy in our lives. The transition is the same in the end, and that is why it is a tragedy. There is a sort of guerrilla going on, so it's a different way of fighting and war making.

Duyndam: Do people know they are being in a guerrilla war? Did I choose to be in a war? No, the war befell on me.

Abma: 'If I'm too obvious against my boss, I will lose my job', so your interests are at stake.

A question from the audience: What makes this new liberal policy so successful and attractive that it dominates all of us and we choose neoliberal leaders?

Biebricher: Look deep into your heart: what is the attraction of being a free, active and mobile subject? There is an appeal in that idea, and that is the power of the neoliberal. If you're not an active, slim, fit, mobile subject, there is something wrong with you. We should not discard all these values of the neoliberal, but the problem is the way we are pressed in this idea: we are being forced to be free. It's like someone says to you: 'be spontaneous!'. It doesn't work that way. It's pure cynicism! Nevertheless, I can see the appeal of the values even for marginalized groups. It's becoming an oppressive appeal because the idea is internalized; it is forced upon us. But it's not freedom and activity that are problematic in themselves, but the way we are forced. It is just ideology and marketing.

Van Nistelrooij (in the audience): From a care-ethical perspective, those involved with care, both receiving and giving, are being marginalized; they are not the self-made man. It is not attractive. And I think we keep falling in the same pitfalls ourselves. If you take into account that you are involved in care: we are already always there in meeting the other. It is not something we choose, but it falls upon us. Shouldn't we take a more radical stand in dependency and such?

Abma: Yes, it is not something you can create. People in power positions are moving themselves away from meeting people that are vulnerable. They are in offices, away from the people they are responsible for! Those powerful people. When they are more often challenged in meeting the people they are responsible for, they might become more humble.

A question from the audience: The notion of solidarity in the traditional welfare state is formally organized. So isn't the participation society the way to give form to solidarity? This

is a more positive way of looking at the participation society; it is not regulated through the state.

Amba: There is something in that, but if we want it to bring us something, it should be done in a different way. Not imposing it on people, but doing it step by step, no masterplans. There are many people now that cannot choose, it has become an obligation.

A question from the audience: But there is the simple fact that the welfare state is not sustainable, so something should change!

Biebricher: But to what extent can you really trigger this transition through the state? You can have a neoliberal critique on this: you cannot make a truly different society through the state. It won't work. You cannot just have a couple of programs to create a solidary society. Besides, individuals are taking care of their children, their parents and they have to work to not become a burden when they get older. We will exhaust these individuals.

A question from the audience: I am still looking for a solution. Okay, small steps. But how in practical can you do these small steps? How, with not letting the state going into bankruptcy?

Abma: we now tend to move into a society with people who are working all the time, and we have people in a privileged position who doesn't have to give care. And we have people who are unemployed, but do give care a lot. We should distribute care in a fair way.

Duyndam: Also, there is no caring society without enough means. The reduction of 25% is just too much: it is not possible.

Chaired session 1
Three PhD's present their research.
Chaired by prof. Dr. Harry Kunneman.

Drs. Jeroen Zomerplaag - Responsibilities of staff in the implementation of a new method for supporting people with disabilities.

Based on a literature study and empirical data this presentation focuses on the meaning of knowledge for professionals coping with complexity in the care for people with disabilities. He made the distinction between two kinds of knowledge: there is 'big K' knowledge and 'little K' knowledge.

'Big K' knowledge is based on research, is captured in publications and is transmitted through training and education. This is what we talk about when we talk about knowledge. It is static; it is in books and such.

‘Little K’ knowledge is based on our experiences and it is in continuous development. It is dynamic. It is in the body of people. It is also developed by people personally and is constantly reformed by experiences.

‘Big K’ knowledge is dominant to ‘little K’ knowledge. As a result, our experiences with the ‘little K’ knowledge is disappearing. People accept the ‘Big K’ because they are uncertain, and the people behind the ‘Big K’ have control and *want* to control the situation. But there should be a balance between big and little K knowledge. People need to let go of exiting meanings that no longer meet, and develop new meanings for what they do not understand. And the development of new meanings happens through interactions with the environment.

The risk in when you develop ‘Big K’ knowledge is that you think you know everything. But practice is too complex to reduce it to a method. So you’ll need the ‘little K’ knowledge of the staff workers; what they think is important. These are the people that use the ‘little K’ knowledge to implement the ‘big K’ knowledge.

Eric van der Vet – Local state of care
Unfortunately, Drs. Van der Vet was unable to present his presentation, so prof. Dr. Harry Kunneman did it on his behalf.

His research was focused on volunteers and on organizations supporting voluntary care. Professionals need pressure from citizens and organizations in order to stimulate them to be more daring.

The focus of the research was on the WMO in Holland. A central theme is of course, that, at least in Holland, we already have a massive informal support. The aim of the dissertation was to formulate insights and recommendations for social policy. The central question was: ‘what can we learn from voluntary care organizations for a government policy that facilitates supports and strengthens the moral capacity on citizens?

There are some options for positioning voluntary care. At first, there is ‘denial’. Look away from this form of care. Second, there is ‘colonizing by professional organizing’: for instance, give them targets. Third, to ‘recognize them and connect them at a horizontal basis’.

Van der Vet made some recommendations for a more adequate incorporation of the practices of care and engagement in local systems of care and well-being. For instance, the formal domain should not colonize, but should be supportive of voluntarism.

Chaired session 2: Workshop Humanistic Studies: Salience and Academic Virtue, by prof. Dr. Gerty Lensvelt-Mulders (chair Theory of sciences and research methodology) and prof. Dr. Joachim Duyndam (chair Humanism and Philosophy).

An interdisciplinary approach to methodology of research in which empirical and philosophical data/perspectives supplement each other is important, since a research question

determines the choice of method. So, thinking about *what* to ask (regards as well how people see reality or how data correspond with reality) is as important as designing the method which will be used to answer it.

Hein Zegers

Science is looking through glasses: it is not reality. Actually it is the least bad reality by fact. Often, 'we don't know', is the conclusion at the end of research. So than we (world of science) ask: write what you do know. In practice it turns out that the sort of information is shaped by this request of journal newspaper. Consequently methods drive the question.

Hein Zegers speaks from a psychological perspective and did research to the question if voluntary simplifiers have a higher life satisfaction than the average population. And he conceptualized life satisfaction with Carol Ryf' s psychological well-being components.

However the answer was: 'not a big difference'. Zegers didn't have this answer 'sold' to the journals, so they asked them if he good write something about the results that was more pressing. So research is sometimes led by expectations of the outside world, and then not the question is driving the method.

Central notion: there is greater attention for positive confirmative results, whereas negative results are abandoned. That creates a bias in research, since there is not enough discussion about the 'why' of certain research outcomes, not at least negative outcomes.

Angelien Steen speaks from a psychological perspective as well. She did research to meaning in life in people with a personality disorder. She wanted to find out about correlations and associations between the personality disorder of people and the *lack* of meaning, which they are often assumed to have.

In advance of the research she wondered: Identity, self-directedness and connectedness are disturbed in people with personality disorder, so it is likely they are more vulnerable in realizing and experiencing meaning in life, but is it also lacking?

The idea that meaning in life is a personality construct supports the possibility the relation between the disorder and meaning in life is not a matter of 'a lack', but factors that obscure the articulation and construction of it. That would draw attention to the importance of narrative therapy.

Mariël Kanne speaks from a critical philosophical perspective. She did research to the meaning and effort of moral case deliberation (MCD) in health care and social care from the perspective of co-creation in good care. hypothese: MCD adds to co-creation of care. The result was no, but it maintained a big interest. What are learning effects? What is a common ground in co-creation and the implementation of MCD?

She did literature study for the theoretical background of MCD and made a conceptual framework containing the concept of ethic care (Tronto), ethic human existence (Ricoeur) and normative 'professionalisering' (Schön e.a.).

The empirical ethics are inspired by Pols.

-there was a focus op intra-normativiteit and questioning norms.

-research in ‘the wild’

-self-reflexivity ethics and epistemology are inseparable

-science is always colored, so should be critical.

Conclusion and discussion: MCD does lead to co-creation, but often ends in: we should talk to clients more. But, maybe when clients are involved in developing good care, research will grow more outcome focused, is said in reflection on the result that MCD did not increase co-creation. This should be taken into account in choosing the research method.

Chaired session 3. Responsibilization from a care ethical perspective, chaired by Dr. Inge van Nistelrooij (University of Humanistic Studies).
This session explored practices of responsibility from a care ethical perspective.

Mr. Drs. Susanne van den Hooff

First of all, mr.drs. Susanne van den Hooff (PhD student and lecturer at Hogeschool InHolland) spoke about ‘Transcending responsibility’. The topic of her contribution was the dynamic process of involuntary admission into long term care of patients suffering from Korsakoff’s syndrome.

Sometimes, deprivation of liberty is necessary for patients suffering from Korsakoff's syndrome. In these cases, the patient does not agree with admission, he presents a danger for himself or others as a consequence of his mental condition. They do not want to receive care, and they don’t acknowledge that they need help. These cases are complex situations. What is the society’s role with respect to these patients, and who is responsible?

The legal professional will argue for the right of self-determination and free will of the patient. But the family has a different view. They feel the need for interference. They feel it is their responsibility to find solutions, and to find the proper care. They have questions like ‘won’t we feel terribly guilty if he dies?’ Thirdly, the healthcare professional also has a different perspective: preventing further damage to the patient. It is the moral obligation to do something about the suffering of the patient and to give proper care. They have to protect the patient from self-destruction and ignoring suffering would be wrong.

As a consequence, all actors look at the dilemma at a different way. How to deal with these different responsibilities and tensions? Van den Hooff’s suggestion is to transcend these responsibilities. So the challenge will be to have a more flexible notion of responsibilities. It is not a fixed notion; professionals need to be more open to the worldview of others, understanding their way of seeing the world and their responsibility. Care could improve if consultations are provided between these different perspectives (legal, medical and personal). It might lead to a smoother process. It won’t be easy, but reach out to each other.

Drs. Susan Brand en Drs. Laura Hoekstra

Brand and Hoekstra reflected on responsibilization in the city of Rotterdam, based on their research on care and support for people with intellectual disabilities. First, Laura Hoekstra told us about her research project.

European welfare states are cutting back their responsibilities for long-term care. Our governance is emphasizing self-reliance. To fall back on your social networks. Also, the municipalities are responsible now, instead of the government.

The Rotterdam Social Support Act focuses on the stimulation of the social cohesion between citizens. They support self-reliance and the participation of citizens. The municipality still protect vulnerable citizens.

The start of the research, beginning in 2011, was the question: what does '*Rotterdammer gericht werken*' mean for people who are chronically ill? How do they cope with the cutting of long-term care?

One of the outcomes, was that a lot of respondents resisted to become more dependent on their social network. They are not seeking alternative help, despite the fact that they do have need for alternative support.

Drs. Susan Brand said she didn't see any of the people for whom the policy was made during her internship. She reflected on Habermas, by experiencing in real life the life world and the system world. With the system world, Habermas meant the economical and administrative standards. According to Kunneman, there is no space for personal meaning in the system world.

Her research question was 'how do WMO-policymakers interpretate the lived experiences of mentally handicapped people?' The mental handicapped group, which was a part of the group for whom the policy was made, is a very vulnerable group. They are kept out. These people cannot speak up for themselves, so how do give these people a voice?

She found that the life world was invisible during her internship. Also, the policymakers expressed limited responsibility for personal lives: it's their own problem. But in the case of mentally handicapped people: can you state that they are fully responsible for themselves? The responsibility felt by the policymakers to the system world, was most important. There was a lack of knowledge the policymakers had about the life-world and there was a lack of 'caring about'. For instance, there was a case of a very lonely woman who was mentally handicapped, but because she didn't cost money, it was not a problem to the policymakers.

So, in the lines of Tronto, the first step is to recognize the need for care. But this was already lacking in the sense that when it doesn't costs us money, there is no problem.

Jeroen van Egmond

Van Egmond reflected on responsibility from a care ethical perspective. From Plato to practice: the ideal world of Plato was perfect, and this is a contrast to the muddy practice we all live in. Practice is messy and complex.

Tronto wrote a definition of care. The first part of her definition is important: 'on the most general level'. So you can talk about care on a lot of levels. This definition is interdisciplinary: you cannot study care from one discipline.
Tronto's definition: *On the most general level we suggest caring be viewed as a species activity that includes everything we do to maintain, continue and repair our "world" so that we can live in it as well as possible. That world includes our bodies, ourselves and our environment, all of which we seek to interweave in a complex, life-sustaining web.* (Tronto, 1993, p. 103).

What have others done for you or had to do so that you could be here today? Care is not just for vulnerable people: we all care for each other. So care doesn't apply to weak and the vulnerable, but to all of us.
People can say 'I care about' or 'I care for'; so everyone is thinking 'I'm caring', and they are all right, but at different levels. So you can be responsible for care, it is not the same as doing the work, but it is still caring. At the same time, making someone responsible, is also making some else vulnerable.

Discussion
Responsibility is a moral thing, but it is also a professional responsibility.
And what about accountability? We could map all these terms. We are talking in nouns, not in verbs. And also, there is a difference between feeling responsible and being responsible. You might not feel responsible, but you can be hold accountable for instance, by law. And what about the notions of the self? Not only the entrepreneurial self, but there are all kinds of perspectives on the self. There is a link between the anthropology and the way you view responsibility. Are you free to decide if you are responsible, or are you already embedded in responsibilities? Kittay has theorized this.

About the first presentation of Mr. Drs. Susanne van den Hooff. Someone in the group asks:
Transcending responsibilities, but how? How can you bring the stakeholders together?
Van den Hooff: it is necessary to get people together early in the process. There needs to be a diagnoses, before there can be court hearings. But they can only be diagnosed, when they are admitted. So that is the problem in this group of patients, so get together early in the process to discuss the responsibilities of each other.

The professional should keep their own responsibility, but also be open to other's view on responsibility. What I like about the term 'transcending responsibility', is that you have to *act*, to do something to get there: dive in the water.

Chaired session 4. Responsibilitation in a changing welfare state – the perspective of people dealing with care dependency on a daily basis. Chaired by prof. Dr. Evelien Tonkens (University of Humanistic studies).

Dignity in a 'participation society': The Effects of Welfare State Reform on Moral Emotions

PhD research project of drs. Jante Schmidt.

How does the transition from welfare state to 'participation society' have an impact on the dignity of care-receivers and care-givers? How do they work on their emotions to preserve their dignity? With the advent of the participation-society – where citizens are expected to take responsibility for their own and each other's well being- it is crucial to understand how people feel about reforms and how their feelings influence their caring capacity. Not only does it have its effects on workload, emotions, relationships and quality of life, which calls for a redefinition on duties and rights between people and state and people among themselves, but we also ask: What is the place of dignity and its consequences in the changing welfare state? In our social system autonomy is deemed very import, is a norm, whereas at the same time there is a change from formal (which suggest: autonomous) to informal care. The research concerns the experiences of the care receivers, the caregivers (family, friends) and (paid and unpaid) careworkers.

Care receivers struggle with shame as a consequence of the stress on both autonomy and reliance on informal care that comes with the turn to the participation society.

The 'new' definition of autonomy seems to be: you can be autonomous from the State, but dependent on family; then you are still autonomous. But: autonomy and care dependency are a paradox; how does one experience independency? Doing everything yourself, with just a little help? The norm of autonomy is relative and situational, it differs per person, so answering tot his norm is subject to constant negotiation. Autonomy feels good, is right (norm); being dependent is shameful, feels wrong. There is a distinction between 'appropriate' and inappropriate dependency. Explicit dependency feels the worst (explicit is: the realization that you need help every day).

There is a difference between informal and formal care: formal care consists of: transport, aiding facilities (i.e. panic button), doctors, institutions; it presumes a certain equality. Whereas informal care implies inequality, a feeling of asking too much, it also creates feelings of guilt and shame because there is no exchange, it is a one-sided dependency. The care receivers experience feelings of shame, which is difficult to handle so they try to avoid this by working on their emotions or the situations so as to preserve their own dignity; in formal situations they do this by empathizing, rationalizing and distracting; in the informal (in equal) situation they manage their needs to adept to the caregiver and they manage the

communication. But in both the formal and the informal care, emotion work is unsuccessful, and experiencing the shame remains painful. From the perspective of the friends and family (caregivers): they struggle with guilt as a consequence of raised expectations (from the State, society); they suddenly get more responsibilities, material and/or immaterial, informality has become the norm, they feel guilt towards the care-receiver that they can't do 'more', and there is pressure: a great expectancy of the informal networks. As for the paid care-workers: they are confronted with a shift to informal care and a concomitant de-professionalization of their job; thus maybe losing pride in their job: first they needed to study to get the job, now lots of tasks get to be carried out by volunteers, or even the whole job is lost to a volunteer! One could ask the question: how can responsibilization attribute to dignity? Or even: does is attribute to dignity?

At the end, Prof. Carlo Leget asked everybody present what their 1 sentence take-home thought would be? Suggestions were: 'it is always you in the end' (remark from Dr. Thomas Biebricher, on the subject of neo-liberalism and the subject as entrepreneur of the self), and: 'how sad that people feel shame when they need to ask for help'.

Day 2 November 5th 2015
Keynote by prof. Dr. Helen Kohlen (philosophisch-theologische Hochschule Vallendar, Germany). Human action as praxis of the unpredictable and its relation to thinking about responsibility.

In this lecture Kohlen provides an insight into Hanna Arendt's life and work; focuses on her understanding of human action (praxis) that will help to analyze current transformations of the health care sector and examine the meaning for our thinking on dependency and responsibility in transforming health care settings. Especially, the work of the care ethicist Annelies van Heijst is highlighted. In conclusion, the sphere of human interaction that should typify health care work Kohlen identifies as an action of an unpredictable praxis in contrast to controllable procedures and techniques that increasingly take place in the health care sector and that have severe consequences for how we view responsibilization in those practices.

The assumption about health care is that it is founded in solid ground. Under the influence of industrialization, economism and growing technologies the 'managed care' of these days arised. It promised efficiency against a waist of unnecessary care. According to the philosophy of Arendt we could see we arrived the modus of 'making'. This modus is reluctant to react on what is typical to human existence, follows from Arendt's thesis about 'the unpredictable of human praxis'. Namely 'pluralism', having no alternative to control.

These ideas are central to her work 'The human condition'. Here in she distinguishes three kinds of work: labor, work and action. There is a hierarchy in this three, since action never evolves from the lowest.

Labor: production and reproduction, cyclish and routined.

Work: is a creative process, focused on permanence and goal. Is about functioning in a process.

Action is the human condition of plurality and creates history, since it is al relational occasion. It finds place without interference of material things. What happens is unpredictable.

Action as praxis is not making, an experiential and multidimensional instant in which thought and action become reunited. It stands for the possibility of something unexpected to happen, to interrupt work and labor.

Transformation of health care practices

Nowadays we can see a reorganization by logic of industrialization. Technologies enforce rationalities of managed care.

The critique of ethicists is that the 'person to person relationships' are undermined by managed care. There is an instrumental rationality that we see in health care, since unpredictable actions/outcomes are out ruled. This asks for prudent care and/or resistance. In the form of:

-a reconsideration of the ways in which unpredictability and uncertainty in health care institutions are managed.

-And the acceptance of responsibility in the process itself.

In conclusion: Arendt placed the disquieting warning that whoever wants to rule out the unpredictable destroys what is really human.

Discussion:

The audience poses that ethics is also captured in the economic (instrumental) logic. How to conquer this strong logic? Kohlen replies, in regard to Arendt, by resistance in community care, on the micro level. But how to conquer the insurance companies? Concerning this we should organize! And how about solutions in other sectors, like education? Or collecting counterstories!

In another contribution to the discussion is said that the problem is not in the character of people who work in management of care of who write policy. The problem is in 'the systems', the way it works. Sometimes the presupposition seems that people in management are 'bad people', but reality is more complex. It is a question of how you relate to 'the' system, taking responsibility for this 'relating' and taking a standpoint. The system is not something 'out there'. Dispositions and the system are intertwined, not irrelative. But the question remains: how do we reject and 'combat' these mechanisms? We should also take into account the balance between the helpfulness of technologies and instrumentalism supported and enforced by technology. With other words, the balance between technology and technologism. In conclusion, trust is very important in relation to let the unpredictable happen. If there is no trust, you will lose trust in human at all. Risk calculations don't encourage trust, since risk management is always focused on controlling, not dealing with

pluralism. However, there is understandably always a certain percentage of risk an organization wants to cover itself for. What is the balance here?

Prof. Dr. Inge van Nistelrooij (University of Humanistic studies)

Van Nistelrooij wants to start by saying that she is a care ethicist and care ethics is not about health care, but it is an ethical perspective, which focuses on care instead of focusing on justice.
She had great difficulty with disapproving the view of Prof. Dr. Kohlen, but she managed to have some critical response.

First of all, what is good care? It is a way of doing. Good, moral good, should be central in moral talk of practices. It is about trying, aiming at the good. It is a way of doing within relationships that is tuned to unique human beings.

About uncertainty: in Dutch, Annelies van Heijst calls it 'ongewisheid'. We are all care givers and care receivers. And care is something which you are never certain about. You try your best, but you never know if you'll reach the good end. You will never know what will be the outcome. Human action is about human interaction.

About the participant's uniqueness: this can only appear through the space created together. You need space to see who is there. If systems decrease the space that we have, then you cannot appear as a unique human being; you cannot see who is there. You cannot appear as a 'who'. According to Van Heijst, there are also acts of expression. And presentation and representation are one. Expressed values are an act of expressing preciousness. Like honoring the dead: they do not know it, but you still do it.

A critical response to prof dr. Kohlen. What do we do when we render people responsible this way? Care ethics pleas for a more discretionary space for caregivers, both professional and informal, that is justified by thinking care as a relational, contextual, situational, affective, political practice. But we also have a risk: we might run the risk of bashing politics, policies and policymakers altogether.
According to Tronto, we need politics in order to avoid several risks. We should take care to the center of political life, because politics should guard quality in unequal relations of care. Politics should guard that we are all dependent, and we are all also capable of making autonomous decisions. It should also guard us to privileged irresponsibility. Some people are able to transfer responsibilities and care to others. All of us have transferred responsibilities to others, but some are able to make sure that they don't have any caring responsibility anymore.

Caring is best envisioned as a series of caring practices, nested within one another. So we talk about nested practices of care. It is nested in a community, and then there is also a society as a whole. You can move back and forth from the community level to the society level.

At the present we still tend to organize our society as a market, where individuals are primarily seen as buyers and sellers. They already have autonomy, we consider ourselves primarily as workers. Also, we have ended up at making caring solely a personal responsibility. In the end, it's up to you.
So if society takes caring as private and personal, caring seems destined to become a too large burden in general and also remain a 'kitchen table'-struggle in order to deal with dependencies, and caring responsibilities of their leisure time. So ultimately, it leads to the incapacities in advanced countries to find enough care workers to meet the needs of people, their children etcetera.

What do we do when we render people responsible, socially? According to Urban Walker (2007), morality is what we do when we work together, it is the outcome of working together. Morality is shown in the way we are doing things, and what we are doing together. The way we understand ourselves, our relationships and the way we value things, are built by looking at practices of responsibility. In the way we practice care, we express what we think about as good care. We can draw a geography of responsibilities; it is a hermeneutic tool to look of what people think about is of value.

These processes have effect upon how people understand themselves, their relationships and their responsibilities. They also create necessary identities, like adult, woman etcetera. These identities are socially salient: not how other people see me, but also, how I see myself.
If we advocate a view of care as unpredictable practice, we run the risk of ignoring the social processes that constitute morality and the underlying cultural expectations to enforce what we see as natural, private and normal.

We run the risk of unjust pressure upon people to deal with dependencies and caring responsibilities as a 'private affair'. We run the risk of increasing pressure on necessary identities. It cannot be defended without a public debate about what kind of society we want; do we want a blame free, risk free caregiving society? Or do we want a society that accepts and includes vulnerability as a basic human condition?

Discussion

Kohlen: Arendt would never have made care a political issue. Not at all, she made a distinction between the private and the political sphere. Something can become political when people come together, and we have to come to a solution together. Care has become such a big issue that we have to turn a social issue to a political issue. We have to come together and get to solutions. This will make it into a political issue.

Van Nistelrooij: Tronto thought, how many mechanisms are working in keeping this in their place. The interrelations between caring responsibilities and at the other hand people with power. Care responsibilities have to do with power.

About the geography of responsibilities: if you imagine one group working in palliative care, and the other in intensive care, there are two totally different cultures. At intensive care there is much more hierarchy for instance. At palliative care it is more organized by values and a more flat hierarchy. It is an example hoe differently it can be organized. Do you organize by position or by shared values? They are all within the system of the hospital, and there is a hierarchy in this as well: palliative care is lower than IC.

A question from the audience: Should we make a guideline for meaningful questions for spiritual counseling and health care institutions in general, in order to make room for these meaningful questions?
Van Nistelrooij: I would like the tension of having something like that, it helps you, but also to keep a distance to that guideline. It is a practice; you do it together, but there is always something to begin with. So a guideline is a start, it is something that you can relate to, something to hold on to, but you also have to have the room to do it differently in your practice.
Kohlen: where came the need to get a guideline? And it is just an instrument, it can stimulate discussion. It is a positive thing when people come together and make *their* guideline, it can be stimulating. But often there are guidelines made to solve problems, which cannot be solved by such a guideline. As Arendt would say: particular questions need particular answers: don't standardize it!

A question from the audience: Can we really debate about the kind of society we want? Is there really a choice? Can we get to a blame free, risk free society? Is there really a chance for that?
Van Nistelrooij: the main reason people choose to put their elderly parents in an institutionalized home, is because we don't want them to get hurt. We want to prevent risks. But we are not worrying about what is good for a person: we just don't want anything to happen to them. But there is one thing certain: things will always happen!