"Practicing care in qualitative organizational research: moral responsibility and legitimacy in a study of immigration management"

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Abstract

Purpose – The purpose of this paper is to provide insight into the reciprocal relations between the caregiving imparted by immigration centre managers and the role of the researcher in responding to the care that is given by managerial caregivers. To enable this, we draw on a feminist theory of care ethics that considers individuals as relationally interdependent.

Design/methodology/approach – The analysis draws on a semi-structured interview study involving 20 Finnish immigration reception centre managers.

Findings – Insight is generated by reflecting on moments of care that arise between research participants and the researcher in a study of immigration centre management. We emphasise the importance of mature care, receptivity and engrossment in building caring relationships with research participants by acknowledging the care they give to others. Our findings draw attention to the moral and epistemological responsibility to practice care in organizational research.

Originality/value – The paper highlights the relationality between practicing care in immigration centre management and doing qualitative organizational research, both of which rely on mature care, receptivity and engrossment in order to meet the other morally. We draw attention to the moral responsibility to care which characterises researcher–researched relationships and emphasise the importance of challenging methodological discourses that problematise or dismiss care in qualitative organizational research.

Keywords Ethics of care, Receptivity, Relationality, Engrossment, Epistemology, Immigration

Paper type Research paper

Introduction

Caring is central to our lives as relational, vulnerable beings and our interactions with others, including those who are most marginalized in society. The issue of migration management brings the politics and ethics of care to the fore through the need to provide care that ensures a disadvantaged group of people's needs are met (Zembylas *et al.*, 2014). Our focus of this paper is on the practice of care in immigration centre management in Finland. Through this, we seek to draw attention to the moral responsibility of qualitative organizational researchers to

practice care, while also acknowledging the gendered nature of caregiving research, and emphasising the need to challenge methodological discourses that problematise or dismiss care as a less rigorous form of research.

Care ethics is associated with feminist scholarship and has its roots in maternal caring and caring relations (Gilligan, 1982; Ruddick, 1980). An ethic of care involves acting "not by a fixed rule but by affection and regard" (Noddings, 2013, p. 24). Thus, the ethics of principle and its universalisability is rejected (Held, 2005). Care ethics have been criticised for promoting a disposition that is easy to sentimentalise and is often relegated to private spheres such as the family. However, some scholars have brought ethics of care into the public domain by arguing that it "builds concern and mutual responsiveness to need on both the personal and the wider social level" (Held, 2005, p. 28). Tronto (1993) argues that care must be understood as a social practice rather than merely a disposition that is easy to privatise and sentimentalise in order to understand the "broader social, moral, and political ramifications of care" (p. 112). Consequently, a growing number of studies focus on social, political and ethical aspects of care in organizational settings (Bond-Taylor, 2017; Williams, 2001), often involving professional social and health service work (Brannelly, 2016; Nortvedt *et al.*, 2011; Pettersen, 2011; Schuchter and Heller, 2018). Of particular relevance here is the ethics of care in responding to immigration, where it has been used to understand ethical dilemmas, bureaucratic dehumanisation and indifference and to provide a counterbalance to macro, socio-political perspectives (Hankivsky, 2014; Porter, 2006; Robinson, 2019). In addition, immigration studies applying care ethics have focused on social and health care work (Ottosdottir and Evans, 2014; Robinson, 2013), voluntary work, asylum seekers and refugees (Darling, 2011; Schmid, 2019).

Our purpose in this paper is to reflect on the relationship between the caregiving that arises in immigration centre management and the role of care in qualitative organizational research. Through this, we seek to demonstrate how caring challenges methodological discourses that promote neutrality and distance (Cassell, 2016; Bell *et al.*, 2017) by emphasising the moral responsibility of researchers to care and to recognize the caring that is done by others. Building on scholarship that draws attention to relationality, reflexivity (Etherington, 2007; Guillemin and Gillam, 2004) and care in research (Caine *et al.*, 2019; Gunzenhauser, 2006; Visse and Niemeijer, 2016), we use the ethics of care to generate methodological as well as empirical insight by showing how shared understandings are generated through empathetic relations between those who care. Specifically, when care is enacted by the researcher, who is the "one-caring", toward the informant who is "cared-for", the researcher is able to "see and feel the other" (Noddings, 2013, p. 30) in ways that enable relational understanding. The ontological relatedness that is generated through care invites a moral epistemological perspective that accounts for the relationship between knowers and moves beyond the duality of the knower and the known (Gunzenhauser, 2006). Crucial to this is the notion of mature care (Gilligan, 1982; Pettersen, 2011, 2012) which enables decisions to be made about whom to care for. This sets limits on when to withdraw from caring, for example when the other does not respond or when caring becomes self-sacrificial (Noddings, 2013).

The article unfolds as follows: first, we review the theory of ethics of care before presenting the empirical context – immigration reception centres in Finland – and describing the methods used in the study. Next, we present our qualitative analysis of immigration managers work which focuses on two interrelated dimensions; first, the care practiced by managers, and second, the role of care in qualitative organizational research. In the discussion, we focus on the relational ontology and moral epistemology that is enabled by an ethic of care. To conclude we reflect on the importance of recognizing and valuing care in qualitative organizational research and challenging methodological discourses which problematise or dismiss it.

Moral responsibility and commitment to caring

> It is this ethical ideal, this realistic picture of ourselves as one-caring, that guides us as we strive to meet the other morally. (Noddings, 2013, p. 5).

Noddings argues that traditional ethical theories are prone to "romantic rationalism" (p. 3) and a commitment to the application of universal principles in moral decision making; this undermines human affect which is central to an ethics of care. Instead she argues that moral justification relies on receptivity, feelings, needs, responsiveness and personal responsibility (Noddings, 2013; Gilligan, 1982; Held, 2005). Consequently, an ethic of care does not begin with moral reasoning but with "the moral attitude and longing for goodness" (Noddings, 2013, p. 2). Thus, caring requires acting "with special regard for the particular person in a concrete situation" (Noddings, 2013, p. 24). This is underpinned by dependence and relationality which makes caring a basic requirement of all societies and communities (Held, 2005). Care is understood as a social practice and a disposition – "we can recognize care when a practice is aimed at maintaining, continuing, or repairing the world" (Tronto, 1993, p. 104).

"Feeling with the other"

Care "implies a reaching out to something other than the self" (Tronto, 1993, p. 102); the focus is on how to meet the other morally (Noddings, 2013). This relies on a person's relationality and interdependency – morally and epistemologically. Caring requires a displacement of interest from our reality to that of others – the needs and desires of others are considered; their reality becomes a possibility to us and we are able to feel it. Thus, care involves "feeling with the other" (Noddings, 2013, p. 30); this becomes a possibility when we are committed to receptivity. It is what Noddings calls "engrossment" where "I do not project; I receive the other into myself, and see and feel with the other" (2013, p. 30). For example, Terkelsen and Larsen (2016) studied professionals working in the psychiatric ward, where fear and aggression are often reported by medical staff as well as patients. They suggest that professionals practice a "ballet-dancer" attitude, a dialogical and diplomatic approach that is preferred over practices of seclusion and restraint. When the staff "put themselves in the patients' shoes" (p. 309), fear, danger and aggression were reduced in the ward. Thus, the humanisation of patient care, by being open to others' needs and realities, forms a common and more empathetic basis for understanding.

Emotions play an integral part in caring. In traditional and rationalistic moral theories, emotions are considered as egoistic feelings, promoting favouritism and aggressive impulses. They are therefore rejected because they are thought to undermine universal principles and interfere with impartiality (e.g. Gilligan, 1982; Held, 2005; Noddings, 2013; Prinz, 2010; Slote, 2010; Solomon, 2003). However, the ethics of care considers sympathy, empathy, sensitivity and responsiveness as moral emotions that "need to be cultivated not only to help in the implementation of the dictates of reason but to better ascertain what morality recommends" (Held, 2005, p. 10). Liedtka (1996) argues that in order for individuals to be caring, organizations must provide an open, supportive and trustful working environment. This ensures they can see and "feel" the other's perspective and are committed to acting on that knowledge. This contrasts with traditional (bureaucratic) organizations that prioritise efficiency and justice.

The ethics of care is criticised for being self-sacrificing, if the one-caring prioritises another's needs over one's own (Grigger, 1997; Hoagland, 1990; Pettersen, 2011, 2012). However, care not only entails responsibility for the cared for but also for the self, as constantly prioritizing others' interests could be understood as avoiding responsibility for one's own deeds (Gilligan, 1982; Noddings, 2013; Pettersen, 2012). It is cautioned that boundless and unconditional caring can place the care giver at risk of burnout and exhaustion (Liedtka, 1996; Pettersen, 2012). Hence care is neither purely altruistic nor purely self-interested (Ferguson, 1984; Gilligan, 1987; Held, 2005; Tronto, 1993). Care is not an

emotional and altruistic attitude of an individual, as compassion, but rather as "a relation in which carer and cared-for share an interest in their mutual well-being" (Held, 2005, p. 35; cf. Pettersen, 2011, 2012). Care is neither a virtue in the same sense as compassion is often understood. The ethics of care is thereby dissociated from virtue ethics which emphasises individual dispositions rather than relationships (Held, 2005; Noddings, 2013).

"I must" as an obligation
Caring involves a commitment to act (Gilligan, 1982; Held, 2005; Noddings, 2013; Tronto, 1993). This denotes a motivational shift in addition to feeling; thus, caring is not only a value and disposition but also a practice (Tronto, 1993). In ethical care, the one who undertakes caregiving, when engrossed by the other, must make a commitment to act. Their motivation to act arises out of concern about, and toward, the welfare and protection of the "cared-for". Consequently, emphasis is placed on "attention, solicitude, and active involvement with others (Ciulla, 2009, p. 3). For Noddings, "natural caring" need not involve morality *per se* as it can be identified as "human condition that we, consciously or unconsciously, perceive as 'good'" and respond to others "as one-caring out of love or natural inclination" (2013, p. 5). However, in order to sustain caring relationships, one must make a moral commitment to the ideal of caring. This ethical ideal is based on an image of the self as one who cares and involves a sense of "I must". "I must" is not an obligation to act, or a duty in a traditional sense, but is accompanied by "I want", which refers to our natural inclination to care – the "impulse to act on behalf of the present other is itself innate" (p. 83) – and be in a caring relationship. Ethical care is needed when the initial "I must" fails. It is realised by relying on ethical ideal of caring via memories of caring and being cared-for (Noddings, 2013). Although, care is not universal in terms of any specific need, it is nevertheless, a "universal aspect of human life" (Tronto, 1993, p. 110).

An ethic of care stresses personal moral responsibility toward individuals and within wider social contexts (Gilligan, 1982; Held, 2005; Noddings, 2013; Tronto, 1993). As Held notes, "the central focus of ethics of care is on the compelling moral salience of attending to and meeting the needs of a particular others for whom we take responsibility" (2005, p. 10). The ethics of care has aroused much discussion, both for and against, the subjectivity and particularity it stresses. It is contrasted with Kantian ethics that stresses universal moral principles, rationality and abstract reasoning and ethics of justice by arguing for autonomy, individuation, and moral choices based on individuals' rights (Gilligan, 1982). Consequently, Gilligan (1987) states that impartiality averts one's ability to imagine oneself in other's position, thus it would be also quite difficult to understand other's perspective.

However, if care is only valued as a disposition that is easily sentimentalised, romanticised, and privatised, and not as a practice, current discriminating social structures in terms of gender, race and class are maintained not challenged. Tronto (1993) calls for care to be situated as a political as well as a moral concept. She argues that power structures inherent in Western society are strengthened as those who are privileged and in a position of power can ignore direct caring responsibilities that are "disproportionally occupied by the relatively powerless in society" (p. 113). Tronto terms this "privileged irresponsibility", where the needs of others are ignored in order to meet one's own. Valuing care as a social practice could possibly challenge current power inequalities by making privileged irresponsibility and devaluation of care visible. Thus, "to treat care as shabby and unimportant helps maintain the positions of the powerful vis-a-vis those who do care for them" (1993, p. 124).

Ethics of care has been used in organisation studies to understand of the relational responsibilities of health care professionals where these values are often undermined through instrumentalising care. Nortvedt *et al.* (2011) suggest that despite the impartiality essential in health care, professionals require scope to practice relational, personal, particularised, rather than purely instrumental, care. This is because the patient–professional relationship has

greater value than care for instrumental medical needs, thus, "in some cases particular circumstances and vulnerabilities represent good reasons for treating patients unequally" (p. 198). As this example illustrates, relational ontology entails that individuals are "motivated and morally addressed by the vulnerability of other persons" (Nortvedt *et al.*, 2011, p. 193) and acknowledges that the moral choices are always embedded in the web of relationships and conflicting demands that call for shared responsibility (Pettersen, 2012). Hence, "interpersonal responsibility is based on a notion of responsibility where justice always entails balancing considerations of care for a particular person in an actual context" (Nortvedt *et al.*, 2011, p. 193; see also Brannelly, 2016; Ottosdottir and Evans, 2014; Pettersen, 2011, 2012). Equality is thereby reframed to mean that everyone is equally worth of respect, consideration and responsiveness to their needs (Liedtka, 1996). In the next section, we explore the ontological and epistemological implications of the ethics of care for organizational research.

Relational responsibilities and care in organizational research

Recently there have been calls for qualitative research that enables reflective, ethico-political awareness by revealing the "vulnerabilities of the researcher and the beauty inherent in the chaos of doing qualitative work" (deGama *et al.*, 2019, p. 3). We suggest that practicing care enables consideration of these vulnerabilities. Noddings (2013) states:

> [a] receptive mode may be both reflexive and reflective; that is, instead of receiving the world or the other, I may receive myself, and I may direct my attention to that which I have already received. (p. 35)

Receptiveness and responsiveness to others' worlds as well as the personal responsibilities of researchers have been the focus of increasing discussion (Brannelly and Boulton, 2017; Caine *et al.*, 2019; Rhodes and Carlsen, 2018; Visse and Niemeijer, 2016; Weems, 2006). Caine and colleagues (2019) state that an ethics of care was "a necessary starting point" for their narrative enquiry, providing a starting point for "some kind of nascent understanding of the other" (p. 4). Visse and Niemeijer (2016) observe that openness to understanding the other and willingness to stay relationally engaged is crucial when fostering a caring praxis – "wherein 'what matters' is determined collaboratively by closely listening to people's perspectives and experiences" (p. 304). Furthermore, in terms of responsibility, Brannelly and Boulton (2017) suggest care and responsibility are intertwined with empowering actions in research as "the ethics of care can be used to understand the origins and implications of the issues, and help to transform practices, develop relationships and evolve to achieve the purpose of decolonization" (p. 348). Thus, they argue for an ethic of care as a theoretical perspective that can guide ethical research practice by helping researchers to address reflective questions about politics and justice.

Bringing subjectivity and relationality into research is argued to be epistemologically and morally necessary by many qualitative researchers (Gunzerhauser, 2006; Brannelly and Boulton, 2017, Rhodes and Carlsen, 2018; Visse and Niemeijer, 2016). Gunzerhauser (2006) argues that "the relation is characterized by particularity; as such, the moral epistemology serves not as a foundation for research but suggests places to begin, such as particular moral commitments" (p. 630). Rhodes and Carlsen (2018) moves beyond research practice that goes beyond relational reflexivity towards "ethical vulnerability" – being thought by the other and unleashing ones' own (researcher's) epistemic authority. Such "generous reciprocity" is based on "the ethos and practice of an ethical primacy of turning to the other with openness and vulnerability" (p. 1306) with no expectation of an equal exchange. In other words, it requires radical openness and affective sensibility to another, wondering together and being responsive and engaging in interaction with another (Rhodes and Carlsen, 2018). Pettersen

(2011) argues that the moral ontology of care ethics, where "moral agents are envisioned as related, interconnected, mutually dependent, and often unequal in power and resources" (p. 55), and moral epistemology, embeds self-reflection and sensitive contextual judgment.

As a relational process, care relies on the participation of the carer and the cared for. It places emphasis on care for oneself as well as for others as the "interest of not being harmed and being able to flourish should count equally for all relevant parties" (Pettersen, 2011, p. 56; Nortvedt *et al.*, 2011). Pettersen (2011, 2012) terms this *mature care*. Relational ontology and reciprocity play a prominent role in mature care, as opposed to an individualistic ontology that has a mono-directional, altruistic or non-conditional understanding of care. Mature care can enable more equal interpersonal, including research, relationships through providing a means to navigate between self-sacrifice and self-interest by avoiding reducing the carer to submissive giver, or the cared for, to passive receiver (Pettersen, 2012). This paves the way for a novel understanding of what care involves, both theoretically and practically, in organizational research. But first, in the next section the research context is presented.

Research context
Between 2015 and 2016, the number of immigration reception centres for asylum seekers in Finland increased by approximately 200 (147 for adults and families; 80 for children, see Finnish Immigration Service, 2017a). This was due to a rapid increase in asylum seekers entering the country, from a steady state of 3–4,000 per year (for the last 10 years), to nearly 32,500 in 2015 (Finnish Immigration Service, 2017b). In response, the Finnish Immigration Service tightened practices and interpretation of asylum policy (Saarikkomäki *et al.*, 2018), for example by no longer considering asylum seekers' fear of violence in their home country as a legitimate reason for international protections as it used to be. Since 2015, the number of negative decisions has increased and so has the number of asylum seekers who stay in Finland illegally when refusing to voluntarily return to their home country or unable to be deported forcibly.

The "Act on the Reception of Persons Seeking International Protection" (746/2011) dictates the reception services available to asylum seekers while their applications are being processed in Finland. Services include housing, social and health care, food or cooking facilities, legal aid, interpretation services, reception allowance, work resources and Finnish language courses. Centres employ nurse(s), social worker(s), instructors who advise clients on daily issues, financial and administrative staff, overseen by a manager and/or assistant manager. These services are provided by reception centres, funded by the government and operated by the state, non-profit organizations or private organizations. The Finnish Immigration Service, under the Ministry of Interior, mandates the operation of the reception centres.

Reception centre managers, usually responsible for only one reception centre, or area managers controlling numerous reception centres, have overall managerial responsibilities including for human resource management. Centre managers are also service managers and civil servants in a sense that they can, for instance, prolong the time of the reception services to a certain extent if a client's condition is such that their life could be at stake without essential services, such as to address health issues.

Caring methodologies?
The methodological approach taken here is critical of positivist ontological, epistemological and methodological discourses that attempt to uncouple science from philosophy, as well as "to reduce knowledge to that produced by science; and to reduce science to systematic procedures and protocols, mechanistic technique, statistical manipulation, and causal

structures" (St. Pierre, 2013, p. 520). Such research discourses encourage binary oppositions, for example, between self and other, subject and object, and knower and known which an ethic of care discourages.

The semi-structured interview study involved a total of 20 immigration centre managers, assistant managers or area managers (7 females and 13 males) working across 20 reception centres in Finland [1]. A purposeful sampling strategy was applied, focusing on immigration reception centre managers because of the recent controversy surrounding immigration and asylum seeking in Finland. By this we refer to agitated situation in Finland in 2015 as reception centres faced resistance, for example, from anti-immigration protesters [2], and crisis like situation as government needed to act rapidly to cope with increased number of entering asylum seekers (e.g. border control, accommodation for asylum seekers, renewing asylum procedures). This provided the sample for a study of management practices and professional ethics (Patton 2002; Yin 2011). The first named author began by contacting potential participants by calling reception centre offices and asking for the managers' contact details since they were not publicly available. In addition, participants were contacted through snowball sampling, asking existing participants to suggest colleagues who may be willing to participate in the study. Managers who agreed to participate were sent a follow-up email with a brief explanation of the study and a consent form. They were also asked in advance to think about any ethical dilemmas they have encountered in their managerial role. Participants were given a choice between face-to-face, Skype or phone interviewing.

Questions were based on predetermined topics, at the same time allowing the interviewer to spontaneously rephrase questions, creating room for discussion and encouraging interviewees to elaborate on their accounts. This enabled interviewees' perspectives and experiences to emerge and their voices to be heard (Patton 2002; Elliott and Timulak 2005). Interviews were carried out by the first author and included the following topics: (1) background information; (2) general questions (e.g. the way of recruitment and satisfaction with the work; (3) an ethical dilemma situation(s) which included specific questions on; (a) the situation (e.g. what happened, why, when and who was involved?); (b) the outcome and its consequences (e.g. feelings and reactions); (c) the reflections (e.g. could there be any other way to act). Participants' average age was 44 years (31–62 years). Their management experience in reception centres varied from 0.5 to 12 years (3 years and 8 months on average). Their average working experience in the context of the immigration was slightly more than 10 years (0–32 years). Their educational background was diverse for example, nursing, social, military and political and administrative sciences.

Interviews were conducted in Finnish and constituted a total of 19 hours and 15 minutes of audio recording. Interviews lasted 58 minutes on average and reflective notes were taken about the interview process. Interviews were transcribed verbatim producing 252 pages of text. The first author read the transcripts multiple times to get a sense of moral issues and ethical dilemmas. Interviews were analysed thematically to enable recognition of patterns; themes were identified based on recurring words and issues discussed in the interviews (Patton 2002; Marshall and Rossman 2006). St. Pierre (2013) argues that "words... become data only when theory acknowledges them as data" (2013, p. 515). Consequently, the researcher has to first recognise the theory or theories that enable participants' words in interviews and only then theorised words that reflect lived experiences can be theorised (see also Harding, 2018, p. 147). Thus, we consider interviews as "already interpreted data we must explain" (2013, p. 515). Participants' quotes were eventually translated from Finnish into English. While translating the data we took into consideration the problematic nature of this task (Xian, 2008). The first author as the translator, acted as "an inter-cultural communicator" (p. 240) who engaged in social and cultural sense-making, seeking to remain cautious while also taking personal responsibility in reporting the "stories [in] as original [a way] as possible" (p. 237). By discussing the data with co-authors, and keeping notes based on

these discussions, she was able to reflect upon her interactions with participants in more depth. In the section that follows we present our findings.

Care in immigration centre management

Immigration centre managers' ethical struggles are related to wider political context of immigration and recent legislative changes in systems and procedures and mainly concerned asylum seekers' social and procedural (in)justice. Held (2005) argues that without care, there is no life, thus "care seems the most basic moral value" compared to justice (Held, 2005, p. 71). In interpersonal relations, justice entails balancing (conflicting) demands of care for a particular person in a particular context (Nortvedt *et al.*, 2011; Pettersen, 2011, 2012). In relation to receptiveness, managers display concern about asylum seekers' well-being. Regarding personal responsibility, they emphasized their limited power to care to the extent they considered reasonable, thus, their care focused on aspects they could influence. They acknowledged the needs of recipients, were engrossed by them and often felt personal responsibility for their well-being (Nortvedt *et al.*, 2011; Simola, 2015; Terkelsen and Larsen, 2016). The context in which immigration centre managers operate is highly bureaucratic, which means care cannot always be realised to the extent that managers desire. This causes them "ethical distress" on the one hand, and frustration and indignation on the other (see Ottosdottir and Evans, 2014; Robinson, 2013). Noddings (2013) states that blind obedience to rules tends to reduce individual responsibility and one's ability to reflect on decision-making situations. Caring means that people "cannot seek ethical shelter in the arms of an institution and its lofty principles" (2013, p. 117). Ferguson (1984) argues that "[b]ureaucratic capitalism separates us from others without freeing us, resulting in isolation rather than autonomy" (p. 157).

Managerial accounts of ethically challenging situations were often related to the wider political context of immigration, including recent legislative changes in systems and procedures that were seen by interviewees as a source of social and procedural (in)justice. Immigration law in Finland changed in 2015, a temporary residence permit for humanitarian reasons (humanitarian protection) was abolished and thus asylum seekers were under greater threat of deportation. There was a sense among managers that at times the law was quite strict and inadequate, thus incapable of humanitarian treatment of asylum seekers. Often compassion and concern were aroused when managers faced a situation where the reception services had to be terminated after asylum seekers were declined a residence permit. For example, one manager noted:

> When you see the clients daily, the relationship gets kind of deeper. Additionally, you realize the humanitarian sides... and then the relationship develops, and of course in that way also [becomes more] compassion[ate] and understanding. [Daniel]

Another manager describes a case affected by these changes in an embodied way as "a great spike in the flesh", expressing her anger and frustration by stating, "the bureaucracy circulates this one little human being in its machinery... I am angry with this system... It is a great injustice and a tragedy the whole case!" [Annabel]. This is consistent with the notion that emotions play an integral part in care. For example, Held (2005) notes that feelings of moral indignation are valued in the ethics of care because they enable recognition of injustice and inhumanity. Empathetic feelings are also important in care ethics and relational work in general. As one manager stated, "you cannot do any human relation work cold heartedly so of course emotions have their role in the game" [Oliver].

Although managers sympathised with and were concerned about asylum seekers/clients, they could not practice care as much as they desired, due to their limited ability to influence asylum decisions, as one manager pointed out: "we do not have... power to say anything (on

the asylum decisions). And knowledge just brings agony with it" [Oliver]. Ethically challenging situations sometimes generated feelings of failure:

It feels a bit helpless and difficult. And then you kind of wish that this individual case could get solved... And then he says that Finland has destroyed his life... I know him and he often appeals to me for help, and of course I have done everything I could have. [Annabel]

Within an ethic of care, affective engrossment is not enough. There must be a moral attitude and commitment to act, which carries with it a connotation of obligation, "I must" (Noddings, 2013, p. 82). Motivation to act arises out of concern, and the one caring is ready to act toward the welfare and protection of the one to be cared for (Gilligan, 1982; Held, 2005; Noddings, 2013; Tronto, 1993). The source of obligation is the value placed on the relatedness of caring and the value that arises from the "reflection on the goodness of these concrete caring situations" (Noddings, 2013, p. 84). Personal responsibility and commitment to act were illustrative in the example below:

Objectiveness is a kind of challenge because I think it is not equalizing. We cannot treat everyone in the same way, even though, we have common rules. Well law is of course the law, there are instructions and procedures, and they all are made to be broken, from my point of view, at that moment when there is a unique case or a state of emergency... We are not living in a bubble. [Oliver]

Oliver's comment, highlights the importance of challenging objectivist assumptions which position care as illegitimate in the context of immigration and in political discourse in general. As Tronto (2013) suggests, "making care into a political concern will improve not only the quality of care, but also the quality of democratic life" (Tronto, 2013, p. 10). Tronto's assertion draws attention to the importance of "caring with". This final phase of care "requires that caring needs and the ways in which they are met need to be consistent with democratic commitments to justice, equality, and freedom for all." (Tronto, 2013, p. 23). We return to this point in the discussion. But first, the next section considers how care is enacted in research and the struggles encountered in seeking to practice caring research.

Moments of care in organizational research

An ethic of care is about how we meet the other morally (Held, 2005; Noddings, 2013). The focus is on receptivity and responsiveness. This requires engrossment in those to be cared for, and when engrossed, the one who cares becomes receptive to another's needs and concerns. Their reality becomes a possibility for us, and we "feel with the other" (Noddings, 2013, p. 30). An ethic of care encourages the development of more reciprocal relations between researchers and participants by drawing attention to the "the first and unending obligation" of the researcher as the "one-caring... to meet the other" (Noddings, 2013, p. 17). Research conducted in this receptive mode means that the other cannot be considered as an object, instead "the relation between the researcher and the participant is characterised by particularity, mutual critique, and tentative understanding" (Gunzenhauser, 2006, p. 630). The need to approach research participants in a receptive, tentative mode was heightened by the sensitivity of the topic of this study. However, it was not until after conducting the interviews that the researcher was able to fully reflect on the role of care in research interviews. This was enabled by the first author keeping reflective notes about the interviews and discussing them with co-authors. The following extract from the researcher's notes illustrates the nature of this reflective process:

As I described the interview situations, including the sensitivity of the subject area I was studying and the impressions I gained of managers' care for clients, we began to reflect on the care (openness and vulnerability) that these situations required of me as a researcher, as the one-caring, in order to try to meet the other.

When in a receiving mode, analysing and planning are set aside (Noddings, 2013). In such situations the researcher tries to remain engaged with, and receptive to, another's needs and experiences by imagining their world "within the perspectival limits of one's own consciousness" (Rhodes and Carlsen, 2018, p. 1035). Following Rhodes and Carlsen (2018), it is important to meet the other (participant) with ethical vulnerability, thus, combining it with mature care which recognises that the carer should have as much care for oneself as for others (Gilligan, 1982; Pettersen, 2011, 2012). This helps to prevent caring from becoming self-sacrificial which potentially leads to emotional exhaustion and compassion fatigue. As Noddings (2013, p. 86) states, "[o]ur obligation is limited and delimited by relation. . . We are not obliged to summon "I must" if there is no possibility of completion in the other". Mature care ensures that relationship does not evolve as paternalistic or exploitative toward the participant. In a caring relationship between researcher as "one-caring" and participant as "cared-for", it is assumed that caring fosters personal growth and flourishing (e.g. Gilligan, 1982; Noddings, 2013), as the example below illustrates:

> Phil: It was pretty nice to go through this case with an outsider this way. This was one way to think about and rehearse these things again.
>
> Researcher: Yes, the things you have had to think about and go through seem quite challenging, so maybe it is good to go through and talk about these aloud.
>
> Phil: Yes, it is. And for many of our clients, it seems to be a matter of life and death.

Caring may be considered therapeutic to the other. In such situations, reciprocity is not economical but generous (Rhodes and Carlson, 2018); much depends on the trust developed in the relationship. The vulnerability that comes from openness to another's world potentially enhances co-creation of meaning, which in turn relies on mutual trust (cf. Noddings, 2013; Rhodes and Carlson, 2018). An ethic of care thereby challenges the conventional epistemological position of objectivity. Instead "the values of trust, solidarity, mutual concern, and empathetic responsiveness have priority; in practices of care, relationships are cultivated, needs are responded to, and sensitivity is demonstrated" (Held, 2005, pp. 15–16). Phil's comments above are indicative of a moment of caring in the research process, characterised by trust and openness, both subjects demonstrating a degree of vulnerability (a risk of being hurt). Caring done by the manager towards the cared-for (asylum seekers) was made visible through Phil's depiction of the ethical challenge he encountered as being a "matter of life and death". The research interview gave him an opportunity to reflect on his role as the one caring with an outsider. However, receiving the other is not always successful, as the other does not necessarily respond to care:

> I also realised that in situations where managers did not perceive there to be ethical challenges associated with their work, it was more difficult for me to meet them morally or with caring attitude, although initially committed to it. I felt that as they denied any ethical aspects specific situations would potentially entail, there was no room for any further discussion about ethics. In these instances, I felt that they were telling me that they were not in need of caring and thus I was not given an opportunity to care. [Research notes]

Phil's comment drew us to Tronto's (1993) notion of power inequalities and the concept of "privileged irresponsibility". It reveals how managers who did not recognise caring as a value and denied their own care also devalued its practice by others. Instead "neediness [was] conceived as a threat to autonomy" making individuals less powerful and capable "others" (Tronto, 1993, p. 120). Such a privileged position has implications for the care that is provided to others, as highlighted by the following exchange:

> Researcher: As reception services end and [the] client is informed about this, have these cases been personally challenging for you?

Samuel: Well no. . . They are basic duties and belong to this job. . . Every job has negative sides and if you cannot handle them, I recommend searching for a job that does not include such negative sides. . . When the law states that the services end, then they will end. It is client's own choice. . . like if she/he would voluntarily return to her/his home country, we would be supporting him/her. . . So these cases do not give me sleepless nights.

Researcher: I do not think I have any further questions. . . It seems you are not emotionally burdened like sometimes ethical challenges might remain in thoughts. . . but in your case I guess rules and instructions are unambiguous and do not include personal pondering that much.

Samuel: Not in my case at least. . . I run this centre according to the law and rules we have here and what Finnish Immigration Service requires from us. There is nothing ethically (demanding).

The example below, contrary to the one above, depicts the transformation from the knower–known relationship to two knowing subjects where "both participants in the relation communicate their necessarily partial views" (Gunzenhauser, 2006, p. 630). By accepting and recognising the need for care the researcher and participant create possibilities for new understanding to emerge. As the encounter involves caring, caring for others is enabled, which may lead to more empathetic understanding in general.

Researcher: Was it in France where the burqa was banned for Muslim women? So as a Finn and a Western woman. . . Well the purpose of this interview is not to bring up my own opinions in any way but. . .

Elliot: Well what if it interests me, like can you make an exception to this? [It is] unlikely [that] you [will] transcribe your own. . . [speech in] your thesis and report.

Researcher: Well I try to understand the other side and respect their religion. . . it might be extremely uncomfortable for them [migrants] and might cause personal problems [if wearing is banned].

Elliot: Yes, that is exactly the point, integration or indoctrination. . . where the boundary lies. That is exactly what I ponder myself. . . (If) the women feel threatened when not wearing it, then the system should ensure that wearing burqa is an individual's own decision. Based on what "isms" and ideologies are we ready to limit individual freedom? Traditionally it has been the notion of security. . . it would nice to know the statistics on crimes resolved due to that ban in France.

The above discussion illustrates a moment where the situatedness of the researcher's knowledge and lived experience as a white Western woman is acknowledged, as she tentatively explores the problematics of making generalisations about all women and especially their oppression (Mohanty, 1991). The researcher was asked by Elliot to "reveal her hand" (Watson, 1994), by expressing her own views about wearing the burqa. At his invitation, she gave up her stance of assumed objectivity and instead sought to inhabit a more relational and reciprocal approach to knowing. Segarra and Prasad (2018) call for a reassessment of "conventional demarcations between ontology and epistemology" (p. 546) and argue that "knowledge – and, by extension, theorizing – is an outcome of lived and embodied experiences" (p. 547), thus theorising is informed by corporeality. Reflections between the co-authors after the fieldwork further identified engrossment. Yet feeling with the other who is cared for is a persistent source of tension as well as insight for the researcher, as the following research fieldnote reflecting on the above exchange illustrates:

The more I imagined being in [Elliot's] shoes, the more I could imagine his challenges. So I took a risk and allowed myself to become vulnerable in relation to his caring, as I felt that without this there could be no connection and possibility of deeper understanding. But in trying to receive the other in a similar way to how they had received me I felt that I lost my objectivity by revealing my personal thoughts.

Traditionally "good" research is viewed as planned, controlled, neutral and straightforward (deGama *et al.*, 2019, p. 4). Practicing care throughout the research process is antithetical to such a stance as the researcher tries to retain an openness to wonder (Bell *et al.*, 2020) by engaging in reciprocal relationships. Although in this case the researcher was committed to a feminist ethics of care, she nevertheless fell back on dominant methodological discourses that tend to equate professionalism, detachment and lack of care, with higher research quality (Cassell, 2016; Bell *et al.*, 2017). As trust was developed in these research encounters, a space for care was created where the participant and the researcher were able to engage in mutual caregiving and care-receiving.

This example illustrates the shift from objectivity/impartiality to subjectivity/partiality that is enabled by treating research as an encounter that enables reciprocal caring relations. Such encounters involve operating in "intuitive and receptive mode that is somewhat more mysterious, internal, and non-consequential (Noddings, 2013, p, 7). Within this, "the cognitive aspect of the carer's attitude is receptive-intuitive rather than objective-analytic" (Held, 2005, p. 31). The researcher and participant form a relationship as two knowing subjects, as collaborative partners who share understanding and try to minimise disparities of power, rather than reinforce distinctions between knower and known (Brannelly and Boulton, 2017; Caine *et al.*, 2019; Rhodes and Carlsen, 2018; Tronto, 1993; Visse and Niemeijer, 2016; Weems, 2006). Privilege, paternalism, and "otherness" are recognized and worked with (Tronto, 1993). Caring research represents an epistemological shift towards an enhanced subjectivity that rejects value neutrality. It reflects a moral epistemology based on particularity as a moral commitment that leads to tentative understanding (Gunzenhauser, 2006; Harding, 2018; Rhodes and Carlsen, 2018).

Discussion: doing caring research
The empirical aim of this study was to explore how immigration centre managers practice care through their work and to consider the ethical implications of this practice. Through this, we have explored the relational care practiced by researchers and participants when studying care in organizations. The methodological reflections presented here highlight the relational interdependence between studying care in organizations and practicing an organizational ethics of care. This relies on the first author's epistemological shift away from seeing herself as "the knower" and the managers she was studying as a subject to be "known" and towards an encounter between "two knowing subjects" (Gunzenhauser, 2006, p. 627), both of whom were engaged in efforts to enact ethical care through their work. Consequently, we suggest that the care practiced by research participants, in this case immigration centre managers, cannot be understood independently of the care involved in doing organizational research. Care is relationally generated through the practice of research participants who care about the researcher, in addition to the researcher as the one who cares for participants. It is characterised by a mature care which advocates the equal worth of all relevant parties (Gilligan, 1982; Pettersen 2011, 2012) and by ethical vulnerability and generous reciprocity (Rhodes and Carlsen, 2018). Mature care entails caring for oneself as well as for others which avoids reducing the carer to submissive giver (self-sacrifice/altruism), or the cared for to a passive receiver (paternalism/exploitation).

Caring involves adopting an attitude that is "receptive-intuitive rather than objective-analytic" (Held, 2005, p. 31). The importance of caring in research stems from the notion that detachment, whether from the self or others, is epistemologically as well as morally problematic. Epistemologically, without care it is difficult, if not impossible, to see the other's world or imagine oneself in another's position. Ethically, the denial and abnegation of caring responsibility encourages indifference and moral blindness. Relations between researchers and participants are thus "simultaneously epistemological and ethical... the quality of

qualitative research is based on the quality of relations developed" (Gunzenhauser, 2006, p. 622). For qualitative researchers, the "specific internal process whereby the [qualitative] scientist "knows" cannot be laid out for inspection" because the process of knowing about phenomena extends beyond method and encompasses intuition, creativity or even "magic" (May, 1994, p. 13). In qualitative organizational research, research agendas are not imposed and controlled by the researcher beforehand. This creates spaces for more reciprocal relationships that explore "ambiguities, oddities and subject areas deemed interesting for exploration by both parties" (Rhodes and Carlsen, 2018, p. 1309, see also Holck, 2018; Yeo and Dopson, 2018).

Qualitative research can also create sites of enchantment which arise through the creation of opportunities for moments of novelty or disruption, deep, meaningful attachments to things studied and possibilities for embodied, affective encounters (Bell *et al.*, 2020). An axiological purpose arises from this that is related to care ethics through the "presumptive generosity" that arises from being open to encounters with others and understanding research as a relational process of knowing.

These findings draw attention to the role of care in knowing, as the outcome of empathetic, embodied, relational encounters. Following Code (1995), Gunzenhauser (2006, p. 628) suggests "the researcher as a carer needs to know about the researched to be able to care about them legitimately… [because] care fails without the grounding in the subjective experience of those who are cared for". While the researcher is more likely to be positioned as the one giving, the researcher and participants "both contribute knowledge" (Gunzenhauser, 2006, p. 630) and generate tentative understandings through their relational encounters with one another. This gives rise to a "commitment of knowing to care" (Gunzenhauser, 2006), an embodied process which exposes the researcher's own vulnerability and need for care through the relational ethic of caring.

Our findings also have implications related to the choices that researchers make about who they care for. This includes making decisions about organizational contexts and activities that justify caregiving, such as those that seek to address inequalities and challenge exploitation and oppression – immigration management providing one example. Researchers must also make judgements based on the responsiveness of the other to care (Noddings, 2013). However, care is both a disposition and a practice that "rests upon judgments that extend far beyond personal awareness" (Tronto, 1993, p. 137). Such judgments "require an assessment of needs in a social and political, as well as a personal, context" (Tronto, 1993, p. 137). Shifting attention towards care alters the ethical purpose of research, away from avoidance of harm and towards practices that foster affection and regard for people and contexts (Bell and Bryman 2007; Bell and Kothiyal, 2018). Tronto (1993) argues that all four phases of care – caring about (recognition), taking care of (assuming responsibility), caregiving (meeting the needs) and care-receiving (responding to caring) – need to be fulfilled in "an integrated, well-accomplished, act of care" (p. 109). Our aim in this paper has been to show how care can be practiced in specific moments during research encounters between two knowers. The epistemological shift from knower/known to two knowers is a continuous balancing act between one's own needs and the needs of others – awareness and indifference, openness and closeness and boldness and insecurity. Although ideally the four phases of care are seamlessly interconnected, "in reality there is likely to be conflict within each of these phases, and between them" (Tronto, 1993, p. 109). Despite the challenges of caring, we suggest that this can enable greater depth of understanding, if both knowers recognize and are committed to caring.

In her later work, Tronto (2013) added a fifth and final phase of care, "caring with", which requires that caring is consistent with democratic commitments to justice, equality and freedom. This necessitates that moral qualities such as "plurality, communication, trust and respect" (p. 35) are used to ensure collective responsibility is taken and to consider citizens in a

democratic caring society, as care receivers and caregivers. The solidarity engendered by "caring with" assumes, not only that individual caring needs differ, but also that they change over time.

It is conventionally assumed, such as in ethnographic research, that researchers develop deeper, more trusting relationships with participants when the time span is longer, compared to single, short encounters. However, in this paper we have sought to draw attention to the possibility for caring relationships during shorter research encounters. This possibility arises from "caring with", as care is thereby situated as a societal and political concern – "within democratic care, politics will be closer to the concerns of the people, and, in this way, more fundamentally democratic" (Tronto, 2013, p. 44).

Caring is affected by power relations in research. For example, when studying corporate elites in international firms, Welch *et al.* (2002) draw attention to power imbalances which favour the informant rather than the researcher. They describe how the data collection process changes when these, typically older male, informants are interviewed, as they attempt to dominate the interview and challenge the (younger female) researchers' statements and views. In such situations, the researcher is at risk of being patronised particularly if a gender difference is also present (McDowell, 1998; Peticca-Harris *et al.*, 2016). As a result, researchers may "display a form of 'hostage syndrome' by suspending their judgment in the face of an elite's display of power" (Welch *et al.*, 2002, p. 615). Peticca-Harris *et al.* (2016) also note the struggle between sacrificing the self in order to maintain good relationships with informants to prove themselves worthy of inclusion in their social world and being self-interested by prioritising their research progress. In such situations, mature care is necessary for the researcher to be able to navigate between self-sacrifice and self-interest and avoid becoming a submissive giver or passive receiver (Pettersen, 2012). The potential of caring research is thus limited unless it acknowledges and challenges "privileged irresponsibility" (Tronto, 1993) amongst groups of researchers, especially when these practices are "bound up with gender and other forms of social inequality" (Zembylas *et al.*, 2014, p. 211).

Conclusion

Our purpose in this paper was to reflect on the relationship between the caregiving that arises in immigration centre management and the role of care in qualitative research. The ethics of care is characterised by relational responsibilities. The relational ontology and moral epistemology of care ethics in immigration reception centre management makes visible the shared responsibility of care which is formed and maintained by an ethical stance that is both relational and responsive to others' needs. This stance is reciprocally generated through communication, dialog and openness to encounters with others.

Using this empirical focus as an illustrative context, we have argued that care enables research to be understood as a relational encounter between two knowers, which is enabled by engrossment, receptiveness and responsiveness. We suggest that care not only involves generous reciprocity (Rhodes and Carlsen, 2018) between two knowers, but also mature care (Pettersen, 2011, 2012) as a means of determining whom to care for. Mature care has also implications in qualitative organizational research that seeks to address inequalities, oppression, and exploitation between knowers where power relations are unequal. We have argued that the process of knowing about care is relational and reciprocally generated. As an embodied process, it celebrates intuitiveness, vulnerability and openness and thereby challenges the conventional methodological discourses that promote neutrality (Cassell, 2016; Bell *et al.*, 2017). Caring knowing emphasises the moral responsibility of researchers to notice needs, recognize caring practices and be responsive to vulnerabilities and inequalities in order to practice care themselves. Through this we have sought to show how different

understandings between knowing subjects can be enabled through relational care ethics. Within this process, knowers become partners who make sense of socially constructed reality together and potentially reinvent themselves through critical self-reflection.

Finally, through care, the ethical purpose of research shifts away from avoidance of harm and towards caring practices that foster affection and regard that enable morally justified caring actions and have the potential to achieve positive moral outcomes in management and organizational research. As Mir (2018, p. 306) notes, the "stigma of illegitimacy" which accompanies qualitative researchers is bound up with patriarchy and this has resulted in qualitative research being feminized. Consequently, we may anticipate attempts to trivialise and marginalise the caring practices of qualitative researchers as insufficiently "rigorous" in a context where methodological discourses of positivist organizational science remain dominant (Cassell, 2016; Bell *et al.*, 2017). Promoting awareness of the moral and epistemological legitimacy of caring research is therefore crucial. Hence, we have argued that researchers need to reflexively notice care and their care-based responsibilities and to guard against learned positivist tendencies to denigrate or deny care [3].

Notes

1. The number of reception centres for adults and families at the time of the study (January 2017 to September 2019) ranged from 38 to 79. This variation was due in part to the fluctuating number of asylum seekers entering Finland (5,657 asylum seekers in 2016, see Finnish Immigration Service, 2017b).

2. BBC News. (2015), "Migrant crisis: Finland protesters throw fireworks at buses", Available at: https://bbc.in/30I1ANm (accessed 8 October 2020).

3. We would like to thank one of the reviewers for encouraging us to further develop and emphasize this point.

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