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Care Sociology: Its Origin and Scope

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Abstract

Sociology as an academic discipline studies scientifically the social events, social structures, relationships, institutions, etc. Within this disciplinary aspect, care sociology deals with the science of social actions as well as the socio-psychological matters within the existing economic institutional marketized forms with certain historical-cultural roots. Sociologists may train the carers who do caring work. A carer can make the distinction between moral and ethical choices where the care sociology places itself with an identity of a branch of knowledge for the practising sociologist.

This paper takes the trouble to search the contributors of care sociology first, and then wants to understand the empirical dimensions of it in contemporary research fields. The analytical portion adds a new path of realization on the social implications of caregiving habitus construction in everyday life. The concluding part contemplates an applied voice of care sociology.

Keywords: Care studies, practising sociology, domestication of carer, unseen work, ethic of care, caring profession, welfare policy, etc.

Introduction

The term sociology has two stems - the Latin *socius* (companion) and the Greek *logos* (study of) - and thus, literally it means a methodical study of the processes of companionship. From this etymological meaning, sociology may be defined as the study of the bases of social membership. It is the analysis of the structure of social relationships as constituted by social interaction. But more technically, no definition is entirely satisfactory because of the diversity of perspectives which is characteristic of this modern discipline.

Auguste Comte, the founding father of sociology, represents a French radical relativism that absolutizes relativity as a principle which makes all previous ideas and systems a result of historical conditions. It is undeniable that sociology encompasses a dazzling collection of ideas and methods and points of interest, and it is undoubtedly true that no theory can explain everything. It is futile, even probable presumptuous, to look for a "grand narrative" that explains everything in one fell swoop. It is old-fashioned, rigid, and overly modernist. Instead, it defines a core view of constructed reality on which sociological practice of all kinds is based, consciously or not, and provides a touchstone for what it means to do with sociology.

Sociology in practice deals with care sociology for its ample scope of applied side. In social policy or in service, care is an enduring and contested issue. Care sociology perceives interest in different forms of collective action through which people both support each other and seek to shape policies and services for people. For example, feminists amongst care sociologists have suggested that women are traditionally governed by the informal controls of domestic use and that female crime is typically a product of the erosion of informal social regulation, when young girls are placed in institutional care. Thus, care sociology draws attention to "the social regulation of the body, especially the way in which social institutions regulate, control, monitor, and use bodies" (Nettleton, 2009: 48).

Although it cannot be the role of an academic sub-discipline such as care sociology to be prescriptive on alternatives, it can offer ideas and ways of thinking about problems to help clarifying such thinking. Moreover, while debates on applied side continue, everyday discourse remains suffused with the language and images of care. Sociologists are concerned about care professions, "the role of professionals in society" and try to analyse the "professionalizing strategies" about care morals, ethics and values (Abbott and Meerabeau, 1998:1). Capability with expertise knowledge make care sociology professionals. Care sociologists, in caregiving reality, know the points of interconnectedness between the care givers and the care receivers. The sociology of care studies finds its practising ways into almost every aspect of receivers' life.

What may be a problem for an individual or a group may not be felt in the same way by others, as Mills observes, 'we cannot very well state any problem until we know whose problem it is' (Mills, 2000: 76). Care sociologist can connect

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the micro actions with macro spaces. She/he knows that the care is necessary not only for individual well-being, but also for social justice. This is the point from which we can shed a light from the sociology of care to the 'sociology of death'. Indeed, this is an attempt to 'carve out … another new specialism' within sociology (Mellor, 1992: 12).

Historical Path: What the Founders Said?

Although care and care work have always formed a theme of fundamental social significance, neither has had much social recognition nor sociological attention commensurate with this importance. Care is delivered and it reduces confusion, tension and despair. So there is an important point: in what way this delivery is being selected? This is obviously a point of sociological research.

Aiming to improve awareness and recognition of the existential and practical challenges of caregiving practices, the methodological tools from sociology make both practical and theoretical contributions. While it is written primarily for sociologists, it will be accessible to a wide audience. Quality of care is very important, specifically when care is paid. If we go through the history of a theoretical and methodological journey of sociology from its origin, it is evident that Harriet Martineau (1802-1876) was the first thinker, who introduced the importance of moral aspects in social continuation. She realized that the study of social systems was a separate scientific discipline, and called it the "science of morals and manners" (Lipset, 1968: 7). Care sociology starts from this point with moral questing to gender role.

For Martineau, it is the drive towards human happiness which shapes morals and manners in any social setting. Her work elaborates one of the first systematic approaches for doing observational research. According to her, the advancement of moral society in all its positive trappings is linked to that one universal drive towards human happiness. If society as a system of happiness wants to run then it is needed to be careful about it (Martineau, 1838). Care for happiness is the beginning point for the sociology of care or care sociology.

Martineau wants to search the laws of citizenship and tries to rehabilitate the criminals. A pathological rectification becomes focal ends in her thoughts. This identification of pathological symptoms by observation method helps to create a scope for doing practice sociology, specifically in the field of care. From Martineau's contribution, sociologists feel aware about the travelling nature of carelessness. Lack of care generates and regenerates the common deficiency in system's health and the resultant is producing multidimensional moral effects. For Martineau, "the symbol of maternal care was not a loving embrace but a sewing needle" (Postlethwaite, 1989: 591). Martineau (1849) intends to show the fear of ill-educated mind. She feels the importance of care in this aspect and tries to emancipate the condition of society through the sociological understanding of human nature.

In the way of development of care sociology Karl Marx (1818-1883) contributed more. To him care is desirable by social change for better life. In his theory the labour process is more caring in feudalism than slavery. Within the capitalist mode of production, labour feels more freedom than in feudal system. He identifies the hidden form of exploitation and alienation within the capitalism. For more caring system, as a humanist approach he suggests socialist care for both productive and reproductive labour. For example, collective farm is a Marxist response to the exploitation and inadequate development of the forces of production created by the capitalist mode of production (Bramall, 1983: 91). Collective farming avoids all the problems by restoring ownership of the means of production to the peasantry. It thereby promotes mechanization, eliminates ownership disputes and liberates female labour power via communal provision of child care. Here the principle that should be established in any collectivist approach to care is that it should be shared care.

This Marxist account, however, slates privately owned capitalist mode of production with a concept of "reserve army of labour" (RAL). RAL has been applied here to women that locate the specificity of women's wage labour within the general Marxist model of capital accumulation (Beechey, 1977; Bruegal, 1979). This perception focuses on the lack of care for women. Sociologically, it is needed to consider the domestic division of labour and the burdens imposed on women undertaking a 'double shift' of wage labour along with child care and housework at home. An emphasis on drawing women into productive labour is combined with social provision of child care facilities and an official ideology that waits the 'working mother' (Weikart, 1994).

Marxist feminist will involve an emphasis on the relations between capitalism and the oppression of women (Barrett, 1980: 9). This care-oppression debate forms care perspective as a right. Demand to establish that right, a new kind of democratic movement paves in Marxist path. In an institutional level, the "domestic labour debate" may start from this point. The Cuban Family Code, enjoining husbands to share housework and child care equally with their wives, represents a unique development in socialist reformulation of care in family life.

Marxist perspective focuses on a care ethics. For justice, it applies insights from feminist care ethics to form care work and for caring with humanistic approach. Marxian theories of morality differ markedly from the relational approaches found in feminist ethics (Robinson, 1999). Marxist epistemology negates the concept of morality and considers it as merely an expression of the interests of the ruling classes. "Capital cares nothing for the length of life of labour-power" (Marx, 1887: 168). It bends its meaning towards a narrow concern with reforming the sphere of distribution – income differentials, wage levels and the like – where in fact his aim was more fundamental and revolutionary, the transformation of production and property relations. Marx's analysis proposes care as a basic form in communist society where everyone does not dare to care others. Indeed, revolution for collective care, Marx intends that alternative approach to social care (including ecological care) by opening up new ways to protect the commitments of a shared human existence.

Thus, when Martineau proposes care for happiness, then Marx negates capitalist care with a materialistic alternative socialist foundation of care value. Emile Durkheim (1858-1917), a French founder of sociology, suggests an individualistic assumption in social theory that supplies clue to affirm the sociology of care. The first clue is allied to the existence of fact as that of 'the social'. Care sociology suggests this tradition from Durkheimian French inquisitiveness. To Durkheim, care is fundamental to the human condition and necessary both to survival and flourishing. Society makes a collective conscience through positive moral choice that helps in resourcing the collectivist approach to care studies, where science of morality replicates Durkheim's sociology.

According to Durkheim (1974:124–5), if the collectivity is not a speaking subject it nevertheless marks the spoken chain: fixed expressions ('les locutions toutes faites'), syntagms constructed on regular forms ('des forms régulières'); words, groups of words ('établis sur des patrons réguliers')

combinations corresponding to general types ('qui ont à leur tour leur support dans la langue sous forme de souvenirs concrets'), etc. (Gane, 1992: 73-74). In *Professional Ethics and Civic Morals* (1957), Durkheim saw sociology as a science of morals which were objective social facts; these moral regulations form the basis of individual rights and obligations. Morality is about reasonable obligation.

In this way Durkheim wanted to deny that a rational appreciation of responsibility, or a utilitarian respect for sanctions, would ever be sufficient as a basis of moral commitment. Morality required compassion, fervour, and a sense of the sanctity of moral obligations to induce a sense of commitment to care. Thus, within every society a plurality of morals that operates on parallel lines (Durkheim, 1993). The family morals differ from civic morals and professional ethics find their right place between these two types of morals (Durkheim, 1957). For Durkheim, the evolutionary ways of ethical judgements have their locales and variations in collective action patterns. Care activities, which are very much associated with ethics, are the special forms of common morality. By this perspective, his analysis indicates the sociological concept, like ritual care.

Here, Durkheim followed Arthur Schopenhauer rather than Immanuel Kant in formation of "care ethics" (Durkheim, 1957: xxvi). Durkheim's notion of ritual articulates the various kinds of care and respect or their opposites: disregard and contempt. This is what Parsons regarded as Durkheim's 'positivist' phase. Durkheim also discusses the relationship between the normal and the pathological, drawing on a biological analogy to offer important insights into how and why the need of care emerge as social categories. According to him, social facts, as things, are external to and coercive of individual (Durkheim, 1982). On the basis of situational context, this coercion may make man suicidal. Durkheim feels an urgency to treat the intersubjective meaning of care studies, which can do the needful to maintain social cohesiveness.

Durkheimian analysis shows that how a society cares for its sick, disabled and elderly members reflects its values. Social scientist Ian Craib makes some pertinent comments relating to this moral aspect of life. Craib (1997: 52) mentions that academic discipline of sociology 'involves the choices of some values over and against other values; it involves what are basically moral choices and the implication is that we need to elucidate the moral choice that we make. Very few sociologists embark on that enterprise.' We think, Durkheim's this methodological concern should help care sociologists to establish the subject-matter of care studies. His sociology of education can be re-explored.

We would also like to mention another name who may also consider as a founding father of care sociology. He is Lawrence Joseph Henderson (1878-1942), a famous American sociologist. As a sociologist he applies the functionalism of physiological regulation to the phenomena of social behaviour basing on his concept of social systems. He implements the concept of social systems to all disciplines that studied the meanings communicated in interactions between two or more persons acting in roles or role-sets. His research produces different important evidences to study care in social systems. According to him the social actions are correlated with different types of care seekers and the manners of caregivers, in which people receive sociobiological care.

Henderson became more familiar with the work of the Italian economist and sociologist, Vilfredo Pareto, in late 1927. He found Pareto's social system to be logically analogous to Willard Gibbs' physico-chemical systems, which held that systems were composed of individual components (individual people) that existed in separate heterogeneous phases (social roles: families, trades, and professions); together, they formed a system (Henderson, 1935a: 10-15). He believed that Pareto's insights could be applied to all areas of study involving interactions between people, with the ultimate goal of developing a science of human relations.

He *considered that* the psychologists and sociologists are the professional custodians of what little scientific knowledge we possessed that was conversant with personal relations. But from them we have, as yet, little to learn, for they are in general little aware of the problem of practising what they know in the affairs of everyday life (Henderson, 1935b: 819). He began speaking about what he referred to as the sociological aspects of medical practice to medical audiences, where he offered both a critique and a potential solution to, what he perceived to be a growing tendency to disregard the personal relations between the physician and the patient in modern medical practice (Henderson, 1936).

His critique focused chiefly on medicine's failure to develop a scientific and systematic understanding of the personal relations between physician and patient. He thought that "sociology could learn from medicine the technique of "close observation" of cases and the resultant formulation of wider and wider generalizations" (Henderson, 1970: 34). Equally concerned about the importance of the care of the patient and the physician-patient relationship, Henderson suggested that these were the crucial components of good care in modern diagnostics and therapeutics. Thus, Henderson's contributions to care sociology might be considered as through the development of this conceptual bridge between the laboratory and everyday social life.

Empirical Path: What are Care Sociologists Doing?

Sociology has been concerned not only with the workings of social systems as a whole, but also with the impact they have on individuals (Brown and Harris, 1979: 4). Empirical research and policy analysis have addressed issues concerning the political economy of care service; shifting assumptions about where care responsibilities lie; the issues of 'who cares' and what are the personal, interpersonal and social impacts of care giving and receiving. Milton Mayeroff (1971) proposes major ingredients of caring and we must remember here the contribution of Erving Goffman (1961), a formal sociologist, for the vocabulary that he typically employs for care sociology research: care, civility, concern, courtesy, goodwill, reassurance, regard, respect, sympathy.

Drawing again on interactionist perspectives in sociology theories, primarily Arlie Russell Hochschild, an American sociologist, proposes that practising sociologists should guide the theories on emotion care. This management of one's feelings and expressions is based on the emotional requirements of a job. Her work, developed within the interactionist branch of the sociology of emotions, refers to the manipulation of emotions that people perform on themselves and others to comply with feeling rules or basic cultural norms of how a person should feel in terms of emotional intensity, direction (positive or negative) and duration in a particular situation (Turner and Stets, 2006; Hochschild, 1983). We depict the internal emotional struggle that many carers describe when the time dedicated to caregiving continues and neither death nor cure eventuates. A carer 'should' feel, i.e. the normative in nature and these

expectations are referred to as 'feeling rules' (Olson, 2015: 14). Conflicting feeling rules also provided one possible explanation for variations in carers' experiences.

The concept of 'sentimental work' was defined by Strauss *et al*. (1982: 254) as, 'any work where the object being worked on is alive and sentient'. A related idea of 'emotional labour' was developed by Hochschild (1983) from a research into the handling of emotions by airline cabin staff, but this concept has been applied in health care settings by Nicky James (1992), who explained that the emotional labour is conceptualized as the labour involved in dealing with other people's feelings, a core component of which is the regulation of emotions. It facilitates and regulates the expression of emotion in the public domain. Sociological research needs emphasis on the widespread changes in the occupational structure in global economies over the past decade including the feminization of local labour markets, the undervaluation of female dominated work and current labour shortages in many 'caring' roles.

Within sociology and cultural studies, theorists such as Brian Massumi (2002) and Michael Hardt (1999) offer yet another category: affective labour. While interactionist theories dominate the sociology of emotions, the 'affective turn' is gaining traction. Affect is used to conceptualise those sensations and visceral changes that may occur beyond cognition and, potentially, beyond, between and across bodies. It refers to the forces or 'states of being' (Hemmings, 2005: 551) that may go unacknowledged, but 'nonetheless shape a person's desire and emotion' (Poynton and Lee, 2011: 637). A care sociologist can do research on class structure and care patterns. When physical examinations and immunizations are typical forms of preventive care, then preventive care is more common among higher socio-economic groups than lower ones and is a major factor is the higher level of health among affluent social classes. A care sociologist must unbolt some empirical avenues to search the ways of care service in postemotional society.

From economic perspective, care sociologists pave the alternative path for caring labour force. Care jobs are fragmented into different emotional kinds and the patterns of allocation denotes the strategical venture against the commercialization of human feelings (Hochschild, 1983). Caregiving as a growing social problem is reflected in a few of the findings from the recent sociological study of human society.

A key focus of caregiving service has always been upon the social relationship between receivers and givers, and the institutional setting within which care is delivered. The place of care is often determined by whether the proposed recipient lives alone, with a spouse, or with family or relatives and their ability to perform required activities of daily living. Age, health status, level of functioning and financial resources are the key elements influencing where caregiving will be provided and by whom. Sometimes families have the resources, but lack the motivation, energy, and commitment to provide caregiving themselves and the proposed recipient is placed in a facility for care to be given by formal caregivers. Practising sociologists must focus on the analysis of child care, peer care, and parent care relationships in different social settings. Family therapy is becoming a part of care sociology.

Care is always an activity of relationship. Several types of care are there. Sometime care needs touching a person's body, incorporates issues of intimacy, personal dignity and confidentiality. The examples are health care, personal care, etc. On the other side, community care and social care which are equally shared by the members of a functionally structured group. Roles are allocated there. In all caregiving system there must be a hierarchically power based relationship pattern. And sometime it is organized (for example, health care), but in a wider scale it is habitual and informal. Reaction has come from feminist writings (Finch and Mason, 1993; Dalley, 1988) who see the exploitation of women's labour as inevitable unseen work with care, including residential care. This type of "feminist critique of community care is based on research into carers' domestic, family and work commitments" (McDonald, 1999: 9).

Proper communication between a care receiver and the carer is needed to minimise the dilemmas and fuzziness. Moral responsibility for their care is essential so that the receiver can develop trust and is sufficiently informed to be a true partner in the decision making process. For care sociologists mothering and gender aspects of social theory are empirically verified. Deidre David, Sidonie Smith, Kay Schaffer, Valerie Sanders, and Diana Postlethwaite acknowledged the importance of gender care and normativity (Bohrer, 2003: 21). Contextual nature of morality may a point to reach in gender and knowledge research.

The history of the care is the history of constricting medical devices. Medical sociologists, like Phil Brown, David Silverman, Peter Byard Davis, Peter Conrad and so on, study the social aspects of health and disease, the social functions of health organizations and institutions, the relationship of health care delivery systems to other social systems, the social behaviour of health care workers and those people who are the consumers of health care, and patterns of health services.

Care sociology with medical knowledge does not evolve it as a field of research to provide some services in support of medicine. Rather, medical sociologists in care service follow their own path and, in fact, became critics of medicine when the situation was warranted, as seen in some well-known studies dealing with the lack of access to health care by the poor, as well as medical mistakes (Millman, 1977), failures (Bosk, 1979), and opposition to health reform. By the late 1990s, medical sociology had not only established an independent position relative to medicine, but it had also turned to mainstream sociology for its basic orientation on care (Cockerham and Scambler, 2010).

Medical sociology studies the profession of medicine or in a wider level the healthcare sector, which may be subdivided into different types (Luke, 2003). For example, 'Palliative care' is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from the symptoms, pain, and the stress of a serious illness whatever the prognosis. The goal is to improve the quality of life for both the patient and the family. There is also 'Hospice care', which is considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury. It involves a team approach to medical care, pain management, and emotional and spiritual care support tailored to meet patient's needs and wishes. Support is available to the family as well (Bruhn and Rebach, 2014: 141). The core of hospice and palliative care is the belief that each person has the right to die pain free and with dignity, and that families will receive the necessary support to allow us to do so. Researches in care sociology deal with such empirical knowledge from medical sociology.

Analytical Path: What Does Reason Suggest?

Medical socialization is not a process that ends with formal

training of forced care. Physicians and other health professionals must learn not only the norms of providing care in everyday organizational settings, such as private offices and hospitals but also the norms regulating the business, legal, and interprofessional relationships and in general, the professional subculture that shapes the larger structural context of medical work. Henceforth care sociology demands an interdisciplinary and interprofessional course of actions with practical knowledge and discourses about the definition of "man as the being who was destined to care for himself" (Foucault, 1986: 47). Foucault (1986: 51) analyses, "taking care of oneself is not a rest cure. There is the care of the body to consider, health regimens, physical exercises without overexertion, the carefully measured satisfaction of needs. There are the meditations, the readings, the notes that one takes on books or on the conversations one has heard, notes that one reads again later, the recollection of truths that one knows already but that need to be more fully adapted to one's own life".

Stigmatized risk groups are sometimes portrayed as deserving of their pain and suffering and unworthy of care and treatment, and this can lead policy makers to ignore the group, as has been suggested was the case in the early days of the AIDS epidemic (Shilts, 1987). In this case of AIDS, prejudicial societal responses not only harm the stigmatized risk group, but place all others at greater risk. Persons with symptoms of a stigmatized disease, may be led to fear of retribution that causes them to avoid seeking appropriate care, even when they have not participated in what the society has defined as deviant behaviour. Care sociology guides pupils to take initiatives in care practice as a privilege-duty.

Adaptation is a fundamental prerequisite of any social system. The role of social networks in a system life has long been a key topic of interest for sociology, traditionally which reflected in the concept of community: 'Community' stands as a convenient shorthand term for the broad realm of social arrangements beyond the private sphere of home and family but more familiar to us than the impersonal institutions of the wider society, what Bulmer calls 'intermediary structures' (Crow and Allan, 1994: 1).

In the field of care sociology, community care is too important because it is "designed" to systematic "uphold" (McDonald, 1999: 1). To be a community, the members of the group must also care for what they profess to be their common tastes and interests. Members accept to participate in its decision-making process by sacrificing some of their individual motives to concrete the sacred ties. Community care must serve the interest of its members by strengthen a network of interpersonal interactions with both resilience and plasticity. Anthea Symonds (1998) proposes several positive ways of policy making for community care. Community facilities, like housing complex service agency, community nursing, community mental health care, etc. are developing an alternative institutional framework to embrace child care, health care outside the welfare state services. New social movement fermented through the conscious voice like "health care is our right".

Health care organizations are being corporatized in their financial part. The exploitative mentality and financial burden compel citizens in seeking alternative forms of care. Disapproving contemporary care provisions, alternative forms are increasingly suing physicians for malpractices. As an alternative, in community caring practices, care sociology may provide some probable solutions to substantiate certain amount of inequality between men and women in decision-making, child care and unseen work in everyday life. Managed care organizations indirectly pressure physicians to alter their medical decisions for cost containment. Generic code combination may be an alternative knowledge form that may also be a cost effective way for care seekers. Indeed, new social policy of welfare state favours institutional care which produces 'institutional neurosis' (Barton, 1959). In the sociological analysis of care and equality, child care is considered as a part of domestic labour. Cooking, cleaning, looking after the sick and elderly are the parts of domestic division of labour in which women are exploited. Risk prevention and safety management play primary role in care sociology for organizational studies.

Caregiving is a dynamic, evolving role influenced by the personal relationship between the caregiver and care recipient and their expectations, the context (formal or informal) in which care is given, the changing nature of the recipient's health, needs, and economic constraints, and family dynamics and expectations. Formal care refers to professionals while informal care usually refers to non-professionals such as family members, friends, neighbours, and community volunteers. Informal care is still the most important source of care for the elderly people. Eldercare is associated with "preventive care" (Kennie, 1993). Care sociologists feel confident about disadvantages and take strategical measures for the risks in care work.

The study of socially induced stress, tension and risk are important in the field of care sociology. These maladies result from the pressures of everyday life style, or from the work environment and organizational culture, or especially from the pressures of burdensome roles such as caregiving to family members with differently abled or mentally ill persons. In every analytical point the care is an essential and clearly identified need. However, in the field of care sociology, it is needed to specialize in medical and technological innovations which are mainly been concerned with the individual and individualised engagement (Webster, 2006). The sociology of scientific knowledge has comprehensively shown that the capacity of care sociology to develop different caregiving systems, which are not corrosive of trust in knowledge expertise, conceptual architecture and performance motivation.

Conclusion

Social change is inevitable in human societies. We create some change, other change occurs naturally. Change in demographics, gender equality, workforce patterns, medical technology, preventive medicine, family values and political economics are some of the factors that have changed the caring systems of a society. Ethnic composition of care service policy and the code of social care language are important elements to study human relationship in care sociology. Albeit of kinship care, the sociology of care attempts to pose a sociological understanding of the structures and processes of any given society within which the policies and codes are enacted to provide the devolution of care.

Within the family life, care is provided within generations, between spouses, partners, siblings, and cousins just as it is across generations. Now, care sociology delivers a market-based and post-Fordist movement to construct a new welfarism. New organizational frame of care system for older persons is becoming a very lucrative field of business investment. The care sociology, as a special subfield of sociology, provides several methodical tools for everyday care working practice.

Self-directed groupwork method, hermeneutic method, descriptive phenomenological method, interpretive anthropological method and discourse analysis are just some of the methods that fit to study caring actions. Care sociology resolves the divisions between "purchaser" and "provider" of care service. It exposes a new power to create care habitus that prevents any collusion between the body and desire. It dilutes the new contradictions within the voluntary divisions of care ideology.

In both health and social care, the role of motherhood becomes once again the focus of attention by care sociologists. Collective child care with love, affection, sympathy or care for children in the community life soon increased public awareness about nutrition and diseases. Conscious self-refutes the sentimental ideals. Thus, care sociology makes your mind up about the care-justice debate. To it, the caring relationship is a miniature social system that provides valued mutual intimacy, support and moral concern.

Care is always a practice rather than a set of rules or principles and obviously it is ethically value loaded to sustain the basic human moral values. Justice, as a form of ethical value with rational principle, dilutes in care thinking and protects the defining capacity of human beings. So, care-justice dichotomy is ended up and makes a compatible mode of practising sociology through care culture.

Thus, the development of care sociology presents an opportunity for practitioners to play a pivotal role in the management of new forms of care habits in the everyday social life, or in social career as experts, rather than as dispensers of elixirs of wonder. Care sociology also represents the fact that the concept of care management is socially constructed and signifies the dynamicity of body social.

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