Challenging Care: Professionally Not Knowing What Good Care Is

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SUMMARY A dominant trope in the anthropology of care—of revealing a practice to be, despite our moral intuitions to the contrary, really a form of care—limits our understanding of the dynamic processes whereby care’s morality is established in practice. In the British care sector the ideal of care is clear: avoiding coercion and neglect. There are manifold rules designed to hold carers accountable to realizing it. But the rules do not reliably lead to the ideal. Rather, they leave undetermined an enormous amount for carers to fill in. In this setting, whether or not a worker’s action becomes “caring” depends on far more than good intentions or following rules. The action’s moral status rests, instead, on the contingencies of the relationship with the care recipient. We should refrain from entering into the evaluative work of rearranging the borders of good care in order to investigate how our informants themselves do this in the midst of care’s relational vicissitudes. Doing so enables us to attend to how debates about what constitutes good care are part of broader patterns by which moral responsibility is assigned and distributed within caring relationships. [care, contingency, disability, ethics, responsibility]

One of the most significant contributions of the still young anthropology of care has been to challenge moral intuitions and philosophical certainties about what constitutes good care. Much of this work targets the idea of individual choice, control, and independence from interference that regulates many contemporary forms of care (e.g., Brodwin 2013; Mol 2008; Pols 2006; Pols et al. 2017; Stevenson 2014; Taylor 2010). In this article I focus on the way a range of ethnographies launch this challenge by “troubling” (Duclos and Criado 2020) the normative dichotomies between good care and its uncaring, neglectful, and coercive opposites (e.g., Brown 2010; Davis 2012; Garcia 2014, 2015; Harbers et al. 2002; Kulick and Rydström 2015; Mol 2008; Pols et al. 2017). These pioneering works of the “divergent registers of meaning around care” develop an anthropological rather than philosophical ethics that is open to the diversity of ways that “different types of care can produce outcomes which both patients and care-givers experience as good or successful” (Brown 2010:137–138).

The dominant way in which these texts launch their challenge to existing understandings of care is through a powerful rhetorical trope: the anthropologist...
reveals that a practice that looks like the complete opposite of care from the outside really is care after all when one understands it ethnographically. This rite of reversal is performed on whatever abstraction might lead us to misunderstand a given local practice. Julie Livingston (2012), Tanya Luhrmann and Jocelyn Marrow (2017), for instance, undermine the idea that care must be transparent to be ethical by describing what is caring about withholding information, lying, and deception in Botswana and India, respectively (for the reverse case of anonymity see Rivas 2004; Stevenson 2014). Similarly Hannah Brown (2010), Sarah Pinto (2014), and Angela Garcia (2015) challenge the idea that care must be premised on consent and the absence of harm by demonstrating the moral and therapeutic value of the deliberate infliction of pain, coercion, confinement, and violence (see also Brodwin 2013; Sufrin 2017; Davis 2012).

Garcia’s (2015) article “Serenity: Violence, Inequality, and Recovery on the Edge of Mexico City” is one of the most impressive accomplishments of this genre. She focuses on the several thousand “informal, unregulated, and destitute” (2015:458) private drug rehabilitation centers, called anexos, that respond, outside the bounds of inadequate public mental health provision, to a sharp “rise in addiction and mental illness” under the shadow of Mexico’s war on drugs (2015: 461). Anexos often forcibly abduct addicts, confine them against their will, and torture them with beatings and cigarette burns (2015:465–11). But Garcia’s ethnographic descriptions work to counter the “liberalized sensibility” (2015:462) that is scandalized by this violence—a moral condemnation that she argues further marginalizes the poor families who turn to this form of care for their addicted kin because they see no “other option but abandonment or death” for their relative (2015:465).

Garcia argues that far from violence being the opposite of care, as we might imagine, anexos “utilize a form of violence as care” (2015:455). She makes the case for this in two ways. First, by demonstrating that, contrary to popular discourse, families themselves are adamant they do not choose anexos with the intention of abandonment but from a desire to save their relative from addiction and street violence. Second, by arguing that the pain is “therapeutic” (2015:465). In the words of one of Garcia’s informants, the violence can be “very effective” (2015:468). Garcia is clear that these effects do not equate to the kind of “invulnerability” or “cure” biomedicine looks for (2015:469). Instead, the echoes between narco-violence and anexo therapeutic practices produce personal and communal “transformation” of the violence that pervades life in Mexico City more generally (2015:469). Too briefly summarized, her argument is that because this violence comes from good intentions and is understood locally to pursue the good, we ought to question its separation from care—moving to classify it, instead, as an unexpected form that care can take.

Garcia’s article exemplifies what is important and promising about this strand of the anthropology of care. It also demonstrates what I take to be a weakness of this way of exploring care’s morality in ethnographic action. Garcia tells us that her aim is not “to subject” anexos “to moral scrutiny” but to “appreciate the concerns” of those who use them, “read their cultural logic,” and “understand the disparate forms of recovery and sociality they produce” (2015:457). But Garcia’s desire to defend anexos against their detractors leads her to a stronger conclusion: that this violence is itself care. The appellation
of care functions as more than a purely neutral descriptor in that claim. It attributes to *anexo* violence a worth and value that we might otherwise miss if we rush to condemn it. Garcia’s article, in other words, has a moral as well as analytical point: to articulate violence’s “redemptive possibilities” (2015:470).

But this mode of evaluation directs us away from what about care’s morality remains unsettled and uncertain, even when we have understood people’s good intentions and their local understandings of what constitutes care. I describe how and why carers for people with intellectual disabilities in a British non-governmental organization (NGO) are unsure whether their actions are caring. I focus on the way that appellations of care are muddied by the complexity of interactions between caregivers and care receivers, and by debates among caregivers themselves. I focus, too, on how the NGO’s commitment to ethical reflection prevents carers from hiding that complexity. In this context, whether or not an action acquires the moral status of “caring” depends on much more than people’s intentions or their understandings of the good. It must be established in the vicissitudes of relationships. My argument is that the trope of evaluative reversal and revelation steers us away from these uncertainties, debates, and contingencies that shape the ethical status of actions within care. The achievement of care, I contend, is both more vulnerable and more political than Garcia’s argument and the revelatory trope in general tends to imply, in the sense that it is more closely entangled with both the vicissitudes of relationality and the contentious distributions of responsibility within them.

**Regulating Interactions**

Bob is a gentle and gracious man in his fifties. Doctors and social workers have assessed him to have a significant “learning” or “intellectual” disability, a mental impairment that affects his capacity to carry out daily tasks involving more complex cognizing. This entitles him to welfare payments from the British government to support his upkeep. These funds are passed on to a Christian NGO called L’Arche UK, which arranges for his housing (in a home rented from the local authority) and continual care to support him and those with whom he lives. In the summer of 2013 L’Arche started employing me to work full time as a care worker in Bob’s home and authorized me to conduct research through participant-observation and interviews. I worked alongside a team of carers who were a mixture of three demographics: young, middle-class, western-European men and women; middle- and working-class British women in their middle age; and women of various ages who had emigrated from Eastern Europe and sub-Saharan Africa.

L’Arche is, like all care organizations in the UK, tightly regulated by social workers, commissioners from the local authority, and the Care Quality Commission. They check up on Bob’s home at regular intervals to ensure that carers are complying with all manner of rules: from giving the precise amount of medication or recording every last penny of money spent, to getting people out of the house to do meaningful activities during the week and giving them the opportunity to form relationships with others.
These rules are attempts to settle the grave risks that attend care: the possibility that a carer who is meant to be supportive might turn out to be either coercive or neglectful. They are intended to prevent, through legal accountability, the kind of harm to which Bob is constantly vulnerable and that caring relationships in the past have so frequently inflicted on individuals like him. They work to define what morally and legally justifiable care is in this context: actions that prevent a person from falling into disrepair, not through paternalistic constraint but rather through working in concert with their preferences and choices.

But following this framework does nothing to guarantee that carers will achieve the ideal form of care it gestures toward. Legally sticking to the rules would produce nothing coherent, let alone ideal, in terms of care. It is perfectly obvious that giving Bob the wrong medication, or denying him access to medication altogether, is not care. But when Bob walks into the road, ought one to respect it as his choice? In practice, there are significant conflicts between the rules. The clarity of the rules and of the ideal do not make the connection between the two any plainer. So quite what care requires and entails is often uncertain. What does care involve when Bob does not want to bathe enough to stay healthy? What does care look like when Bob tells you that he wants to go out for the whole day but then gets upset about leaving the TV when it is time to leave?

L’Arche offers new carers a less legalistic way to handle these uncertainties in the form of routines. As part of my training in my first week on the job, I was given a sheet of paper detailing every aspect of Bob’s morning—from exactly how warm to run the bath to how to give him his newspaper, from what to say to wake him up to when to give him his medication. Each care recipient’s “key worker” draws on their own experience, and that of other key workers before them, in order to design a routine specifically tailored to that individual’s preferences and needs. Peter had played this role for Bob for several years, and the routine he developed worked around activities to which Bob had reacted badly and those with which he happily cooperated. These written routines give a precise set of actions for carers to follow as they care for any particular individual, and they exist as particular scripts within a less formally defined plotline for the day and week, such as giving Bob a bath regularly or taking him out to the pub for a burger every Saturday.

Peter also gave all new carers informal advice about just how to interact with Bob to go along with the practical steps contained in the routine. Most important, he told me, was to avoid asking Bob questions at any point in the morning or when he was about to do something difficult. Bob, Peter told me, would always say “no” whatever you asked him, simply because he found being asked anything difficult and anxiety provoking. Best just to do, without asking, what it is you know Bob likes and he will find it much easier. As the distillation of Peter’s sensitive and experienced guesses at Bob’s preferences, the routine promised to give carers confidence that they were indeed caring for Bob in a way that he wanted. The routine mediated the insights of an experienced carer to those who struggled to juggle the complexities of the task.

But this project of connecting good intentions to an ideal through patterned interaction was, again, successful only to a limited degree. This was because of
the contingencies that lay outside of the routines; principally, how Bob reacted to different carers. I helped Bob get up almost every day for a year. But, despite following Peter’s advice to the letter, Bob continued to be angry whenever I supported him (and he reacted similarly when more occasional carers like Mier and Jacob did too), throwing his newspaper on the ground at breakfast and cursing under his breath when I brought him his toast. Although I saw him leave the house calmly with Peter often, whenever I told Bob it was time to go out—even when it was for the trip to the pub on Saturday—he became upset.

Neither my intentions to care for Bob nor my following of the routines for doing so were enough to make sure that my actions turned out to be good care. To leave Bob alone in all of these situations might well have been neglectful—it would have stopped him having a bath, eating breakfast, and going out. Yet to intervene in Bob’s life in this way was not to act in concert with him. Was his anger because he did not want to go out after all? Or did he actually want to go out but was unhappy about something else? Was it simply that he did not like me? If the latter, then there was little I could do. You cannot act in concert with someone who does not want to act in concert with you (Mol 2008:94–95). What constituted care in these circumstances? No answers to that question could be settled in advance, because the moral status of my actions resided in their relationship to Bob's current interior state. Good care depended on factors outside of my control. Whether or not I managed to care was thus open to what Bernard Williams (1981) calls “moral luck” (see also Kittay 2019).

**Breaking Rules and Making People**

Precisely how to interpret Bob’s feelings, and thus the morality of these situations, was a common topic of discussion among carers. Emma, a relatively recent arrival, questioned why we did not just leave Bob alone when he got upset about going out because she thought it was obvious that he wanted to stay in. Marla, a more experienced carer, had a more complex view that commanded more sway. She treated Bob’s anxiety at going out as a conflict between two genuine desires: to watch TV and to go out. If Marla was right about this, then to take either option would be to ignore one of Bob’s desires. To go out would be to coerce the part of him that wants to stay in, and to stay in would be to neglect the part of him that wants to go out. Either would be a form of coercion or neglect and thus not care. To put it differently, while Bob remained conflicted, there was no way to act with him. “You cannot act in concert with one who does not act in concert with himself” (Korsgaard 1992:332). On Marla’s interpretation, the moral luck resides in whether or not there even are any possibilities for care to begin with.

Peter, though, read the situation differently. He told me that for the first years after Bob moved in to L’Arche he rarely left the house, and when he did so he would get so upset in the process that he would destroy all the wall hangings, throw the post all over the floor, and shout about how much he hated the place. The introduction of a TV did not change this. Bob was firmly wedded to it and hated to do much other than watch it. Peter’s point was that Bob’s anger at leaving the house was the sign not of a clear choice but rather of fear. For
Peter, Bob was unhealthily attached to the TV as a result of his anxiety about going out.

In the years before I arrived, Peter had been steadily encouraging the team to take Bob to do things that he would never choose to do himself. Peter would listen to what Bob was talking about excitedly (watching films with “strong language” in them, football matches, and listening to Tom Jones) and then arrange for carers to take him to the cinema, watch a football match at a pub, or travel to a concert. Peter’s hope in imposing upon Bob activities that Bob himself would never choose was that it would, in the long run, give Bob more choices and allow him to shape his own life to a greater extent. Peter thought that care entailed coercion in this case. But, in contrast with cases where carers come to accept the coercive logic of an institution, this was not because he thought coercion was justifiable or caring in and of itself (Chapman 2014). It was because, in a situation with no choice but to either neglect or coerce, coercion at least contained the possibility of transforming Bob’s capacities for the future. In intervening coercively in his life by forcing him out of the house, Peter hoped that Bob might come to be someone who did not need to be coerced to leave the house but could act in concert with his carers in their attempts to support him.

This did not diminish Peter’s responsibility but rather increased it. His interventions could only be vindicated retrospectively—their ethical justification resting to a large extent on the contingencies of who Bob became through them in the months and years that followed (Paul 2014). As it happens, the program was remarkably successful, as all the other carers recognize. Bob can now do many more things than he could a couple of years before. He has overcome his aversion to the bus, for instance, so he can travel much farther. He is less anxious during his day, and in particular when leaving the house, and it is much more likely that he will, in fact, leave. It is hard to converse with Bob about precisely what these changes mean to him, but his continued affection toward Peter and the reduction in his anxiety suggests this care did what it was meant to do: increased his well-being and freedom simultaneously, protected him and gave him choice at one and the same time.

It would thus be easy to conclude that what Peter did was care. I, like other newer carers, often tried to copy someone authoritative such as Peter in order to have some surety that what we were doing in these uncertain situations was good. But L’Arche rarely allows its carers to escape these ambiguities. It encourages them, instead, to reflect both individually and in team meetings on the complexities of their interventions. Often when newer carers asked whether an act was really caring or not, a manager would take it seriously as a topic for discussion while also encouraging us to “stay with the question” rather than think there was a resolution to it. Carers are taught, that is, to be professionally ignorant about what good care looks like in order better to debate that among themselves.

The result is that, as carers stay in L’Arche, they become less rather than more sure about what care entails. Peter told me:

I don’t know if I’ve done it all right. I don’t have the perfect answer. I know now that I’m happy we’ve made those strict decisions because people are able to do much more than before … But nevertheless, you should always think, “do you
act in their interests? Or do they have the capacity to make that decision?” You shouldn’t generally overrule.

Peter’s longevity in the organization meant he got to see the positive results of his interventions. But he would not settle on a secure interpretation of them as moral. Was it really in Bob’s interests to force him out of the house in any particular instance? Even if it was, might Bob actually have the capacity to take that decision for himself without interference? The suspicion of coercion or neglect haunted even the most well-intentioned, sensitive, and fruitful actions. Carers’ attempts to do the right thing lead them only further away from any certainty that they have, in fact, done it or would even know what it looked like if they had.

**Conclusion**

The uncertainty that surrounds care in L’Arche contributes to anthropological attempts to disrupt philosophical attempts to fix care’s morality without reference to the vicissitudes and variability of social life. Whether or not an action comes to be evaluated as “care” in L’Arche is dependent on more than intentions, rules, and local understandings of the good. It relies, also, on the interactional contingencies of the caring relationship itself. Most notably, it relies on Bob. The uncertainty here concerns not just whether carers can reliably know what Bob is feeling. It concerns also the fact that, because Bob is human, their actions do not have a simple reliable effect upon him that could ever be known in advance. Because Bob is continually changing, in part through the care he receives, the shape and pattern of even those contingencies keeps shifting.

The shape of these uncertainties is unlikely to be universal (indeed, their dependence on social context is precisely my point). The relative absence of material about debate and uncertainty in Garcia’s article about the anexos likely indicates an ethnographic difference worth attending to. It might be that, existing outside of state and professional regulation, care’s morality or even efficacy is not such an explicit concern in anexos as it is in L’Arche and thus not the subject of such extensive reflection. These differences do not correlate straightforwardly with the (culturally specific) distinction between “formal” and “informal” care. For instance, kinship care of an elderly relative in India (Cohen 2000) or of children in China (Kuan 2015) can be the cause of intense moral concern. But different assumptions about the stakes of caring actions, and their dependence on the recipient’s mind, can also mitigate against the necessity for this kind of reflection in analogous forms of care (see Aulino 2016 on eldercare in Thailand; and Mezzenzana 2020 on childcare in the Ecuadorian Amazon). Similarly, there are plenty of ways in which professional care settings outside the family can close down, rather than provoke, ethical reflection (Chapman 2014; Johnson 1998; Lester 2009).

My argument is not that the example of reflection in L’Arche represents something universal about how doubt manifests and is managed in care. The presence of intense uncertainty in L’Arche is the product of a very particular combination of high ideals and strict rules in the contemporary British care sector. This combination works to place a huge stake on fragile and complex
caring interactions, without leaving any way to fix these interactions in any reliable way. Debate about care is generated by the transfer of responsibility to carers for controlling the realization of a moral ideal within the vicissitudes of interactive relationships that they, by definition, cannot morally exert total control over. Carers are thus always responsible for the realization of a care that is not within their power. These differences in the way that moral responsibility for care is distributed raise sharp questions of any philosophy that attempts to fix obligation and blame outside of the particular ways in which interaction is configured in a given context.

But my argument is that an ethnographic attention to the distribution of responsibility challenges not only philosophical theories about care but also the dominant way in which anthropologists have sought to undermine them to date: through the trope of ethnographically unmasking surface appearances in order to reveal what, underneath, really constitutes care in a given context. L’Arche’s particular way of responding to the distinct moral climate it sits within reveals the limits of this trope. Because my informants do not know what care consists of, I cannot claim to do so either (unless I were to claim that their uncertainty itself really is caring—though I would find that disingenuous on a number of fronts). Their debates and doubts thus help us appreciate the inherently vulnerable, political, and interactive nature of claims to know what good care is—including those made by anthropologists. The revelatory trope directs us away from questions about just how any local moral understanding plays out in practice. (In Garcia’s case, for example, who resists the cigarette burns and remains skeptical about their efficacy or legitimacy?)

When we classify something as care for evaluative reasons (such as to defend its value ethnographically against its detractors), we find ourselves in the company not only of philosophers but also those we seek to study. In as much as the revelatory trope sets up anthropologists as spokespeople for what good care really looks like on the ground, it runs the risk of reproducing a particular therapeutic ideology rather than the interaction between different visions of good care and the way they play out in the contingencies of relationships. This threatens to reduce care’s ethics to a two-dimensional moral imagination (however richly we paint it) rather than something more expansively established in the dynamic interactions by which responsibility is assigned. If uneven debates about what constitutes good care are part of what creates the morally fraught conditions in which carers work, then there is an important role for an anthropology of care that understands these ethical processes before it contributes to them.

References Cited

Aulino, Felicity
2016 “Rituals of Care for the Elderly in Northern Thailand: Merit, Morality, and the Everyday of Long-Term Care.” American Anthropologist 43(1):91–102. https://doi.org/10.1111/amet.12265.

Brodwin, Paul
2013 Everyday Ethics: Voices from the Front Line of Community Psychiatry. Berkeley: University of California Press.
Brown, Hannah  
2010  “If We Sympathise with Them, They’ll Relax: Fear/Respect and Medical Care in a Kenyan Hospital.” *Medische Anthropologie* 22:125–142.

Chapman, Chris  
2014  “Becoming Perpetrator: How I Came to Accept Restraining and Confining Disabled Aboriginal Children.” In *Psychiatry Disrupted: Theorizing Resistance and Crafting the (r)Evolution*, edited by Bonnie Burstow, Brenda A. LeFrançois, and Shaindl Diamond, pp. 16–33. Montreal: McGill University Press.

Cohen, Lawrence  
2000  *No Aging in India: Alzheimer’s, the Bad Family, and Other Modern Things.* Berkeley: University of California Press.

Davis, Elizabeth Anne  
2012  *Bad Souls: Madness and Responsibility in Modern Greece.* Durham, NC: Duke University Press.

Duclos, Vincent and Tomás Sánchez Criado  
2020  “Care in Trouble: Ecologies of Support from Below and Beyond.” *Medical Anthropology Quarterly* 34(2):153–173. https://doi.org/10.1111/maq.12540.

Garcia, Angela  
2014  “The Promise: On the Morality of the Marginal and the Illicit.” *Ethos* 42(1):51–64. https://doi.org/10.1111/etho.12038.

Garcia, Angela  
2015  “Serenity: Violence, Inequality, and Recovery on the Edge of Mexico City.” *Medical Anthropology Quarterly* 29(4):455–472.

Harbers, Hans, Annemarie Mol, and Alice Stollmeyer  
2002  “Food Matters.” *Theory, Culture & Society* 19(5–6):207–226.

Johnson, Kelley  
1998  *Deinstitutionalising Women: An Ethnographic Study of Institutional Closure.* Cambridge: Cambridge University Press.

Kittay, Eva Feder  
2019  *Learning from My Daughter: The Value and Care of Disabled Minds.* New York, NY: Oxford University Press.

Korsgaard, Christine M.  
1992  “Creating the Kingdom of Ends: Reciprocity and Responsibility in Personal Relations.” *Philosophical Perspectives* 6:305–332. https://doi.org/10.2307/2214250.

Kuan, Teresa  
2015  *Love’s Uncertainty: The Politics and Ethics of Child Rearing in Contemporary China.* Berkeley: University of California Press.

Kulick, Don and Jens Rydström  
2015  *Loneliness and Its Opposite: Sex, Disability, and the Ethics of Engagement.* Durham, NC: Duke University Press.

Lester, Rebecca J.  
2009  “Brokering Authenticity: Borderline Personality Disorder and the Ethics of Care in an American Eating Disorder Clinic.” *Current Anthropology* 50(3):281–302. https://doi.org/10.1086/598782.

Livingston, Julie  
2012  *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic.* Durham, NC: Duke University Press.

Luhrmann, Tanya and Jocelyn Marrow  
2017  *Our Most Troubling Madness: Case Studies in Schizophrenia across Cultures.* Oakland: University of California Press.

Mezzenzana, Francesca  
2020  “Between Will and Thought: Individualism and Social Responsiveness in Amazonian Child-Rearing.” *American Anthropologist* 122(3):540–553. https://doi.org/10.1111/aman.13345.

Mol, Annemarie  
2008  *The Logic of Care: Health and the Problem of Patient Choice.* London: Routledge.
Paul, Laurie Ann
2014  *Transformative Experience*. Oxford: Oxford University Press.

Pinto, Sarah
2014  *Daughters of Parvati: Women and Madness in Contemporary India*. Philadelphia: University of Pennsylvania Press.

Pols, Jeannette
2006  “Washing the Citizen: Washing, Cleanliness, and Citizenship in Mental Health Care.” *Culture, Medicine and Psychiatry* 30(1):77–104. https://doi.org/10.1007/s11033-006-9009-z.

Pols, Jeannette, Brigitte Althoff, and Els Bransen
2017  “The Limits of Autonomy: Ideals in Care for People with Learning Disabilities.” *Medical Anthropology* 36(8):772–785. https://doi.org/10.1080/01459740.2017.1367776.

Rivas, Lynn May
2004  “Invisible Labors: Caring for the Independent Person.” In *Global Woman: Nannies, Maids, and Sex Workers in the New Economy*, edited by Barbara Ehrenreich and Arlie Russell Hochschild, pp. 70–84. London: Granta Books.

Stevenson, Lisa
2014  *Life beside Itself: Imagining Care in the Canadian Arctic*. Berkeley: University of California Press.

Sufrin, Carolyn
2017  *Jailcare: Finding the Safety Net for Women Behind Bars*. Berkeley: University of California Press.

Taylor, Janelle
2010  “On Recognition, Caring, and Dementia.” In *Care in Practice: On Tinkering in Clinics, Homes and Farms*, edited by Annemarie Mol, Ingunn Moser, and Jeannette Pols, pp. 27–56. Bielefeld: Transcript Verlag.

Williams, Bernard
1981  *Moral Luck: Philosophical Papers 1973–1980*. Cambridge: Cambridge University Press.