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research article

Leadership and care ethics in the voluntary sector: a tensions approach

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The subjects of leadership and care ethics have a limited presence in the voluntary sector literature. However, interest has grown in the former in recent years, and the latter has been suggested as a potential counter discourse to contemporary neoliberal narratives of the sector. What is missing from these accounts is an acknowledgement of the often unresolvable ethical and leadership tensions that are encountered in practice contexts. This article offers a nuanced view of how care ethics flows through leadership, using empirical data to illuminate an alternative reading of the literature. It contributes to debates around leadership in the voluntary sector by both offering a nuanced, ethically inflected theoretical understanding and providing an approach through which to inform leadership practice.

Keywords leadership • care • care ethics • tensions • local infrastructure organisations

Key messages

- Leadership and care ethics have a limited presence in voluntary sector literature.
- Accounts of care often ignore tensions inherent in practice.
- A nuanced view of how care ethics flows through leadership captures these tensions.
- The article adds to understanding how care ethics is applied in practice.

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Introduction

This article explores the interplay of leadership and ethics within a voluntary sector context, focusing on care ethics and the tensions that emerge in its practice. Both leadership and ethics have long-established academic traditions, although neither have a large presence in the voluntary sector specific literature. Leadership has seen increased attention in recent years (Paton and Brewster, 2008; Macmillan and McLaren, 2012; Nesbit et al, 2016; Terry et al, 2020; Jacklin-Jarvis and Rees, 2021; Lough, 2021; Mumbi

and Obembe, 2021; Rees et al, 2022) however it remains a 'maddening concept' (Alvesson, 2017) which is both difficult to define and difficult to assign significance to. Attempting to fully justify and explore a specific definition of leadership within this article would require more space than is available and perhaps ultimately be a futile task. However, very broadly, we can approach leadership as relational practice (Raelin, 2020); that works when it enables people, organisations and communities to achieve their goals (Grint and Smolović Jones, 2022).

This account of leadership is morally neutral in terms of ends. It does not tell us whether what we are achieving is morally 'good' or whether the means by which we achieve it is morally acceptable. Hence there is a need to think of leadership in terms of both effectiveness *and* ethics (Ciulla, 2009). This is particularly important when organisations are oriented to the notion of 'the good', such as is common within the voluntary sector (Dean, 2020). Despite this broadly ethical narrative, voluntary sector scholars have shown limited attention to the relation between ethics and leadership. In this article we seek to remedy this omission by deploying the normative theory of care ethics (Gilligan, 1982; Tronto, 1993; 2013; Noddings, 2002; 1984/2013; Held, 2006) as a way to explore relational leadership practice (Cunliffe and Eriksen, 2011; Raelin, 2011) in a voluntary sector context. We seek to develop practice relevant theory by identifying a series of tensions in which care ethics flows through leadership, as a way to enable reflexivity and reflective practice.

The article begins with an exploration of relevant literature, describes the method adopted, and then goes on to define and examine the practice tensions that emerged at the intersection of leadership and ethics. These tensions are illuminated via the interplay between relevant theory and data gathered from empirical research carried out with local infrastructure organisations (LIOs)[1] in England. We end with notes on implications, limitations, and potential future research.

Leadership and care

There is a vast diversity of leadership literature across academic traditions, not least Leadership Studies itself, and various approaches have been offered and debated over many decades. Grint and Smolović Jones (2022) categorise these approaches as person, position, product, purpose and process. Other contemporary leadership scholars distinguish between the study of leaders and leadership (Crevani et al, 2010; Raelin, 2016; 2020), the former focused on person (individual qualities, styles, hierarchical position, and achievements); the latter focused on the practices and processes through which people interact to 'make things happen' at all levels (Huxham and Vangen, 2000). In this article we adopt the latter approach, identifying social practices at the intersection between care ethics and leadership and uncovering the tensions at the heart of those practices. In this conceptualisation, leadership emerges through day-to-day activities that frame issues (raising or lowering the importance of those issues), move things forward to achieve outcomes, and commit energy and resources to these processes (see also Drath et al, 2008; Raelin, 2016).

Interest in leadership within the voluntary sector literature has a less developed history but has grown in recent years. Working within a practice conceptualisation of leadership, this section explores literature that considers the interplay between leadership and ethics, with the latter understood from the perspective of care ethics.

There is a strong tradition in ethics of emphasising reason and objectivity; in this sense the way we relate to others ethically springs from a place of rationality and abstraction (Chappell, 2014). If we apply this understanding to leadership, we get a somewhat disembodied account of how we ought to treat others within leadership practice that is removed from the emotional and relational realities of lived experience. Recently, however, scholars have sought to counterpose notions of care and caring to these accounts (Ciulla, 2009; Nicholson and Kurucz, 2019; Tomkins, 2020; Younger, 2021).

Care seeks to displace, wholly or in part, a focus on reason and objectivity through an approach to ethics that is located in *needs*, interjecting a relation of care based on need recognition, as a central element of leadership practice. 'Caring leadership' (Younger, 2021) is seen as desirable, constituting something like human flourishing as an ethical obligation and relational practice. The image of leadership practice as a respectful exchange beyond the simple acknowledgement of reason to one that individualises, recognises, listens to the other and, importantly, responds in an appropriate manner full of warmth, conjures up positive images of inter-relational recognition; a leadership imbued with ethical relations.

Despite this appealing image, critics have claimed that, in offering an entirely positive gloss on the concept of care, the idea of dependency is insufficiently scrutinised (Tomkins, 2020). There are healthy and unhealthy modes of dependency; writers such as Gabriel (2015) suggest that the image of care portrayed in caring leadership operates at a mythic level that fails to distinguish between care as a relation of mutual acknowledgment and respect and one of exploitation and asymmetry. In a related argument it is argued that care is gender laden in a reductive manner – care is a discourse that is over-burdened with gender and its deployment reproduces embedded gender norms; as such care becomes feminised at an ideological level that is then reproduced in practice (Pullen and Vachhani, 2020). Beyond the idea that caring may be gendered in an unhelpful manner, other critics have suggested that caring has a defining naivete, perhaps even idealism. Care, it is argued, occurs within a specific context, one that is inevitably replete with power and resource asymmetries (Tomkins, 2020). These asymmetries will be familiar to all working in and researching the voluntary sector (see for example, Hogg and Baines, 2012; Verschuere and De Corte, 2014; Jacklin-Jarvis, 2015; Bouchard and Rauflett, 2019; Body, 2020). Care may be in the gift of the powerful, perhaps in a performative manner, and care flowing from the powerless – often the voice of those being cared for – to the powerful can be absent for structural reasons. Within the voluntary sector, care becomes synonymous with leadership in this sense in the way that organisations are positioned as 'involving', 'representing', or 'speaking' for (potentially powerless) individuals and communities, indeed, often this is essential to organisational mission (for example, Walker et al, 2020; Sanders, 2022).

While critiques of 'caring leadership' have a degree of validity, how convincing they are is limited by their indeterminate account of care and a lack of engagement with the debates within the theoretical literature on the ethics of care. Indeed, 'care' in caring leadership is often expressed in the simple relationship between need identification, recognition and then appropriate response. While such an account has virtue in its simplicity, it fails to acknowledge the tensions, challenges and difficult emotions within care, the political and institutional structures within which care circulates, and its relationship with justice. In contrast, these themes are explored in the 'ethics of care' literature detailed below. In approaching care in

this way, we seek to add nuance to offer an account that captures the challenges in practising care. We go beyond assertions of the desirability or otherwise of a rather undifferentiated 'caring leadership' to think about ways in which care flows through leadership practice – the vibrant meeting of leadership and care concerns working within and through tensions, rather than resolving them. This may present a vision of care ethics and leadership that is less utopian and more challenging than that presented in the ethical leadership literature and one that is less cynical than those of its critics. Instead, it is hoped that it is one that better captures voluntary sector practice and the challenges therein.

Care ethics

Ethics theory has long been dominated by an attachment to reason as a way to discern what ethics is and reach ethical judgements (Chappell, 2014). Irrespective of a particular ethical theory we select, we seek to move away from the immediacy of a situation and judge what it is right to do. If we are thinking in the moment, we might find ourselves clouded by rash emotions and act in a way that is not consonant with morality; or indeed act in accordance with morality but do so accidentally. In this attachment to rationality, we treat ethics as objective, something to be discovered or uncovered and then deployed appropriately. Influential models of moral development, from the work of Kohlberg onwards, are defined in terms of increasing ability to be a rational moral actor (Habermas, 1990). We can see this within the voluntary sector in debates about rational approaches deployed within movements towards 'professionalism' (for example, King, 2016; Hemmings, 2017; Brock, 2020).

Within this attachment to reason, leadership ethics is about acting in accordance with morality and, when facing a situation in which a moral dilemma is posed, in (mentally) excusing ourselves from the situation and determining what the right thing to do is from the perspective of the disinterested rational observer (McManus et al, 2023).

This detached view of ethics appears to run up against practices in the voluntary sector where, for example, issues of harm are addressed, vulnerable people supported, and community is rallied. When practice concerns relations between embodied and emotionally complex individuals with needs, desires, and wants, to say that the ethical in leadership should be removed from these relations seems restrictive. Although other scholars acknowledge the role of emotions in morality (Bagnoli, 2011), a group of thinkers have sought to redress what they see as the excessive focus on rationality by reframing ethics in terms of emotions, need and practices. Collectively, they are referred to under the terms 'care ethics' or 'the ethics of care' and represent – as one of the early theorists of this approach referred to – 'ethics in a different voice' (Gilligan, 1982) counterposed to the dominant focus on rationality. Within the voluntary sector literature, Sandberg and Elliot (2019) have introduced care ethics in this way as a 'counter narrative' to rational (neoliberal) approaches.

Care ethics starts with the first experience of needs. In human experience this first experience is between a primary care-giver and a care-receiver (a baby) whose needs for care are satisfied within this relation of total dependency. Care ethicists suggest that rationality inflected views of ethics seek to move away from this dependence through the establishment of autonomy and our increased ability to deploy reason to solve our own issues; as such we devalue relations rooted in

dependency and suffused with needs and appropriate practices that respond to them. In contrast, care ethics sees ethical value in these relations of dependency and the further relations that we develop as we grow and experience society and its interactions. Indeed, the ethical is about inquiring into, taking on responsibilities and enacting care *within relations*. We are not responding to the needs of others based on a rational appreciation of their moral worth or deservingness of care, but from the fact and experience of need within relations. We respond to the emotional pull of living with others and see dependence as a human condition worthy of nurture, as Fisher and Tronto state:

> Caring can be viewed as a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web. (Fisher and Tronto, 1991 cited in Tronto, 1993: 103)

Allied to this emphasis on the positive valorisation of dependencies, care ethics is presented as both a theory of ethics and account of practice. It is experiential in the sense that care is 'about' and 'within' relationally 'being' with others in the world. As such, the idea of care ethics holds appeal for thinking about ethics and leadership, where leadership is understood as an embodied relational practice.

Tronto (1993; 2013) sees care as a practice that moves in a series. The first phase, 'Caring about/Attentiveness', talks about being curious about care needs both in terms of those relations that we are already within, but also in expanding our perspective, being sufficiently interested in our world to inquire where care needs might be – an 'engrossment' in our world. The second phase, 'Taking care of/Responsibility', is an extension of this curiosity through the taking on of responsibility to respond to care needs and a precursor to the next phase. The third, 'Care-giving/Competence', is the *practice* of responding to these needs for which responsibility has been taken. It is the 'doing' of care. The final phase, 'Care-receiving/Responsiveness', gives emphasis to those receiving care, acknowledging their voice and responding appropriately, thereby establishing a more dialogic and democratic basis to care practice. It is important to recognise that care ethics gives a positive valorisation to dependency and the role of care-giver and care-receiver as specific and contextual positions in practice rather than a necessary ongoing hierarchy. The temptation therefore may be to suggest that practising care ethics in leadership concerns enacting these phases, leading to relations marked by warmth, positive dependencies and an emphatic narrative of caring. However, as Tronto states: 'While ideally there is a smooth interconnection between caring about, taking care of, care-giving, and care-receiving, in reality there is likely to be conflict within each of these phases, and between them' (Tronto, 1993: 109). In the narrative of care practice, Tronto sees – among other things – misrecognition of care, inappropriate practices, outsourcing of responsibility, rage on behalf of care-receivers and anger in response to paternalistic interventions (Tronto, 1993). Care as a practice is therefore not naïvely utopian but fraught with tensions, missteps and difficult emotions. As Tronto states, 'care involves conflict' (Tronto, 1993: 136). As such, leadership and the ethics of care needs to acknowledge the tensions and conflicts inhabiting care practice rather than bury them under a utopian vision of emotional warmth.

Methodological overview

Although mainstream philosophical ethics has tended to see empirical matters as irrelevant to theorising about ethics, a few thinkers have sought to redress the balance and see a more vibrant relationship between empirics and ethical theory (Miller, 1992; 2013; Weaver and Trevino, 1994; Cugueró-Escofet and Fortin, 2014; Bailey and Winchester, 2018). We see this approach as offering an opportunity to enable greater dialogue between empirical data and philosophical theory that brings theory into greater relevance for lived experience (having affinities with an abductive approach to analysis and theory building). As such the data is used to both illuminate and develop the overall argument presented in the following sections.

The empirical work developed through informal conversations with practitioners during the COVID-19 pandemic in England. These conversations took place within the context of pre-existing relationships between two of the authors and organisations in the voluntary sector, with the dual aim of supporting those in practice and understanding the impact of the pandemic. The data is therefore embedded in ethnographic principles in terms of wider engagement with participants and their organisations (Hammersley and Atkinson, 2019). These initial discussions led to the development of a formal research project involving data collection via two sets of interviews with six practitioners spanning the time period of September 2020 to March 2022 (notably through both COVID-19 and the beginning of the subsequent 'cost of living' crises). All participants worked in senior management roles in LIOs and included five who described themselves as 'chief executive officers' and one who described their role as an 'executive manager'. The interviews were semi-structured and followed a broad topic guide focussed on responses to the COVID-19 pandemic within participants' organisation; the response of the wider voluntary sector; the impact on participants' roles specifically; and the leadership of organisations, the sector, and the contextual locality in which participants worked. The interviews lasted between 45 and 80 minutes and were professionally transcribed.

The commitment to an approach acknowledging the interplay between normative theory and data meant that an iterative analytical process was employed that both analysed the data and, at the same time, modified the theory used as an explanatory tool. This involved initial thematic analysis that was carried out by the authors individually; subsequent discussion between the authors and agreement in relation to initial findings; reflection back to theory; theory modification; and sense-checking back to the data. This process continued until the formulation of findings and the (re)construction of the explanatory theoretical approach was agreed.

As with Tronto's political reading of care ethics, the data alerted us to tensions; revealing that the manner in which care is inflected within leadership is marked by challenges, uncertainty and occasionally conflict. Alongside our initial reading of the data was our increasing engagement with the ethics of care theory. However, the data also revealed that these tensions were not simply about being *better* practitioners of care but about tensions *within* practice. Tension appears, as in the political reading of the ethics of care, intrinsic to practice; however, the data suggest that in the interface between care, ethics, and leadership, it is not a matter of resolving specific – for example inter-personal – tension, but living with and through tensions in an ongoing manner. As such, our approach to communicating practice-relevant theory is presented as a dialogue between theory and empirical data in the form of what we term practice

tensions, rather than a separate presentation of findings followed by a discussion. The following section presents this dialogue.

Leadership, care and practice tensions – a dialogue between theory and data

The challenge that we encounter when deploying this reading of care ethics into the field of leadership is that it becomes critical to preserve these tensions within an account of practice in a manner that acknowledges rather than seeks to dissipate them. The literature of management tensions (although the term is equally applicable to leadership) offers insight here. Rather than seeking a way to solve or dissolve tensions, the approach seeks to offer insight through the expression of tensions as way to inform practice (Huxham and Beech, 2003). The normative advice is to acknowledge and work within these tensions as a reflective practitioner rather than attempt to find a solution that somehow resolves them. In this vein we describe a series of practice tensions that arise at the intersection of care ethics and leadership. For each we offer a label capturing the essence of the tensions and the two opposing poles; noting that these 'poles' are not either/or options but a way of expressing extremes through which practice navigates. The notion of tension is concerned with choices between alternative forms of practice, but those choices are not dualistic either/or options (Huxham and Beech, 2003). A summary is offered in Table 1.

Inquiry tension

Care ethics concerns being curious about the world and the care needs within it; the problem is that that such curiosity could conceivably be inexhaustible. The inquiry tension captures the sense in which a focus on care both operates within constraints and urges us towards expanding our knowledge of care need.

At one pole – 'Expanding the possibility of care' – there is the requirement for leadership practice to broaden the potential to hear, notice and investigate care from outside one's immediate relations. It is not a responsive mode where needs are responded to if they arise but an active seeking of and interest in their expression. It can also be a *deepening* of relations with those to whom we already interact. Inquiry here presages leadership practice that involves taking on the responsibility of care within these relations, embracing the possibilities for care within leadership practice.

Table 1: Practice tensions

Tension	Pole 1	Pole 2
Inquiry	Expanding the possibility of care	Limiting focus and care identification
Boundary	Enacting care with all-identified	Nurturing prior affective relations
Self/other	Caring for others	Caring for self
Action orientation	Action in concert with/listening *to*	Action on behalf of/pushing *for*

As one respondent noted, the increased use of technology during the COVID-19 pandemic enabled a deeper inquiry and engagement with those whose voices are less immediately present:

> It's very difficult because the groups we work with some of them are very alert and quick. For example, if we say we've got a new fund for this, we know which six groups are going to send in their applications in the first week. We also know which groups desperately need funding, but even with a lot of handholding won't be able to get an application in, possibly at all, but certainly not within a few months […] Technology makes it easier for us to deal with those groups that are always first in the queue, and that allows us to focus our resources on the groups that are always last in the queue and are not so good at coming forward and are not so savvy with technology. It allows us to do that bit of support and handholding at a more one-to-one level with those groups. (INT68)

The other pole – 'Limiting focus and care identification' – speaks of rationing and constraining attention, in a certain sense, actively foreclosing the inquiry of care. Practitioners are limited by their time, working in prescribed roles within organisations. Leadership practice therefore concerns the need to temper the claim for curiosity with the precepts of organisational life. Inquiry could be an endless process of discerning more and further needs both in terms of depth and breadth. Engaging in inquiry with such expansiveness could not only be excessively time consuming but also intrusive; similarly, spending all of one's time searching for need might detract from core organisational requirements. In this pole, leadership practice becomes a matter of defining boundaries and enacting processes to delimit attention, as one respondent noted:

> So, what we do is to look at the business case of that, have we got income that pays those staff, and then look at what is the contribution a project would make. And so, the charge for that is balanced out against the costs of running the project, so that we keep it as part of our non-profit making offer. (INT94)

At the level of the tension itself, leadership requires working through the poles of the inquiry tension, recognising that, while care invites an ever-expanding curiosity, this occurs against a backdrop of limited capacity. Leadership works through care against constraint, not using constraint to withdraw from care practice but also not over-burdening the relations with need and excess responsibility. Care ethics within the inquiry tension is about a pragmatic reflexive curiosity that seeks and responds to needs in a tempered and reflective manner. We can see this tension play out more widely in voluntary sector debates around organisational mission and 'mission drift' (see for example Macmillan, 2010; Hemmings, 2017; Milbourne and Murray, 2017). These debates also have relevance for the next tension, which relates to the boundaries of care.

Boundary tension

Where the inquiry tension concerns focus and implies a *potential* of care; the boundary tension moves towards decisions to take on *responsibility* for identified needs and

enacting these responsibilities through care practice; in essence, drawing a boundary between those who actively receive care and those who do not.

The first pole of the tension – 'nurturing prior affective relations' – concerns rationing responsibility and practice to those already interacting with an organisation, those that are known. In a voluntary sector context, these can be existing clients or service users. It is a pragmatic recognition that the expansiveness of responsibility flowing from inquiry could become overwhelming or indeed oppressive; there becomes an excess of need from which it is impossible to respond. Here extant relations take priority through their closeness, and responsibility flows from this often-embodied relation. Inaction beyond the boundary is emphasised as the most effective response to current needs and a protective measure against the promiscuity of need beyond these bounds (Held, 2006).

The second pole – 'enacting care with all-affected' – challenges the boundary through a more expansive domain of responsibility, that of all those affected, or potentially affected, by organisational practice (either at present or in future). The challenge of such borderless thinking is that the immediate relation is lost, the intimacy of care ethics begins to be loosened, and potentially care could over-run competence both in terms of capacity for action and the overwhelmingness of seemingly infinite care needs, regardless of any standards of practice. Boundaryless care embraces others without discrimination but may stymie responsibility in so doing.

In working through the boundary tension, leadership steers between the assertion of a special status for the 'known' (which thereby closes off attention and responsibility for those outside this boundary) and the rejection of boundaries entailed by an expanded curiosity and responsibility to all-affected and outside extant relations. The former could be read as the restricted domain of the possible; the latter the expansive domain of the potential. Here leadership adopts practices of reflexive boundary drawing (and redrawing), moving between the known and the unknown with a view to both effectiveness and expansiveness while steering between parochialism (in both responsibility and practice) and ineffective diffusiveness where boundaries become meaningless and competence unachievable. One respondent described working through this tension via an initial expansiveness as a response to the context of the COVID-19 pandemic with a subsequent strategy of moving back to the core as a bounded domain.

> I thought this was such a good model and so I saw our role as trying to promote this model across the rest of the borough and get other people organised and interested in it so we held a meeting with the schools, businesses and community organisations and there was a lot of interest and different people offered different things but nobody's kind of taken it on and so we've kind of stepped in as kind of the glue kind of holding different bits together but we're ending up kind of doing project management on what is essentially like a direct delivery project, so that's kind of, so we're now trying to not find a way out of it but find a way that we can do it without pulling us too far away from kind of what our core is. (INT23)

In the sector more widely, recent debates about eligibility and rationing of food bank support also pick up aspects of this tension and demonstrate that a variety of different responses are possible (see, for example, Butler, 2023; Lee et al, 2023). These all require at some point the creation of a boundary of care through, for example, the introduction of

'access criteria' or 'referral pathways'. Leadership involves recognising the legitimacy of the boundary tension while finding a way forward – 'getting things done' – in relation to wider aspects of organisational sustainability and accountability to stakeholders.

Self/other tension

Practising care requires establishing and maintaining a relation into which care is interwoven and responded to effectively. This includes an encumbering of care within the self that demands work. Practising leadership also demands attention to both the self and others, particularly in contexts of responsibility (for example line management, service delivery, and so on) as explored in the previous tension. The self/other tension recognises this care work and speaks of the balance between self and other as care is practiced. The tension also recognises the special relation we have to our self and its preservation and/or flourishing; the self is important to us in a manner in which others are not, in that our life-projects matter to us in a way they cannot for others (Williams, 1993). In a more traditional leadership framing we may see this in the context of 'career development' for example.

The first pole of this tension – 'Caring for self' – recognises that practising care might come at a cost, for example: we may feel overwhelmed (where curiosity becomes excessive); deform relationships through mistaken identification of needs; feel rage at the treatment of others; and/or be burdened by the simple exhaustion from doing too much. At this end of the pole, the self is emphasised with a need for self-monitoring and self-protection such that sufficient self-care exists in order to offer competent care to others. Narratives of exhaustion were present in the data, as one participant described when talking about restricting time, despite increased funding, as an act of self-care: 'Then we got some more funding, but actually, the beginning of October, X and myself both dropped down to 30 hours a week so still higher hours than before and we do have funding to work full-time but I think both of us are just a bit knackered' (INT23). The other pole points towards the defining normative quality of care ethics, that of 'Caring for others', of enacting the responsibilities drawn from being inquisitive about the world and our relations. Care here references the selflessness of the practice of putting others before the self, of downplaying the self as a commitment. As one respondent talked about putting themselves in a place of giving care and giving others a rest from care practice:

> And everyone came together. Even though we're remotely working, everyone was still coming together about getting stuff done, and moving things forward. And I was very clear with them that I would not expect them to do anything that I wouldn't. So, when it came to Easter last year, and I said, right, you guys enjoy your break. I'm going to be on call, though, so I'm going to be doing this. (INT48)

Here, of course, runs the possibility of exhaustion or overwhelmingness of the sacrifice of the self for others, where the ever-expanding circle of care places excessive burdens that lead to burnout or to ineffective, superficial or diffuse practice. In which case the 'other' colonises the 'self' in an oppressive manner such that the self no longer becomes an object of care.

In working through this tension, leadership moves between two recognitions. On the one hand, recognition that self-care is needed lest practices, attention and responsibilities fall aside through an admixture of exhaustion, anger and/or feelings of ineffectiveness against a world of need. On the other, a recognition that excessive concern with the needs of the self and an emphatic prioritising of self might border on narcissism. This needs to be balanced through the pressing concern for others at the heart of care. Here leadership operates with a monitoring of the manner in which care flows to both self and others both in 'in the moment' responses and in broader individual and organisational practice. Within the voluntary sector literature, longstanding debates about burnout and fatigue both in relation to leadership and community engagement pick up on this tension (Purdue et al, 2000; Paton et al, 2007; Murdock, 2014).

Action orientation tension

The action orientation tension shifts attention to the quality of the relation between care-giver and care-receiver as expressed through care practices.

The first pole of the tension – 'Action in concert with/ listening to' – is one in which the care relation embraces participative equity (noting that care often involves inequality through instances of dependency). Here care practice is based on understanding need and agreeing practices as appropriate. The care-receiver can challenge the process in the spirit of respectful dialogue. Care practice is, therefore, founded on listening to and acting with the other. For voluntary sector organisations this often concerns the question of the basis of representation, as expressed by one respondent: 'I think that's something that we will need to do whilst recognising the fact that we have a responsibility to share the voice of groups. And sometimes we have to deliver messages which are not welcome. We do have to do that quite a lot' (INT86). It is noteworthy that this respondent is hinting at a militance that may accompany care and that within representation there are risks, of discomfort or upset, such that even when the enactment of care flows through representation difficult emotions may be raised.

The second pole – 'Action on behalf of/pushing for' – emphasises leadership practice that deciphers needs and responds effectively without undue delay. Within this practice needs may be identified that are perhaps not known to the care-receiver, or that the care-receiver is not in a position to enunciate or have a way to present. At the extreme end of this interpretation, the identified needs may not correspond to those articulated by the care-receiver, for a variety of reasons. Essentially, this is a more directive form of action, as a respondent stated:

> And at that time, myself and X, who's our CEO, my boss, we stormed the doors of our local resilience forum and basically said, okay, who's sitting round these tables for the voluntary sector at the moment? No-one. Why? You should have someone there. And they were like, well, do you guys want to come on? And we were like, fine. So still to this day, X sits on the [strategic] group, and I sit on the one below. (INT48)

This can be an insistent voice on behalf of the other(s) that exposes a lack of care at a structural level, where leadership seeks to remonstrate against broader institutional

structures and/or prevailing political ideology (Tronto, 2013). However, this has the potential to deform through misapplication, inattention to needs, or inappropriateness of any action – as such, the care relation may break down. The absence of voice (acting 'with') may lead to practice that becomes a self-serving and self-perpetuating ideal outside and abstract from any care needs expressed within particular relations.

In working through this leadership tension there is a challenge to steer between respect for relational equity as fundamental to practice, versus the need for activity in speaking and acting on behalf of a need. The former retains the integrity of relationships but at the cost of action, the latter can deform but may offer practices that respond to care. In this respect leadership operates with a praxeological relationality, meaning there is continual monitoring of the way that needs are met in the context of both the demands for action and their framing of the relation in which practice occurs. Voluntary sector organisations confront this tension more widely in the twin demands placed upon them to ensure democratic participation among members and their wider community, versus the need to create a coherent message and singular voice in communications with policy makers and other partners (see, for example, Albareda, 2018).

Summary and conclusion

One of the desirable features of the ethics of care is that it enables the conceptualisation of ethics and leadership as an embodied and affect-laden relational practice. Care ethics enables us to see how care flows through leadership practice, imbuing the 'how' of leadership with ethical content. As noted above, this could lead to a broad injunction that leadership should be more caring, more attuned to emotional needs, more emotionally resonant. Our account agrees with the broad tenor of this approach – that care ought to flow through leadership. However, we seek to add nuance through the deployment of a political reading of the ethics of care, which emphasises inherent practice tensions, which leadership needs to steer through. As care flows through leadership, care is itself renewed and interrogated in a reflexive way. On occasion, care draws tight boundaries in which prior affective relations are nurtured in a democratic and dialogic manner. In others, care flows in an expansive manner, with inquiry seeking out and taking responsibility for a broader range of care needs. In others still, responsibility is constrained through the need to care for the self. All variations foreground the tensions and risks that inhabit care practice, such as difficult emotions, paternalism, and misidentification. This understanding is particularly significant for voluntary sector organisations that identify themselves as distinctively close and responsive to communities and service users.

This approach offers a way to practise care in leadership in a manner that holds these tensions in place, rather than attempting to dissolve them. Leadership is framed in a way that is sensitive to context; avoiding suggestions that there is only one way of enacting care or being ethical. In so doing, we answer critics of 'caring leadership' by offering an alternative conceptualisation of care and its relation to leadership. These practice tensions emphasise the risks of care and a way to think through care ethics and leadership practice that keeps risk as intrinsic to these relations. This approach may lack the clean and direct guidance that we might seek from moral theory; however, this is a more realistic account of the vibrant dynamics between care and leadership within a voluntary sector context and in keeping with the practice emphasis of care ethics. As such it is expected that other tensions will arise from further empirical work.

Our account of leadership and care ethics treats it as laden with tensions and risks that, when enacted in practice, can lead to both relational warmth founded on a valorisation of dependency and vulnerability within a defining generosity, and withdrawal, deformed relationships and difficult emotions. As a practice, care ethics cannot guarantee what it seeks. When applied to leadership these risk and tensions are carried through and there is no one way of leading that enacts care in a wholly effective manner. However, this does not mean that we should not strive to care in leadership practice, but that we should do so in recognition of the practical tensions it entails. As such we suggest it is not so much a 'leadership ethics of care' but a vibrant meeting of leadership and care ethics that offers the possibility for care to flow within leadership but also acknowledges its alter.

For the voluntary sector, this presents a way to enact leadership that acknowledges the difficulty of practice within organisations that position themselves as uniquely able to respond to need yet are always and essentially limited in terms of capacity and resources. For LIOs in particular, their focus on creating consistent messaging for members can provide an established boundary to care, but championing sector diversity within the context of growing societal and environmental needs can seem to exert an almost limitless pressure to 'care more'. Working within the tensions we identify may help to work through these pressures and ultimately lead to more informed (and, indeed, ethically inflected) leadership practice.

Limitations and future research

This article presents an analysis that moves between theory and data to create new insight into leadership in the voluntary sector. Although the data on which this article is based are rich, there is no doubt that more empirical work would be beneficial. In particular, future research that focuses on contexts other than LIOs would be of value, as would research that considers voluntary sector leadership outside of crisis situations, although arguably crisis is a defining feature of much work in the sector. Research in countries other than England would also be of benefit as notions of leadership and of care are likely to have national and cultural variations.

Note

[1] LIOs are voluntary sector organisations that support other voluntary sector organisations. In England they often have the name 'Council for Voluntary Service' (CVS) or one that includes reference to community or voluntary action. They are also often members of the National Association for Voluntary and Community Action (NAVCA). Specific roles and offers vary, but generally include some form of volunteer support, support for organisational policies and procedures, liaison with other sectors, representation with partners, support with funding, and so on.

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Conflict of interest

The authors declare that there is no conflict of interest.

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