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ARTICLE

A Relational Approach to an Analytics of Resistance: Towards a Humanity of Care for the Infirm Elderly – A Foucauldian Examination of Possibilities[1]

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ABSTRACT: This paper develops a Foucauldian analytics of resistance in relation to components of a system of governance – a governmentality. Techniques of resistance that can transform a governmentality towards the development of a new politics of truth require the design of techniques of resistance to counter directly oppressive techniques of biopower and disciplinary power, in turn to produce new regimes of practices or counter-conduct that can engender a new mentality and set of discourses to convey it. Strategies of resistance towards transformative change in the governance of a population as well as of the self therefore require development following, and in relation to, an analytics of governance. I thread these points through a particular case, the problem of care for the infirm elderly in the United States, focusing specifically on nursing homes by critically synthesizing issues from inter-disciplinary literatures and casting them in terms of governmentalities. I frame the problems of eldercare broadly in terms of interrelated neoliberal and (western) scientific mentalities and associated discourses, and then examine the associated techniques of biopower, disciplinary power, and regimes of practices to identify roots of problems, explain failures of policies, and crucially, to frame the design of techniques of resistance to produce new regimes of counter-conduct. I suggest avenues of resistance in relation to existing governmentalities on the terrain of inter-firm relations and everyday life in nursing-home care, all currently entangled with government policies, economies of documentation, and dehumanizing scientific practice.

Keywords: Foucault, epistemology, resistance, governmentality, neoliberalism, medicalization, eldercare

[1] Acknowledgement: I thank the *Foucault Studies* editors and the anonymous reviewers for their helpful comments.

This paper develops an analytical framework for identifying and developing possibilities of resistance. Examining 'possibilities' may, however, seem remote. Seminal examples of similar concerns include discussions in critical theory regarding radical democracy,[2] Nancy Fraser's[3] call for the three 'R's' (recognition, redistribution, and representation), and Iris Young's[4] discussion of the problems of segregation and call for relational autonomy. The interdisciplinary critical theory scholarship is stimulating but ambiguous about, or lacks reference to, mechanisms to connect theory with practice. In this regard Foucault's late scholarship is helpful because his concern was precisely with the relation between discourse and materiality, societal mentalities and regimes of practices, and regarding resistance, "a way that is more empirical, more directly related to our present situation, and one that implies more relations between theory and practice."[5] Although Foucault did not offer an explicit analytical framework for governance[6] or resistance, it is possible to cull his scholarship for critical analytical points and 'connect the dots' where he did not.[7]

I draw from an epistemological approach to governmentality that I developed, [8] making use of analytical anchor points towards an analytics of resistance. This framework focuses mostly on governance and briefly on resistance and technologies of the self; it entails identifying and explaining interrelations among regimes of practices, the mentality/ies that govern such regimes, the discourses that convey the mentality/ies, and the techniques of power – disciplinary power and biopower – that ground the mentalities, as well as the articulation of the governance of populations and of the self. The underlying epistemological argument in this paper is relational: a Foucauldian analytics of resistance should connect with, and follow from, a governmentality analysis. Consistent with Foucault's view that resistance is imminent and situated in the "antagonism of strategies,"[9] an analytics of resistance requires first an analysis of governance. A central task is to identify oppressive techniques of biopower and disciplinary power so that techniques of resistance can be

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[2] For example, S. Benhabib (ed.), *Democracy and Difference* (Princeton, NJ: Princeton University Press, 1996); E. Laclau and C. Mouffe, *Hegemony and Socialist Strategy* (New York: Verso, 2nd edition, 2001).

[3] N. Fraser, *Scales of Justice* (Malden, MA: Polity, 2008).

[4] I.M. Young, *Inclusion and Democracy* (New York: Oxford, 2000).

[5] M. Foucault, "The Subject and Power," in J.D. Faubion (ed.), R. Hurley and others (trans.) *Michel Foucault/Power* (New York: The New Press, 2000), 329.

[6] Foucault used 'government' not 'governance.' Here and throughout the text I use 'governance' to avoid implying 'the state' as the principal referent in light of Foucault's clarification that government extends well beyond 'the state' or *formal* government.

[7] See for example M. Dean, *Governmentality* (Los Angeles: Sage, 2010); Ettlinger (2011).

[8] N. Ettlinger, "Governmentality as Epistemology, *Annals of the Association of American Geographers*, vol. 101 (2011), 537-560. https://doi.org/10.1080/00045608.2010.544962.

[9] Foucault, Subject and Power, 329. See also M. Foucault, "Power and Strategies," in C. Gordon (ed.), C. Gordon, L. Marshall, J. Mepham, and K. Soper (trans.) *Power/Knowledge* (New York: Pantheon, 1980), 142, and M. Foucault, "Sex, Power, and the Politics of Identity," in S. Lotringer (ed.), L. Hochroth and J. Johnston (trans.), *Foucault Live* (New York: Semiotext(e), 1996), 386.

appropriately targeted.[10] Towards the development of a new set of truths, techniques of resistance require designs for a 'counter-calculation' in relation to techniques of power as tools to cultivate new regimes of practices – counter-conduct – among all actors, in turn to engender new discourses and mentalities. Key here is a relative chronology regarding new practices and discourses: the latter follows the former, not vice versa, the conventional approach to resistance.

I ground the points I make about an analytics of resistance with reference to problems surrounding care for the infirm elderly in the United States, i.e. those who are no longer able to care for themselves due to physical and/or cognitive impairment.[11] Infirmity in old age is a pressing issue worldwide as societies continue to age, without, however, effective designs for change.[12] New developments in policy do little more than nibble at the edges of profound problems and commonly entail increased funds, even if insufficiently. Extra dollars may be needed,[13] but this common approach lacks transformative mechanisms. From a Foucauldian vantage point, fundamental changes that have occurred in society emanate not from government, but rather "deep in the social nexus."[14] Foucault argued that institutions and policy are important, but that policy represents the crystallization of shifts anchored in civil society.[15] Policy legitimizes and institutionalizes existing change that is informally developed.[16] Moreover, as I will explain through an analysis of governance, increased government funding as the popularly presumed solution misses the techniques of biopower that have resulted in problems, and consequently treats effects rather than causes while preserving existing systems.

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[10] Disciplinary power or anatomo-politics and biopower can be examined independently, although Foucault indicated that the two complement each other and that an overall analysis of governance accounts for both. For example, M. Foucault, R. Hurley (trans.), *The History of Sexuality*, vol. I (New York: Vintage Books, 1990), 140-141; M. Foucault, D. Macey (trans.), *Society Must Be Defended* (New York: Picador, 1997), 250-252; M. Foucault, M. Senellart (ed.), G. Burchell (trans.) *Security, Territory, Population* (New York: Picador, 2007). See also T.F. Tierney, "Anatomy and Governmentality," *Theory and Event*, vol. 2, (1998).

[11] Accordingly, the referent here is not old age in general or institutions of 'assisted living' where assistance is collective (meals in dining rooms, shopping and recreational excursions) and individuals care for themselves (e.g. dressing, bathing and toileting, eating, medications).

[12] B. Neilson, "Ageing and Globalisation in a Moment of So-Called Crisis," *Health Sociology Review*, vol. 18 (2009), 349-363. https://doi.org/10.5172/hesr.2009.18.4.349.

[13] Care for the infirm elderly is extremely expensive. Costs for caring for people with dementia exceed those for cancer and heart disease; see G. Kolata, "Costs for Dementia Care Far Exceeding Other Diseases, Study Finds," *Nytimes.com*, Oct. 27 (2015), http://www.nytimes.com/2015/10/27/health/costs-for-dementia-care-far-exceeding-other-diseases-study-finds.html.

[14] Foucault, Subject and Power, 343.

[15] Foucault, Subject and Power, 343; see also Foucault's comments about the roots of gay liberation in Sex, Power, Politics of Identity, 390, and his discussion of analyzing institutions in "Questions of Method," in *Michel Foucault/Power*, 232.

[16] A clear example: the sea change in attitudes in the United States regarding same-sex marriage; government policies followed attitudinal shifts to legitimize and formally act on changes in civil society.

The landscape of eldercare includes different collective living arrangements, hospitals, and home care, not to mention the government and the insurance industry and their offices and agents. And eldercare of the infirm is itself a small subset of the neoliberal governance of aging.[17] In the interests of space and with the intent of developing depth regarding resistance in relation to the governance of eldercare of the infirm, I focus specifically on nursing homes, the first major institutionalized, societal avenue by which to capitalize on an ageing society. The long-term trend has been one of medicalization and the bureaucratization of affective care, such that those who linger beyond the apparent capacity of their bodies and/or minds commonly live out the last part of their lives starved for meaningful social interaction in a hospital-like environment.[18] Affluent, long-term, paying residents arguably have nicer physical conditions than the majority of seniors dependent on public funding, but even the 'best,'[19] with few exceptions, are a last resort because of the socially alienating environment.[20]

The analytics of resistance to nursing-home problems I develop suggest that resistance aimed at transformative changes requires effective targeting of contestation, predicated on a critique of the system of governance to uncover roots of problems beyond their effects. There indeed are other forms of resistance that demand respect, such as the courage of nursing-home residents to reject the passive roles ascribed to them, sometimes materializing in vocal resident councils[21] that contest nursing-home dynamics. In his scholarship on ethics Foucault engaged the transformation of one's subjectivity as an act of resistance in the governance of the self.[22] However, this

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[17] For example, B. Rosenberg, *Ageing, Community, and Neoliberal Governance* (London: Routledge, 2016); S. Katz, *Disciplining Old Age* (Charlottesville: University of Virgina Press, 1996).

[18] N. Foner, *The Caregiving Dilemma* (Berkley: University of California Press, 1994); C.M. Grogan, "The Medicalization of Long-Term Care," in C.M. Mara and L.K. Olson (eds.) *Handbook of Long-Term Care Administration and Policy* (Boca Raton, FL: CRC Press, 2008). https://doi.org/10.1201/9781420013245.ch4; J.N. Henderson, "The Culture of Care in a Nursing Home," in J.N. Henderson and M.D. Vesperi (eds.) *The Culture of Long Term Care* (Westport, CT: Bergin & Garvey, 1995), 37-54; M. Kitchener and C. Harrington, "The U.S. Long-Term Care Field," *Journal of Health and Social Behavior*, vol. 45 (2004), 87-101.

[19] As indicated later in the paper, positive instances of nursing-home care exist, but these are uncommon and financially exclusive. This paper focuses on mainstream nursing-home care by which most institutionalized infirm seniors are subjected.

[20] See B.C. Farmer, *A Nursing Home and its Organizational Climate* (Westport, CT: Auburn House).

[21] Vocal resident councils do not necessarily result in change (Devitt, M. and Checkoway, B., "Participation in Nursing Home Resident Councils," *The Gerontologist*, vol. 22 (1982), 49-53). https://doi.org/10.1093/geront/22.1.49. Scholars have problematized participatory governance in a range of contexts (e.g. regarding digital participation on the web see Powell, A., "Hacking in the Public Interest: Authority, Legitimacy, Means, and Ends," *New Media and Society*, vol. 18 (2016), 600-616; regarding participatory planning see Huxley, M. "Historicizing planning, problematising participation," *International Journal of Urban and Regional Research*, vol. 37 (2013), 1527-1658). https://doi.org/10.1177/1461444816629470.

[22] For example, Foucault, Subject and Power, Ethics of Concern for Self, *The Hermeneutics of the Subject* (New York: Picador, 2005).

kind of change does not necessarily translate into change in the governance of a population – overall system change – which is the focus of this paper. This is not to impart a hierarchy of values regarding different types of resistance, but rather to recognize that the exercise of agency can achieve some, but not necessarily all, ends. Agency indeed figures in the analytics of resistance developed here, specifically in the context of techniques of resistance aimed at particular techniques of power. Although in his engagement with ethics Foucault intended 'governmentality' to encompass the articulation of the governance of the self and of a population,[23] he nonetheless left this important relation unattended theoretically and empirically. This paper aims at this connection through a relational epistemology of resistance and governance. The ensuing analytics of resistance offers a means by which to effectively strategize – calculate – a new politics as well as a means to explain why and how existing strategies lack transformative capabilities.

Beyond government documents and the media, the academic critical literature on nursing homes emanates in the social sciences almost completely from critical sociology,[24] and from critical studies in nursing[25] and medically related fields such as gerontology, public health and policy.[26]

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[23] M. Foucault, "The Ethics of the Concern for the Self as a Practice of Freedom," in P. Rabinow (ed.), R. Hurley and others (trans.) *Michel Foucault/Ethics* (New York: The New Press, 1997), 300.

[24] For example, T. Diamond, *Making Gray Gold* (Chicago: University of Chicago Press, 1992). https://doi.org/10.7208/chicago/9780226144795.001.0001; Foner, *Caregiving Dilemma*; Foner, "Hidden Injuries of Bureaucracy," *Human Organization*, vol. 54 (1995), 229-237. https://doi.org/10.17730/humo.54.3.g5350404082264q3; E. Goffman, *Asylums* (Chicago: Aldine, 1961); J. Gubrium, *Living and Dying at Murray Manor* (New York: St. Martin's Press, 1975); S.H. Lopez, "Culture Change Management in Long-Term Care," *Politics and Society*, vol. 34 (2006), 55-79. https://doi.org/10.1177/0032329205284756; Lopez, "Efficiency and the Fix Revisited," *Qualitative Sociology*, vo. 37 (2007), 225-247. https://doi.org/10.1007/s11133-007-9062-0; J.S. Ulsperger and J.D. Knotternus, "The Social Dynamics of Eldercare," *Sociological Spectrum*, vol. 28 (2008), 357-388. https://doi.org/10.1080/02732170801898422; Ulsperger and Knotternus, *Elder Care Catastrophe* (Boulder: Paradigm, 2011). Within the social sciences, from criminology see also J. Braithwaite, T. Makkai, and V. Braithwaite, *Regulating Aged Care* (Northampton, MA: Edward Elgar), and from political science see M.A. Mendelson and W. Mendelson, *Tender Loving Greed: 2009 Notes* (Prescott, AZ: One-Off Press).

[25] See for example Estes, C.L. *The Aging Enterprise* (San Francisco, Jossey-Bass, 1979); Farmer; C. Harrington, C. Hauser, B. Olney, and P.V. Rosenau, "Ownership, Financing, and Management Strategies of the Ten Largest For-Profit Nursing Home Chains in the United States," *International Journal of Health Services*, vol. 41 (2011), 725-746; C. Harrington, B. Olney, H. Carrillo, and T. Kang, "Nurse Staffing and Deficiencies in the Largest For-Profit Nursing Home Chains and Chains Owned by Private Equity Companies," *Health Services Research* 47 (2012), 106-128. https://doi.org/10.1111/j.1475-6773.2011.01311.x.

[26] J.F. Childress, "If You Let Them They'd Stay in Bed All Morning," in R.A. Kane and A.L. Kaplan (eds.) *Everyday Ethics* (New York: Springer, 1990), 79-89; C. Hawes ad C.D. Phillips, "The Changing Structure of the Nursing Home Industry and the Impact of Ownership on Quality, Cost, and Access," in B.H. Gray (ed.) *For-Profit Enterprise in Health Care* (Washington, D.C.: National Academy Press, 1986), 492-541; K.R. Kaffenberger, "Nursing Home Ownership," *Journal of Aging & Social Policy*, vol. 12 (2000), 35-48. https://doi.org/10.1300/J031v12n01_04; C.W. Lidz, L. Fischer, and R.M. Arnold, *The Erosion of Autonomy in Long-Term Care* (New York: Oxford University Press, 1992); R. Pradhan and R. Weech-Maldonado, "Exploring the Relationship Between Private Equity Ownership and

The critical literature on nursing homes is rich but either critiques without offering designs for change, or studies that argue for alternative systems lack a holistic framework that aims for a humanity of eldercare based on an analysis that connects governing mechanisms – techniques of biopower and disciplinary power – with discourses, mentalities and regimes of practices. There is a relatively small literature on Foucauldian gerontology. Stephen Katz, as well as Simon Biggs and Jason Powell, for example, have drawn attention to the utility of Foucault's conceptualization of discourse, disciplinary power, and social regulation to examine the medical gaze on seniors and their treatment.[27] Critiques of discourses have targeted 'successful aging',[28] the neoliberal vision of, and prescriptions for, senior 'activity,'[29] government discourse,[30] and old age as abjection,[31] while consideration of resistance has engaged possibilities for seniors to refuse their interpellated subjectivities.[32] This paper critically synthesizes wide-ranging literatures on US nursing-home care, and casts it within an analytical framework of governmentality to enable an examination of possibilities, conceptualized here in terms of techniques of resistance that would enroll seniors as well as caregivers and even corporate actors who are complicit in regimes of subjection. In the process I also draw from critical accounting studies[33] and issues from critical literatures in business, education, and feminism.

The remainder of the paper first examines the governmentalities of nursing-home care to render fundamental problems visible and to establish appropriate targets for resistance, which I

Nursing Home Performance," *Advances in Health Care Management*, vol. 11 (2011), 63-89. https://doi.org/10.1108/S1474-8231(2011)0000011007; D.G. Stevenson and D.C. Gabrowski, "Private Equity Investment and Nursing Home Care," *Health Affairs*, vol. 27 (2008), 1399-1408; B. Vladek, *Unloving Care* (New York: Basic Books, 1980). https://doi.org/10.1377/hlthaff.27.5.1399.

[27] Katz, *Disciplining Old* Age; S. Biggs, and J.L. Powell, "A Foucauldian Analysis of Old Age and the Power of Social Welfare," *Journal of Aging and Social Policy*, vol. 12 (2001), 1-20. https://doi.org/10.1300/J031v12n02_06; Powell, J.L., "Social Theory, Aging, and Health and Welfare Professionals," *Journal of Applied Gerontology*, vo. 28 (2009), 699-682. https://doi.org/10.1177/0733464809335596. Useful overviews of Foucauldian gerontology include: J.L. Powell, and S. Biggs, "Foucauldian Gerontology," *Electronic Journal of Sociology*, vol. 7 (2003) and J.L. Powell, *Social Theory and Aging* (Lanham, MD: Rowman and Littlefield, 2006), 93-116. See also J.L. Powell and A. Wahidin (eds.), *Foucault and Aging* (New York: Nova Science., 2006).

[28] E. Tulle-Winton, "Growing Old and Resistance," *Ageing and Society*, vol. 19 (1999), 281-299. https://doi.org/10.1017/S0144686X98007193.

[29] S. Katz, "Busy Bodies," *Journal of Aging Studies*, vol. 12 (2000), 135-152. https://doi.org/10.1016/S0890-4065(00)80008-0; B. Rosenberg, "Social Spaces for Seniors," *Journal of Sociology*, vol. 51 (2015), 467-477. https://doi.org/10.1177/1440783312474083.

[30] S. Katz and B. Green, "The Government of Detail," in S. Katz, *Cultural Aging* (Toronto: Broadview Press, 2005).

[31] P. Higgs and C. Gilleard, *Rethinking Old Age* (New York: Palgrave, 2015).

[32] Tulle-Winton, Growing Old and Resistance; see also Tulle (ed.), *Old Age and Agency* (New York: Nova Science, 2004)

[33] For example, the Foucauldian-inspired journal in critical accounting studies, *Accounting, Organizations and Society*; A.G. Hopwood and P. Miller (eds.) *Accounting as Social and Institutional Practice* (New York: Cambridge University Press, 1994).

elaborate in the next section. I follow with a summary and schematic representation of the analytics of eldercare, encompassing governance as well as resistance *and the relation between the two*, and I conclude on a more general note about the analytics of resistance across contexts.

Throughout the ensuing discussion I weave in linkages between nursing homes and related problems in societal 'sectors' other than eldercare, taking a cue from Foucault regarding the iteration of specific problems and practices across societal sectors (for him, for example, the military, education, medical institutions, and prisons). Such iteration helps explain how broad-scale societal mentalities and associated aspects of governance materialize in context-specific ways across different institutional and organizational milieux.[34] The point is that despite the apparent invisibility of the infirm elderly and problems of eldercare, the issues are neither self-contained nor as far removed from problems in other societal sectors as they seem. Accordingly, I comment, even if briefly in the interests of space and at times in footnotes, on similarities between specific problems that are localized[35] in eldercare and those localized elsewhere, including the 'audit explosion'[36] across all societal sectors, the role of real estate in the finance economy, the nanny-maid-sex trades, the economization of social work, and marginalized populations[37] other than the infirm elderly such as the homeless, recovering drug addicts, and exploited workers. My purpose here is to render societal problems visible by localizing them in a particular sector (eldercare), while recognizing their general significance in light of their materialization in many other sectors.

Nursing Home Governmentalities and Possibilities for Counter-Conduct

Leaving their homes behind, the old infirm enter nursing homes largely stripped of the material possessions to which they have been accustomed, indeed attached, over a lifetime, and enter a new, medicalized environment at the end of their lives, separated (except for occasional visits) from the people with whom they have shared happiness as well as tragedies, friendship, fun. Their lives at point of entry become 'bare' in Giorgio Agamben's terms,[38] excluded from the lives they have led.[39] Their new stewards wear hospital uniforms, provide medical assistance, and help with basic physical needs. Residents become patients – what I call the 'resident-patient.' Ethnographic accounts of

[34] Foucault, Questions of Method.

[35] Foucault argued that problems are localized, but not power, which is diffuse. He used the term 'localized' in a non-Euclidean, topological sense, that is, spread across space (e.g. the penal system across space, the education system across space …).

[36] M. Power, *The Audit Society* (New York: Oxford University Press, 1997).

[37] Examples of Foucauldian analyses of specific marginalized populations include B. Cruikshank "Welfare Queens," in F. Schram and P.T. Neisser, *Tales of the State* (New York: Rowman & Littlefield, 1997), 113-124 regarding the construction of 'welfare queens;' R. Fairbanks II, *How it Works* (Chicago: University of Chicago Press, 2009). https://doi.org/10.7208/chicago/9780226234113.001.0001, regarding the neoliberalization of recovery houses for former drug addicts; G. Raj-Reichert, "Safeguarding Labour in Distant Factories," *Geoforum*, vol. 44 (2012), 23-31 regarding labor.

[38] G. Agamben, D. Heller-Roazen (trans.) *Homo Sacer* (Stanford: Stanford University Press, 1995).

[39] Henderson, Culture of Care in a Nursing Home.

nursing homes have elaborated how resident-patients, after the initial stripping of identity, then move in a tightly scheduled, unfamiliar world with little privacy, little activity outside the nursing home, little decision-making power, and under the authority of nursing-home staff in what Erving Goffman[40] called "a total institution."[41] What governs such an uncaring environment? As elaborated below, I suggest two interrelated governmentalities are at work: neoliberalism and the science of eldercare.

Nursing homes and the production of neoliberal life

Neoliberalism, I suggest, does not produce nursing homes; rather, from a Foucauldian vantage point, it is the other way around: the dynamics surrounding and constituting life in nursing homes produce neoliberalism and in turn are governed by it. Per Foucault, neoliberalism is less a policy package (trade liberalization, privatization, deregulation) that results in inequality,[42] and more a regime of practices on a landscape of (imperfect) competition, signaling inequality and an uneven playing field of power relations.[43] Policy matters per Foucault as a means to maintain inequality and manipulate the uneven field of power relations, but inequality is the driver, not the result, of policy, and is forged through regimes of practices that encompass all actors, not just the marginalized. On the terrain of inter-firm relations, as discussed below, nursing homes are responsible for wide-ranging costs, ironically including the costs of their own acquisition. Neoliberalism, as the transformation of social problems into economic opportunities,[44] signifies that responsibilization and economization pervade all aspects of the social fabric at multiple scales in everyday life and in the dynamics of organizations such as firms. Below I identify the components of neoliberal governmentality at the scale of inter-firm relations, understanding nursing homes as businesses; subsequently, I engage neoliberal dynamics inside nursing homes themselves, and then turn to the science of eldercare.

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[40] Goffman. See also Diamond; Farmer; Foner, Hidden Injuries of Bureaucracy; Gubrium; J.L. Howsden, *Work and the Helpless Self* (Washington, D.C.: University Press of America, 1981); Lidz, Fischer, and Arnold.

[41] Foucault's 'heterotopia' (M. Foucault, "Of Other Spaces," Diacritics, vol. 16 (1986), 22-27. https://doi.org/10.2307/464648), referring to internally heterogeneous sites of otherness that counter the mainstream, lends itself to Goffman's notion of the aberrant nature of a 'total institution.' Yet following the publication of his essay on heterotopia in 1966, Foucault did not return to the concept, which is inconsistent with his later scholarship. For a discussion of the structuralist nature of the concept, see A. Saldanaha, "Heterotopia and Structuralism," *Environment and Planning A*, vol 40 (2008), 2080-2096; consider also the inconsistency between 'heterotopia' and Foucault's topological approach to space (Ettlinger 2011, footnote 14). https://doi.org/10.1068/a39336.

[42] For a Marxist interpretation of neoliberalism, see D. Harvey, *A Brief History of Neoliberalism* (New York: Oxford, 2005).

[43] M. Foucault, M. Senellart (ed.), G. Burchell (trans.) *The Birth of Biopolitics* (New York: Palgrave, 2008). For an elaboration of differences between Foucauldian and Marxist approaches to neoliberalism, see N. Ettlinger and C. Hartmann, "Post/neo/liberalism in Relational Perspective," *Political Geography*, vol. 48 (2015), 37-48. https://doi.org/10.1016/j.polgeo.2015.05.009.

[44] Foucault, 2008.

Nursing homes as vehicles of investment: entanglements of property, policy, and inter-firm relations

Over the course of the 20th century and continuing through the present, nursing homes, which to the general public are out-of-sight and out-of-mind, implicitly have been a crucial part of the economy as magnets for larger firms outside health care. These larger firms have transformed eldercare into remarkable avenues by which to reap huge profits, which is peculiar in two interrelated ways.

First, the peculiarity of nursing home profitability lies in the gap between reality and perception insofar as the general public hardly thinks of nursing homes as highly profitable.[45] Rather, nursing homes tend to be perceived as having low profit margins and insufficient funding, reflected in cheap food and understaffing. The paradox is intelligible in terms of corporate strategy and financial flows: a 2002 report on nursing homes across the United States in *U.S. News & World Reports* revealed that around 70% of nursing homes systematically channeled revenues to other firms in practices of 'self-dealing,' including shifting profits to a corporate parent,[46] dividing the parents' costs amongst many nursing homes, or using revenues to purchase goods and services (often from ancillary businesses owned by the parent firm) before reporting profits.[47] Nursing homes thus have been profitable, but the profits have been claimed by other firms in a complex web of ownership.

Second, the evolving profitability of nursing homes has occurred in a peculiar US context: the co-evolution of private ownership with continual public funding.[48] By 2011, 85% of all nursing homes were supported by government funds and almost 70% were for profit.[49] The main reason for the dominance of for-profit nursing homes is their attractiveness to other corporations as vehicles of investment, largely due to guaranteed government funding that began during the Great Depression. Although nursing homes may be out-of-sight and out-of-mind to the general public, the discourse in the business world has been that nursing homes are 'hot.' By the end of the 1960s an article in *Barron's* offered the stunning declaration that "… nursing homes… stand for the hottest investment around today"[50] with price/earnings 40 times higher than those for blue-chip stocks.[51]

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[45] Kaffenberger.

[46] Nursing homes often use their revenues to pay rental fees for facilities and management, or consulting fees to the parent corporation or related firms before reporting profits; see C.H. Schmitt, "The New Math of Old Age," *U.S. News & World* Report, vol. 133, no. 12 (2002), 66-72.

[47] Schmitt.

[48] Kaffenberger.

[49] For relative percentages of for- and non-profit nursing homes see Highbeam Business, "Skilled Nursing Care Facilities Market Report," *Highbeam Business* (2012), http://business.highbeam.com/industry-reports/business/skilled-nursing-care-facilities.The for/non-profit distinction can be artificial insofar as the numerous avenues of profitability open to for-profit nursing homes also have been open to the non-profits; see Gray, *For-profit Enterprise*; Mendelson and Mendelson; Schmitt; Vladeck.

[50] Cited in Hawes and Phillips, 499.

[51] Hawes and Phillips, 499.

Although the stock market boom of the 1960s eventually went bust in the wake of scandals, lawsuits, and miscalculations about the degree of Medicare coverage,[52] as I will explain, new developments perpetuated the lure of the nursing-home industry in different ways through the present. The history of the nursing-home industry is in part a history of the changing mechanisms or techniques of biopower, co-constituted by inter-firm relations and government policies, which have rendered nursing homes attractive to other firms as vehicles of investment.

Over the course of the 20th century the increasing availability of government funding implicitly transformed nursing homes into industrial and financial cash cows. The social security acts beginning in the 1930s put more cash in the hands of aging people, permitting them to pay for care in non-profit and for-profit nursing homes that were in the process of eclipsing almshouses, the early 20th century public institutions of charity care.[53] Amendments to the Social Security Act in the 1950s introduced the vendor payment system, whereby the federal government provided matching fund to states, which made payments not to the elderly, but rather directly to nursing homes. At this juncture the biopolitics of nursing homes entailed the removal of resident-patients' voice from the morass of nursing-home financing. The vendor status legitimized nursing homes as political entities in the arena of lobbying, specifically for rate increases and favorable regulations. The combination of regular government funding to nursing homes and their vendor status signified that nursing homes became both explicit members of the business community as 'vendors' and also attractive investment vehicles for businesses disassociated from the care.[54] Meanwhile, the aging of US society guaranteed a continual stream of entrants into nursing homes. Demand intensified during the 1960s with the deinstitutionalization of mental institutions and unloading of mental-health patients into nursing homes, compounded by the entry of large numbers of women into the workforce, and thus the increasing absence of available caregivers in households for elderly parents.[55] Later, in the 1980s, the introduction of the prospective payment system (PPS) in hospitals (fixed, pre-determined reimbursement from Medicare based on a classification of the services required for an illness) incentivized fast discharge rates and routed patients to nursing homes for short-term, convalescent stays, further contributing to the demand for nursing homes.[56]

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[52] Hawes and Phillips, 499.

[53] See Hawes and Phillips; Kaffenberger.

[54] Hawes and Phillips; Kaffenberger.

[55] Hawes and Phillips; Kaffenberger.

[56] For a Foucauldian-inspired, penetrating analysis of the development of the PPS and related systems of cost accounting in hospitals, see A. Preston, "The Birth of Clinical Accounting," *Accounting, Organizations and Society*, vol. 17 (1992), 63-100. For implications regarding nursing homes see Hawes and Phillips; Pradhan and Weech-Maldonado. https://doi.org/10.1016/0361-3682(92)90036-R.

As the nursing-home industry grew, the for-profit sector outpaced the not-for profit sector, a process that was integrally related to complex investments associated with property, a core feature of competitive strategy linked to the finance economy.[57] While government assistance to individuals for eldercare in the depression era helped create a continual supply of entrants to nursing homes, loans from the Federal Housing Authority (FHA), which also began during the Depression, became crucial elements of emerging profitability because they reduced the cost of financing real estate.[58]

By the 1950s the federal government made construction loans available for private nursing homes via the Small Business Administration (SBA) as well as the FHA.[59] Although SBA loans were important at the outset, they were, however, limited to small businesses. On the other hand, FHA mortgages, which paid 90% of project cost, loomed especially large in the 1960s, ushering the business of speculative real estate into the nursing home-industry[60] and a building boom that exceeded actual need among the elderly.[61] Government-backed construction loans enabled private owners of nursing homes, especially larger businesses, to open numerous large, modernized facilities, which eclipsed earlier mom and pop nursing homes, and moreover facilitated the development of nursing-home chains. Chains ostensibly produce increased profitability in association with economies of scale,[62] but crucially, it is the sophisticated accounting techniques associated with chain management that maneuver a high ratio of debt to total assets to ensure cash flow.[63] Further, chain management began to finance growth not by borrowing, but by going public with the sale of stock, which was used as collateral to secure loans. The stock market thus became a new source of capital for nursing homes, and parent corporations outside the care industry began investing not only in nursing homes but also in businesses that supplied them with goods and services (e.g. pharmaceuticals, food and laundry services, management, real estate development, construction).[64]

The establishment in 1965 of Medicare and Medicaid for short and long-term care, respectively, deepened interest in nursing homes as *property* investments. Reimbursement via Medicaid was flat-rate until 1972, prompting owner/operators to cut costs in long-term care to free up part of the flat-rate funds to purchase new facilities. In contrast, reimbursement via Medicare was cost-

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[57] J.S. Hanan, "Home is Where the Capital Is," *Communication and Critical/Cultural Studies*, vol. 7 (2010), 176-201.

[58] Kaffenberger.

[59] The Hill-Burton Act of 1946 extended government-backed construction loans for hospitals to public and non-profit nursing homes.

[60] Vladek.

[61] Hawes and Phillips; Kaffenberger.

[62] Kaffenberger.

[63] Vladek, 120-121. Note that non-profits tend to rely on private placement of bonds or notes more than real estate speculation; see Vladeck, 111.

[64] Harrington et al., Ownership, Financing, Management Strategies; Hawes and Phillips; Pradhan and Weech-Maldonado.

based (reimbursement for costs that nursing homes reported for short-term care), including reimbursement for mortgage interest as well as the depreciation of capital equipment, which included the nursing-home facility. Firms made use of government coverage of mortgages by 'pyramiding,' using a mortgage on one nursing home to finance the purchase of others.[65] Shifting profits among multiple properties entails a web of interlocking ownership that obscures responsibility and thus liability for violations in care, thereby constructing a means of self-protection to ensure continued profitability,[66] a strategy that has persisted through the present.[67]

The chief source of profitability became separating nursing-home operations and management from land and buildings to extract high returns from the real estate component of the nursing-home industry. The dynamic of real-estate speculation simultaneously signified increased profitability for the firms buying and selling nursing homes and shoestring budgets for nursing homes themselves. Speculators would extract value from fixed assets by withdrawing cash in the early years of a mortgage (rather than investing in a facility, staffing, and the care of residents) and selling as soon as the amortization of a mortgage exceeded depreciation – a profitable venture in the context of increasing prices of nursing-home facilities.[68] The flipping of nursing homes – the selling-reselling cycle – artificially increased the cost of care by inflating lease and rental charges, thereby prompting additional cost-cutting measures.[69]

Expansion from the mid-1970s onward occurred less by construction and more by acquisition and merger in association with declining tax deductions on aging facilities and capital gains (profit from the sale of equipment and buildings) as well as the federal Health Planning Resources Act of 1974, which sought to reduce unnecessary expenses of health care incurred by technology purchases as well as building.[70] Consolidation typically occurred in the 1980s and '90s through acquisitions (of nursing homes as well as firms producing complementary goods and services) and mergers of nursing-home chains.[71] Nursing homes functioned as operating corporations as well as real-estate partnerships, often via Real Estate Investment Trusts (REITs), with a lease or management contract connecting the two functions to enable partners to take depreciation and interest deductions against personal income, shift profits to the real-estate operation, and thereby under-

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[65] Hawes and Phillips; Mendelson and Mendelson.

[66] Hawes and Phillips; Mendelson and Mendelson; Vladek.

[67] C. Duhigg, "At Many Homes, More Profit, Less Nursing, *New York Times*, September 23 (2007), http://www.nytimes.com/2007/09/23/business/23nursing.html?pagewanted=1%3Erssya-hoo&ei=5089&en=ba37662c8b5c6589&ex=1348200000&partner%3Cbr%20/&emc=rss&_r=0; GAO, *Nursing Homes* (Washington, D.C., United States Government Accountability Office Report to Congressional Requesters, GAO-10-710, 2010); Pradhan and Weech-Maldonado; Schmitt.

[68] Vladek.

[69] Hawes and Phillips.

[70] The Health Planning Resources Act of 1974 mandated a proposal and approval procedure for all building and technology purchases.

[71] Harrington et al., Ownership, Financing, Management Strategies; Pradhan and Weech-Maldonado.

report profitability and limit.[72] Debt-financed acquisitions and mergers rendered nursing homes responsible for paying off debts while the parent corporations earned increasing profits; the means for payment within nursing homes was cost minimization and cutting,[73] while new construction entailed an economization of space, notably by reducing or bypassing social space.[74]

By the late 1990s aggressive acquisition activity and the inability of nursing homes to service debts resulted in bankruptcies as a means to restructure debt,[75] rendering nursing homes attractive to private equity firms.[76] The way to raise capital in the new millennium became private equity investments, specifically leveraged buyouts (LBOs) to exploit real estate for the debt required to fund acquisitions while capitalizing on limited disclosure requirements.[77] Emblematic of the profitability from flipping nursing homes, one private equity firm, Formation, sold Habana Nursing Home and 185 other facilities to General Electric in 2006 for $1.6 billion, earning more than $500 million in four years.[78]

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Firms over time have engaged in a regime of practices that render nursing homes productive and highly profitable as vehicles of investment. The mechanisms for such corporate rewards have changed from building expansion and public funding reimbursement schemes to REITs and private equity deals. Irrespective of specific tactics, the common underlying strategy has been the use of nursing-home real estate as a fixed asset, separate from nursing home operations, to increase productivity and reap massive profits – the central technology of biopower in Foucauldian terms. The separation, and concomitantly, multiple levels of ownership, obstructs lawsuits and thereby

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[72] Harrington et al., Ownership, Financing, Management Strategies; Highbeam Business; Olson.

[73] Duhigg; Economist, "Private Equity Buys into Care Homes," *The Economist*; November 25 (2010), http://www.economist.com/node/17581666; GAO; Harrington et al., Ownership, Financing, Management Strategies; Harrington et al., Nurse Staffing and Deficiencies.

[74] Vladek, 116.

[75] A common claim on the part of nursing homes is that the introduction of PPS in nursing homes in 1997 (implemented in 1998) cut into their expenses by eliminating cost-based reimbursement. However, this explanation overlooks the complexity of interlocking ownerships and the considerable profits that are channeled into real estate and other operations. Bankruptcies were a means to restructure debt, accounting for the complicated dynamics and strategic leveraging that have underwritten the nursing home industry; see Harrington et al., Ownership, Financing, Management Strategies.

[76] Harrington et al., Ownership, Financing, Management Strategies.

[77] See GAO; Harrington et al. Ownership, Financing, Management Strategies; Pradhan and Weech Maldonado. The increasingly complex, interlocking web of ownership accordingly has rendered lawsuit cases extremely expensive and has deterred about 70% of lawyers who previously had engaged in nursing-home lawsuits; one lawyer reported a case in which he had to sue 22 different companies, and in another, he won a $400,000 verdict but collected only $25,000; see Duhigg.

[78] Duhigg.

ensures continual profitability without legal oversight of improper care. Nursing-home care connects with extra-nursing home business deals, which prompt cost-cutting measures inside nursing homes to pay the debt incurred by the buying-selling cycle among parent and related corporations, as well as rent, leasing, and consulting charges. The corporate gaze on nursing homes that casts them as trading chips in a web of corporate ownership then disciplines nursing-home managers to continually cut costs and the quality of care despite profitability.

The history lesson is that an effective critical technology of resistance should focus on altering the lure of nursing homes as investments for other firms, *specifically by targeting their real-estate attraction*. Policies to prohibit or at least disincentivize the separation of nursing home operations from the real-estate component might be helpful, but the problem is that such legislation is unlikely, especially in the absence of a groundswell of support for such action from civil society where knowledge of the nursing home industry is scant and problems remain invisible. Foucault's point about non-institutional change preceding institutional change – policy – is apt.

In response to reports on the various problems surrounding nursing homes, policies and calls for policies have been developed with little result. New regulations associated with the Affordable Care Act (ACA) of 2010 require full disclosure of direct and indirect ownership to render firms responsible and liable for care. Yet new regulations have yet to be implemented,[79] and would be ineffective in any case because new protocols treat effects (multiple levels of ownership) rather than causes (nursing homes as real-estate investments by virtue of the separation of fixed assets and daily operations). Another policy approach is to improve care in nursing homes by tying government funding to specific levels of staffing;[80] yet staffing levels also are a symptom of extra-nursing home business deals, which, if permitted to persist, will have the same results in light of the lack of government oversight, conditioned by the problem of multiple levels of ownership. Another, longstanding strategy to ensure quality care in nursing homes is similar to strategies to resolve problems of labor abuses: licensing, certification, accreditation, and the development of standards.[81] This approach, however, depends on the effectiveness of inspection and enforcement, both of which have exhibited considerable weakness.[82] Moreover, as in the case of labor abuse,

[79] J.K. Lowenstein and L. Creamer, "Analysis Shows Widespread Discrepancies in Staffing Levels Reported by Nursing Homes, *Center for Public Integrity*, November 12, http://www.publicintegrity.org/2014/11/12/16246/analysis-shows-widespread-discrepancies-staffing-levels-reported-nursing-homes.

[80] Schmitt.

[81] T.S. Jost, "The Necessary and Proper Role of Regulation to Assure the Quality of Health Care," *Houston Law Review*, vol. 25 (1988), 525-598.

[82] P.C. Aka, L.M. Deason, and A. Hammond, "Political Factors and Enforcement of the Nursing Home Regulatory Regime," *Journal of Law and Health*, issue 1 (2011), 1-43; GAO; C. Harrington, "Residential Nursing Facilities in the United States," *British Medical Journal*, vol. 323, (2001), 507-510. https://doi.org/10.1136/bmj.323.7311.507.

standardized regulations often have unstandardized effects in light of context-specific problems.[83] Further, despite discourse to the contrary, inspections commonly cater to the needs of the corporations whose facilities are inspected, rather than vulnerable subjects inside the facilities who purportedly are the intended beneficiaries of the audits.[84]

Returning to Foucault's point about resistance entailing "an antagonism of strategies," would it not make sense to develop strategies to counter directly the profit motive and associated mechanisms or 'techniques of power'? Why not make use of, rather than try to dismantle, the apparently inexorable drive to profitability by designing a strategy that would implicitly enroll corporate actors in counter-conduct? This is a tall order, but worth thinking about. For example, recognizing that corporate social responsibility often is a pragmatic rather than an ethical response to consumer demands, consider the possibility of manipulating rather than trying to change this common corporate impulse. Towards approaching such a challenge, social enterprises, which tend to occur outside the United States (e.g. in Spain, Australia, and the United Kingdom), and which entail socially responsible corporate activities, are instructive.[85] In contrast to the US model of corporate social responsibility that operates via philanthropy channeled through neoliberal logics and practices,[86] corporate socially responsible enterprises prioritize social over economic goals. Their activities may not necessarily entail profitability, although many firms do enhance their profitability through increased satisfaction among a variety of stakeholders by developing a socially responsible reputation.[87] One approach to corporate social responsibility that regrettably is uncommon would situate corporate stake holders in nursing home dynamics: a face-to-face strategy to emplace corporate actors in the contexts that otherwise exist in financial accounts to transform their perceptions through *experience*.[88, 89] Discourse alone cannot change mentalities. A key imperfection of the system of corporate governance of nursing homes is the absence of direct experience of corporate actors in

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[83] For a nuanced discussion of the unstandardized effects of standards relative to context-specific circumstances regarding sweatshop labor, see J. Rothenberg-Aalami, "Coming Full Circle?," *Global Networks*, vol. 4, (2004), 335-354. https://doi.org/10.1111/j.1471-0374.2004.00097.x.

[84] Regarding labor, see Raj-Reichert.

[85] J.K. Gibson-Graham and J. Cameron "Community Enterprises: Imagining and Enacting Alternatives to Capitalism," in S. Healy and J. Hillier (eds.) *The Ashgate Research Companion to Planning Theory* (Burlington, VT: Ashgate, 2010), 291-298; J.K. Gibson-Graham, J. Cameron, and S. Healy, S, *Take Back the Economy* (Minneapolis: University of Minnesota Press, 2013).

[86] K. Mitchell and C. Lizotte, "The Grassroots and the Gift," *Foucault Studies*, vol. 18 (2014), 66-89. https://doi.org/10.22439/fs.v0i18.4652.

[87] P.L. Cochran, "The Evolution of Corporate Responsibility," *Business Horizons*, vol. 50 (2007), 449-454. https://doi.org/10.1016/j.bushor.2007.06.004.

[88] For a critical normative discussion of an experiential approach to the proactive construction of corporate social responsibility, see J. Roberts, "The Manufacture of Corporate Social Responsibility," *Organization*, vol. 10 (2003), 249-265. https://doi.org/10.1177/1350508403010002004.

[89] Consider, for example, the role of experience among former homophobes with family, friends, and co-workers out of the closet in the sea change in US attitudes regarding same-sex marriage.

nursing homes, which are real places where people, residents and staff play out their lives; this is a space of potential rupture and change. Such an approach in the context of nursing homes would require orchestration by consumer advocate organizations, constituted in part by nursing home representatives among staff at all levels as well as residents, as opposed to inspectors appointed by the government or nursing homes themselves. The goal would be for firms to 'adopt' particular facilities or even chains and visit not just nursing home spaces and directors or marketing executives, but crucially, residents and staff to recognize voices that can speak to problems of care, all the while capitalizing via advertising their social achievements. The fundamental strategy is to target *people* in the corporate world through 'situated learning,'[90] an approach in innovation studies[91] borrowed from theory of learning through experience *in context* and through interactions in 'communities of practice.' The agenda is to develop what feminist Donna Haraway famously called 'situated knowledges'[92] to stimulate corporate actors to delink nursing-home operations and real estate themselves, and in this way enroll them in targeting the central technique of biopower that has been so deleterious. The regime of practices surrounding situated learning among corporate actors might eventually crystallize in a legal framework in the United States to facilitate the kind of cooperative social enterprises that have evolved elsewhere, notably in Europe.[93] Models exist for the development of strategic partnerships among for-profit businesses, government, and non-profits to potentially pave the way for increased social activity among US corporations, although to date these avenues have yet to materialize in the United States.[94] Here is a potential space for researcher-activists to communicate such possibilities to other activists and work together to convey socially-driven goals *and their material advantages* to the attention of corporate actors engaged in the buying-selling cycle of nursing homes. The programmatic design is to make use of the corporate intrusion into eldercare rather than engage in the unlikelihood of wresting power from it. As Foucault pointed out, "The problem, then, is not to try to dissolve them [power relations] in the utopia of completely transparent communication, but to acquire the rules of law, the management techniques, and also the morality, the *ēthos*, the practice of the self, that will allow us to play these games of power with as little domination as possible."[95] Power relations require engagement at multiple

[90] Seminal works on situated learning include J. Lave and E. Wenger, *Situated Learning* (New York: Cambridge University Press, 1991) and E. Wenger, *Communities of Practice* (Cambridge: Cambridge University Press, 1998).
[91] See for example A. Amin and P. Cohendet, *Architectures of Knowledge*, (New York: Oxford University Press, 2004) and A. Amin and J. Roberts, "Knowing in Action: Beyond Communities of Practice," *Research Policy*, vol. 37, (2008), 353-369. https://doi.org/10.1093/acprof:oso/9780199253326.001.0001.
[92] D. Haraway, "Situated Knowledges," *Feminist Studies*, vol. 14, (1988), 575-599. https://doi.org/10.2307/3178066.
[93] J. Defourny and M. Nyssens, "Conceptions of Social Enterprise and Social Entrepreneurship in Europe and the United States," *Journal of Social Entrepreneurship*, vo. 1, 32-53.
[94] M. Mennel, T. Mendelson, K.A. McElhaney, and B. Marquard, *The Roadmap Toward Effective Strategic Social Partnerships* (Deloitte University Press: 2013 online).
[95] Foucault, Ethics of Concern for Self, 298.

levels,[96] including the dynamics of everyday life inside nursing homes, to which I now turn.

Inside nursing homes: cost-driven governance, economies of documentation, and the race against time

Eldercare in nursing homes – the problem of caring for some of society's most vulnerable, at the most vulnerable time of their lives – became driven not only by cost-cutting prompted by extra-nursing home deals, but also by the costs of care itself, which are considerable in light of the need for round-the-clock care. By the early 1990s less than 1% of the elderly population in the United States could afford nursing home care out-of-pocket.[97] By 2015 the average annual costs of long-term residence in nursing homes in a semi-private room totaled $80,300.[98] Although some nursing homes cater fully to the affluent elderly, this pool is too small to sustain most nursing homes. Accordingly, most nursing homes run entirely on the basis of public funding or a combination of public funding and private-pay. Federal dollars fund Medicare, which pays for short-term residence, usually following hospital stays; state dollars fund Medicaid, which pays for long-term residence. Medicare overall pays at a higher rate than Medicaid, explaining the admission preference among some nursing homes for short-term resident-patients on Medicare,[99] but both Medicare and Medicaid pay at rates well below those of private pay. The low rates combined with the siphoning off of profits to other firms explain cost-cutting strategies within nursing homes. Further, PPS, established in nursing homes in 1998 (a decade following its establishment in hospitals), has resulted in a deepening of existing cost-related difficulties because prospective payment reimburses nursing homes based on a pre-determined fixed rate calculated on the basis of long-term resident-patients' problems at the time of admission; as a pre-determined rate, it underestimates costs that can increase as resident-patients' conditions worsen and incur more costs.

The nature of public funding calculations, therefore, has exacerbated cost-related constraints, which reach all aspects of nursing home life. Meals, which are major events of the day for resident-patients, have the potential to be important, even if little pleasures, but commonly are unappealing and rarely if ever include fresh fruit or vegetables. More generally, pressure from shareholders to increase returns from nursing homes has deepened the longstanding strategy of

[96] See for example Foucault's discussion of 'ascending analysis' in "Two Lectures," in *Power/Knowledge*, 98-102 and Foucault's discussion of multi-level analysis in Truth and Power, in *Power/Knowledge*, 114.

[97] J. Hendricks, "Governmental Responsibility: Adequacy or Dependency for the USA Aged," in D.G. Gill and S.R. Ingman (eds.), *Eldercare, Distributive Justice, and the Welfare State* (Albany, NY: State University of New York Press, 1994), 255-285.

[98] See "Annual Median Cost of Long Term Care in the Nation," https://www.genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html.

[99] Hawes and Phillips.

cost containment by way of cutting the most significant cost of care, namely staff.[100] A common approach to cutting staff is to increase the number of low-paid licensed nurse practitioners and nurses' aides (who provide most of the care to the infirm elderly) while decreasing the number of higher-paid registered nurses.[101] The increase in low-paid staff often is below the minimum government-mandated threshold,[102] a situation sustained by lack of government oversight on corrupt practices of self-reporting as well as by the complex ownership structure that obscures responsible agents and deters legal action.[103]

Beyond cost minimization and cutting as a perpetual element of biopower in nursing-home management, the dynamics of nursing-home care pivot on ways to satisfy the legal requirements for public funding, without which most nursing homes cannot function. Nursing home biopolitics entail a maze of regulations that nurses and nurses' aides must navigate, resulting in a regime of practices of continually filling out forms.[104] Nursing homes even have a defecation book: every bowel movement is documented.[105] Documentation in nursing homes is part of the regime of accounting practices that has burgeoned throughout all societal sectors to transform qualitative problems into measurable, quantifiable and commodified units.[106]

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[100] Regarding cost containment strategies and effects of understaffing in nursing homes see Duhigg; GAO; Harrington, "Residential Nursing Facilities in the United States," *British Medical Journal*, 2001; Harrington et al., Ownership, Financing, and Management. https://doi.org/10.2190/HS.41.4.g; Harrington et al., Nurse Staffing and Deficiencies; Pradhan and Weech-Maldonado; Schmitt. Stevenson and Gabrowski found that private equity investment in nursing homes does not impinge on quality of care. However, there is evidence to the contrary in academic literature (see Harrington et al., Nurse Staffing and Deficiencies; Weech- Maldonado); government documents (GAO); and investigative reporters (Duhigg; Schmitt). A fundamental problem with Stevenson and Gabrowski's study is the data on which they based their conclusions. Their data, from certification accounts and quality indicator scoring, are questionable due to self-reporting and the absence of any kind of checking by government (Aka et al; GAO, 35; Harrington, Residential Nursing Facilities; Lowenstein and Creamer; K. Thomas, "Medicare Star Ratings Allow Nursing Homes to Game the System," *New York Times*, August 24 (2014), http://www.nytimes.com/2014/08/25/business/medicare-star-ratings-allow-nursing-homes-to-game-the-system.html.

[101] Olson; B.K. Seblega, N.J. Zhang, L.Y. Unruh, G.-M. Breen, and T.T.H. Wan, "Changes in Nursing Time Staffing Levels, 1997-2007, *Medical Care Research and Review*, vol. 67 (2010), 232-246. https://doi.org/10.1177/1077558709342253.

[102] Olson, 164.

[103] For lack of oversight regarding understaffing, see Lowenstein and Creamer and Thomas. Legal action also can be deterred by arbitration clauses that resident-patients or family members sign on entry. For a discussion of this arbitration issue in relation to wide range of societal 'sectors,' including nursing homes, see J. Silver-Greenberg and R. Gebeloff, "Arbitration Everywhere," *New York Times*, October 31 (2015), http://www.nytimes.com/2015/11/01/business/dealbook/arbitration-everywhere-stacking-the-deck-of-justice.html?_r=0.

[104] Foner, *Caregiving Dilemma*; Foner, Hidden Injuries of Bureaucracy; Ulsperger and Knotternus, Social Dynamics of Eldercare; Ulsperger and Knotternus, *Elder Care Catastrophe*.

[105] Gubrium, 138.

[106] See for example Hopwood and Miller; Power.

Nursing homes are enrolled in the regime of documentation to demonstrate qualification for Medicare and Medicaid payments. Consequently, anything that is not documented does not happen.[107] In this context, extra care, conversation and the like, become liabilities in the system of evaluation because such activities consume time, are undocumented, and do not 'count' towards reimbursement. Conversely, anything that is documented is Truth. For example, if notes are generated about a resident-patient that staff on the next shift should know, then communication *has* occurred, even if the staff on the next shift lack the time to read the notes. The likelihood of insufficient time to read notes generated about resident-patients is high, as explained below, resulting in an absence of communication about resident-patients' conditions.

Drawing from about 40 ethnographic accounts as well as secondary data, Jason Ulsperger and David Knotternus[108] found common bureaucratic practices in nursing homes across the United States. One notable problem is a rigid division of labor between nurses and aides; comments and suggestions from aides, who see resident-patients the most, are unwelcome. Further, nurses themselves are 'outside the loop' of discussions about the resident-patients that include only the director and head staff (e.g. heads of nursing and marketing; the nursing-home social worker), who rarely interact with the resident-patients. Further, across all nursing homes Ulsperger and Knotternus found webs of rules amid a discourse of efficiency, meaning that all staff are supposed to accomplish all tasks that are part of the regulatory framework. The 'tyranny of regulation'[109] takes on a panoptical significance, producing an environment in which nurses and aides are disciplined in a regime of practices connected to documentation while discouraging and even punishing agency and creativity.[110] The unduly large scale and scope of tasks required of aides, in a high staff-patient ratio, produces a pressure cooker as aides become engaged in a daily race against time to complete prescribed tasks, all of which require documentation. Aides, who regularly care for resident-patients, cannot afford to take extra time to engage patients *with* care if they are to complete their assigned tasks.[111] Nurses' time is consumed with documentation and walking the halls with a pill cart to dispense prescriptions to resident-patients at appropriate times throughout the day.

Crucially, many researchers have documented the impossibility of accomplishing all the required tasks in the span of a shift, and cost containment strategies preclude hiring more staff to enable completion of tasks.[112] However, some staff covertly critique the system, tap their emotions,

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[107] Diamond, 210.

[108] Ulsperger and Knotternus, Social Dynamics of Eldercare.

[109] See Childress; Braithwaite et. al; Ulsperger and Knotternus, Social Dynamics of Eldercare and *Elder Care Catastrophe*.

[110] Foner, *Caregiving Dilemma*; Lopez, Culture Change Management.

[111] Diamond; Foner, Hidden Injuries of Bureaucracy; Lopez, Efficiency and Fix Revisited.

[112] Foner, *Caregiving Dilemma*; Lopez, Culture Change Management and Efficiency and Fix Revisited; E.A. Miller, V. Mor, D.C. Grabowski, and P.L. Gozalo, "The Devil is in the Details," *Journal of Health Politics, Policy and Law*, vol. 34 (2009), 93-135. https://doi.org/10.1215/03616878-2008-993; Ulsperger and Knotternus, Social Dynamics of Eldercare.

empathize with resident-patients, resist the pressures, and creatively and proactively *break* the rules to accommodate patients' needs as much as possible.[113] In this light, abuse derives from actually following the rules, as well as staff resentment of resident-patients whose behavior or requests disrupt the flow of work and the path to completion of tasks.[114] Further, the self-governance among staff under pressure to complete tasks helps clarify why nursing-home staff often use their discretionary powers to discipline resident-patients by medicating them with tranquilizers to ensure docility and avoid time lost to disruptive behavior as well as a wide range of contingencies;[115] such practices receive implicit support from doctors, who often prescribe antipsychotic medications with kickbacks from pharmaceutical companies in mind (Goodwin 2014).[116]

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Are there, then, responsible parties for the disturbing dynamics of daily life in nursing homes? Particular staff may be sources of problems as some nursing-home personnel may be unpleasant and even downright nasty. Yet most personnel commonly are kind and work hard while being sorely underpaid despite the physically and emotionally exhausting nature of the job, let alone those who have to work multiple jobs; these people are too tired to scrutinize and resist the system. Moreover, persons of color and 'imported'[117] staff, notably from Africa and the Caribbean, endure

[113] Lopez, Efficiency and Fix Revisited.

[114] D.A. Boehm, "The Safety Net of the Safety Net," *Medical Anthropological Quarterly*, vol. 19 (2005), 47-63. https://doi.org/10.1525/maq.2005.19.1.047; J. Braithwaite, *Regulatory Capitalism* (Northampton, MA: Edward Elgar, 2008), 149. https://doi.org/10.4337/9781848441262; Foner, Hidden Injuries of Bureaucracy; Lopez, Efficiency and the Fix Revisited.

[115] Gubrium, 148-149; P. Span, "Overmedication in the Nursing Home," *New York Times*, January 11 (2010), http://newoldage.blogs.nytimes.com/2010/01/11/study-nursing-home-residents-overmedicated-under-treated/?_r=0.

[116] J. Goodwin, "Drug Abuse," *AARP Bulletin*, July/August (2014), http://www.aarp.org/health/drugs-supplements/info-2014/antipsychotics-overprescribed.html.

[117] For a discussion about international medical migration, the companies that recruit skilled medical personnel from less developed countries, and abuses, see P.M. Pittman, A.J. Folsom, and E. Bass, "U.S.-Based Recruitment of Foreign-Educated Nurses," *American Journal of Nursing*, vol. 110, no. 6 (2010), 38-48. https://doi.org/10.1097/01.NAJ.0000377689.49232.06. International medical migration and associated processes are integral to the entwinement of the globalization and commodification of care with uneven development; see H. Bradby, "International Medical Migration," *Health*, vol. 18 (2014), 580-596. https://doi.org/10.1177/1363459314524803. Regarding other 'sectors,' the interdisciplinary feminist literature has examined the commodification of care regarding the nanny, maid, and sex trades; see for example B. Ehrenreich and A. Hochschild (eds.), *Global Women* (New York: Holt, 2002) and L. McDowell, "Roepke Lecture in Economic Geography – The Lives of Others: Body Work, the Production of Difference, and Labor Geographies," *Economic Geography*, vol. 91 (2015), 1-23. https://doi.org/10.1111/ecge.12070.

racist abuse from white resident-patients[118] – an example of how apparent victims (resident-patients) also perpetrate injustice. The fundamental problems lie with governmentalities, not particular groups of people.

There exists in US nursing homes a dispositional rationality grounded by the coupling of techniques of biopower (the combination of cost-minimization and cutting practices associated with a discourse of efficiency, and bureaucratic regulations associated with a discourse of accountability) and disciplinary power (the governance of nurses and aides in regimes of documentation and wide-ranging technical tasks, respectively). In this context delivering eldercare based on caring about residents, beyond requisite duties, is impossible except when some ethical subjects choose to break the rules, a key imperfection in the existing governmentality. Exceptional cases of resistance among nurses and especially aides, who are closest to resident-patients, may include and even be prompted by some resident-patients who refuse docility and proactively invite social interaction and friendship. Generally, however, work entails a race against time to accomplish all prescribed tasks and document them, a regime of practices governed by a mentality of economization and grounded by the rules of funding – the techniques of biopower that ensure the survival of nursing homes as places of work and facilities of so-called care.

'Care' itself is multidimensional. To disentangle precisely what is and is not cared for in nursing homes, and before engaging techniques of resistance to neoliberal life in nursing homes, I turn now to a governmentality that is imbricated with neoliberalized work, the science of eldercare.

The science of eldercare, the governance of limitations, and their relation to neoliberal life

The hospital-like ambiance of nursing homes reflects a mentality of modernization that hinges on a (western) science of care, which treats physical and/or cognitive limitations. Entwined with the neoliberal mentality of economization, the governance of limitations through a medical gaze[119] elaborates the relation between funding and care beyond costs. For example, the documentation of resident-patients' limitations at time of entry signifies that those with more limitations yield a higher fixed rate from Medicaid. Perversely, then, the sickest resident-patients are the most (financially) productive,[120] explaining why some nursing homes opt for Medicaid-financed long-term resident-patients despite the higher payments by Medicare for short-term stays. The scientific mentality that casts care in terms of limitations enhances profitability, while economies of documentation regulate regimes of care.

Medicalized eldercare of the infirm reacts to the problems of increasing physical and/or cognitive impairment as people age, but neglects the people inhabiting the bodies that are treated, and thereby alienates resident-patients as the associated regimes of practices lack sociality and feeling.

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[118] See for example C. Berdes and J.M. Eckert, "Race Relations and Caregiving Relationships," *Research on Ageing*, vol. 23 (2001), 109-126.

[119] M. Foucault, A.M. S. Smith (trans.) *The Birth of the Clinic* (New York: Vintage Books, 1994).

[120] See Foner, *Caregiving Dilemma*; A.L. Morrone and J. Smoller, "Cost Tracking for Nursing Homes, *CPA* Journal, vol. 73 (2003), 50-51.

Remarkably, discussion with resident-patients is outside the purview of jobs for all regular staff at nursing homes. Aides' everyday responsibilities and practices include: regularly turning each resident-patient in bed to ensure against bedsores, changing diapers, documenting bowel movements, bathing and toileting, grooming, brushing teeth, dressing, bringing seniors to the dining room, walking with those who can semi-walk along the hallways for exercise, responding to call lights, cleaning bathrooms, and washing laundry, to name a few tasks in a staff to resident-patient ratio ranging from a low of 1:5 to a high of 1:15.[121] As noted, dispensing prescribed medicine is the domain of nurses, who spend a considerable amount of time walking up and down the hallways with a cart of prescribed pills, stopping at each room, at each bed, to dispense medications at doctor-designated times. Each nursing home has one or two doctors, each of whose market covers multiple nursing homes to boost their income; they therefore have little time to spend with resident-patients on their visits, which mostly entail re-prescribing medications and responding to immediate medical problems or emergencies. Each nursing home by law also has a social worker, whose time is spent giving tours to potential newcomers, arranging entry from other institutions such as hospitals or assisted living facilities, arranging specialized (e.g. dental) medical appointments for resident-patients, administering standardized tests to those developing cognitive limitations to determine when and if they classify as cognitively limited, and talking with families when a resident-patient is discharged. Curiously, social work in nursing homes has become less a social calling and more the face of business as financial responsibilities discipline their activity and frame their daily practices – a remarkable economization of care.[122] Each nursing home also has a psychiatrist, who, like the internist, covers multiple nursing homes. The psychiatrist, who talks for a limited amount of time once a week to *some* resident-patients, usually at the request of families, is the only person employed in a nursing home whose job requires extended conversation with resident patients. Resident-patients, whether physically or cognitively impaired, certainly are free to talk with one another, but nursing homes typically are physically constituted by hospital-like halls; resident-patients dependent on public funding have neither private space nor sufficient public space intended for social interaction – a result, as previously indicated, of the biopolitics of nursing home construction that results in cost minimization.

Treatment for residents who are understood as *cognitively* limited, as evidenced by standardized tests, is *locational*; they are separated – quarantined – from those who pass the cognitive tests, and they remain segregated. These people often are regarded as living 'in another world,'

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[121] C. Harrington, J. Choiniere, M. Goldmann, F.F. Jacobsen, L. Lloyd, M. McGregor, V. Stamatopoulos, and V. Szebehely, "Nursing Home Staffing Standards and Staffing Levels in Six Countries," *Journal of Nursing Scholarship*, vol. 44 (2012), 88-98. https://doi.org/10.1111/j.1547-5069.2011.01430.x.

[122] S. Llewellyn, "Boundary Work," *Accounting, Organizations and Society*, vol. 23 (1998), 23-47. https://doi.org/10.1016/S0361-3682(96)00036-0; for a more general discussion regarding social work in neoliberal life see S.F. Schram and B. Silverman, "The End of Social Work," in S.F. Schram, *The Return of Ordinary Capitalism* (New York: Oxford University Press, 2015), 109-133. https://doi.org/10.1093/acprof:oso/9780190253011.003.0005.

thereby legitimizing acts of ignoring from the perspective that nothing can be done for people outside the realm of 'this world.' The construction of an inside/outside binary and labels such as 'dementia' legitimize disregard for requests from resident-patients, cries for help, and even mundane conversation.

Despite the development of alternative philosophies of care, nursing homes have remained relatively unchanged. Indeed, Bruce Vladeck, author of an influential critique of nursing-home care in 1980,[123] wrote a retrospective article in 2003 in which he declared that not much has changed.[124] Alternative approaches to eldercare do, however, exist. There are places such as Vicarage by the Sea in Maine for people with dementia where meals are made with fresh local ingredients, staff-resident ratios are low, and crucially, residents regularly experience nature – gardens, the sea, walking paths;[125] but this highly desirable approach to eldercare is both uncommon and highly exclusive, and remains unavailable to seniors reliant on Medicaid. One notable approach that has been developed at many sites and is open to Medicaid, is 'the Eden Alternative,'[126] which recognizes the need for social diversity (often addressed by bringing in children for specific events), biological diversity (often addressed by the presence of animals such as dogs or cats), attractive and functional green environments such as gardens (present at most nursing homes, although resident-patients are locked inside because aides lack the time to sit with them outside), and generally, person-centered care. Yet the Eden Alternative has been pursued without appropriate guidance regarding the incorporation of its values and their materialization in a hierarchy of tasks in nursing homes.[127] Moreover, 'person-centered care' in the Eden model falls on aides, who already are over-tasked.[128] Overall, nursing homes associated with the Eden 'way' differ little from other nursing homes because the administrative culture remains unchanged.[129] Developments in nursing-home construction in the last decade, especially for private-pay resident-patients, provide a homier, more social and less hospital-like environment (e.g. suites of a few private bedrooms around a living room, as opposed to long hallways without private bedrooms or small-scale social spaces);[130] yet the persistence of the longstanding administration of care – treatment of limitations – along with the race

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[123] Vladek.

[124] B. Vladek, "*Unloving Care* Revisited," *Journal of Social Work in Long-Term Care*, vol. 2 (2003), 1-9. https://doi.org/10.1300/J181v02n01_01.

[125] P. Whitehouse, D. George, J. Wigg, and B. Joseph, "From Demedicalisation to Renaturalisation," in J. Gilliard and M. Marshall (eds.), *Transforming the Quality of Life for People with Dementia through Contact with the Natural World* (Philadelphia: Jessica Kingsley, 2012), 55-69.

[126] W.H. Thomas, *Life Worth Living* (Acton, MA: VanerWyk and Burnham, 1996).

[127] S. Brownie and S. Nancarrow, "Effects of Person-Centered Care on Residents and Staff in Aged-Care Facilities," *Clinical Interventions in Aging*, vol. 8 (2013), 1-10. https://doi.org/10.2147/CIA.S38589.

[128] E. Anderson and J. Spiers, "Alone in Eden," *Western Journal of Nursing Research*, vo. 111, no. 12 (2015), 24-25.

[129] Lopez, Culture Change Management.

[130] L.J. Cutler and R.A. Kane, "Transforming nursing homes," *InformeDesign*, vol. 5, no. 9 (2007), https://www.pioneernetwork.net/Data/Documents/TransformingNursingHomesnformedesignnewsletterKaneCutler.pdf.

against time render creative architectural advance little more than veneer.[131] Ironically, a 'case for adoption' of the Eden Alternative is based on quantitative metrics on organizational impacts that speak more to market position, profitability, and efficiency than to fundamental problems of elder-care. Metrics include: increased levels of occupancy; increased percentage of private pay census; reduction in the use of agency staff; increases to operating margins; improved market position; waitlists for residents; and strengthening of outside community support (donations) and volunteers.[132] Similarly, metrics regarding the Eden Alternative's impacts on quality care – apparently 'person centered care' – focus entirely on bodies: incidences of use of restraints, weight loss, falls, agitation, pressure ulcers, medication use, time in bed or chair, and re-hospitalization.[133]

The medical gaze that drives the central question framing treatment and so-called care is 'what *can't* resident-patients do?'. The widely circulating, haunting poem 'See Me' captures the mental anguish felt by one anonymous woman as she lay in a geriatric ward of a hospital room before dying – a venue quite similar to nursing homes (**textbox 1**).

[131] Lopez, Culture Change Management in Long-Term Care.
[132] Pioneer Network, "Positive Outcomes for Culture Change – The Case for Adoption," *Tools for Change*, vol. 1, no. 2, https://www.edenalt.org/wordpress/wp-content/uploads/2009/06/Tools_for_Change-Adoption_v3.pdf.
[133] Pioneer Network.

Textbox 1. See Me, anonymous poem.[134]

What do you see, nurses, what do you see?
Are you thinking, when you look at me –
A crabby old woman, not very wise,
Uncertain of habit, with far-away eyes,
Who dribbles her food and makes no reply,
When you say in a loud voice — "I do wish you'd try."

Who seems not to notice the things that you do,
And forever is losing a stocking or shoe,
Who unresisting or not, lets you do as you will,
With bathing and feeding, the long day to fill.
Is that what you're thinking, is that what you see?
Then open your eyes, nurse, you're looking at ME…
I'll tell you who I am, as I sit here so still;
As I rise at your bidding, as I eat at your will.

I'm a small child of ten with a father and mother,
Brothers and sisters, who love one another,
A young girl of sixteen with wings on her feet.
Dreaming that soon now a lover she'll meet;
A bride soon at twenty — my heart gives a leap,
Remembering the vows that I promised to keep;
At twenty-five now I have young of my own,
Who need me to build a secure, happy home;
A woman of thirty, my young now grow fast,
Bound to each other with ties that should last;
At forty, my young sons have grown and are gone,
But my man's beside me to see I don't mourn;
At fifty once more babies play 'round my knee,
Again we know children, my loved one and me.

Dark days are upon me, my husband is dead,
I look at the future, I shudder with dread,
For my young are all rearing young of their own,
And I think of the years and the love that I've known;
I'm an old woman now and nature is cruel –
'Tis her jest to make old age look like a fool.

The body is crumbled, grace and vigor depart,
There is now a stone where once I had a heart,
But inside this old carcass a young girl still dwells,
And now and again my battered heart swells.

I remember the joys, I remember the pain,
And I'm loving and living life over again,
I think of the years, all too few — gone too fast,
And accept the stark fact that nothing can last –
So I open your eyes, nurses, open and see,
Not a crabby old woman, look closer, nurses — see ME!

The main regime of practices that produce the psychological devastation felt by the author of 'See Me' and so many others in nursing homes and geriatric wards in hospitals is treatment focused on bodies guided by a science of eldercare centered on people's limitations. In addition to economies of documentation, then, techniques of biopower that ground the mentality of the science of modernized eldercare also include training regimes for doctors, nurses, social workers, and aides in medical treatment based on people's limitations. The mentality is one that casts resident-patients as units of treatment in a dehumanized understanding of old people that is legitimized through the discourse of efficiency and mandated through documentation that renders financial support possible. The mentality, associated discourse, and approach to treatment are evidenced in other societal sectors. For example, treatment of the homeless is so bound up in a medicalized gaze, notably for those who are mentally ill, and more generally in dehumanizing bureaucratic processes, that many, if not most, homeless people who have perhaps a shred more freedom than the institutionalized elderly, refuse care and (temporary) housing.[135] Bodies of the infirm elderly and homeless alike seem to become detached by staff from the thinking, remembering, and feeling persons themselves. Although rich ethnographic field research in nursing homes has clarified the medicalization of nursing-home space and the resultant alienation of resident-patients from social life, what remains unattended, however, is what to do about the profound problems.

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A crucial technique of resistance to counter the treatment of limitations would treat residents' *capabilities* – both physical and cognitive. Towards this end, another alternative approach to eldercare, 'narrative medicine,' pioneered by physicians such as Rita Charon,[136] challenges the objectifying gaze of modernist western medicine by tapping the experience of patients through their narratives. Instances of doctors practicing alternative medicine exist,[137] but the general approach is far from systematized and remains outside the realm of mainstream nursing-home care. Care-givers engaged in narrative medicine regard those in need of care as having agency. Staff value residents' narratives about their physical and cognitive conditions and the histories of those conditions, *and find clues to improved health in those narratives*, enrolling residents in their own treatment. Narrative medicine fundamentally is a *relational* approach to holistic health that understands knowledges

[134] See Me, anonymous poem: http://www.nursinghomealert.com/share-this-poem.

[135] On dehumanizing constraints on the homeless see T.M. Luhrmann, "'The Street Will Drive You Crazy'," *American Journal of Psychiatry*, vol. 165 (2008), 15-20. https://doi.org/10.1176/appi.ajp.2007.07071166, and S. Murphy, "'Compassionate' Strategies of Managing Homelessness," *Antipode*, vol. 41, (2009), 305-325. https://doi.org/10.1111/j.1467-8330.2009.00674.x.

[136] R. Charon, "Narrative Medicine," *Journal of the American Medical Association*, vol. 286 (2001), 1897-1902; R. Charon, *Narrative Medicine* (New York: Oxford University Press, 2006).

[137] See for example R. Mead, "The Sense of Ending," *The New Yorker*, May 20 (2013), 92-103.

about the body and mind as part of a social process.[138] It casts people's bodies and minds as part of a complex, interconnected system that encompasses and entangles the psycho-social, the cultural, the political, and the ecological.

Towards grounding narrative medicine in nursing homes, techniques of resistance ideally would target re/training all nursing-home staff (aides, nurses, doctors, social workers) in narrative medicine as central to diagnosis and treatment (that is, not added on and relegated to a low position in a hierarchy of tasks). However, in our less than ideal world such training would have to be informal at the outset, possibly even covert on the part of some staff and reliant on ethical subjects, consistent with the breaking-the-rules approach.

More generally, a bottom-up approach to treatment as a technique of resistance is best conceptualized not in isolation, but rather as complementing the techniques of resistance discussed in the preceding section in an assemblage approach[139] to the construction of new governmentalities. Towards crystallizing the approach into a system of governance, the goal ultimately would be to revise techniques of biopower regarding the accounting and evaluation system such that justification of public funds (Medicare and Medicaid) to nursing homes through evaluative procedures would emphasize the documentation of residents' narratives, and crucially, the *relation* between these narratives and treatment.

Another complementary relational technique of resistance would entail an integrationist approach to *variation* in residents' cognitive and physical capabilities. Whereas focusing on limitations casts some people as 'demented' with a sentence of quarantine, focusing on capabilities and their variation would permit the possibility that the author of "See Me" could have interacted in meaningful ways with others if given opportunities.[140] Rather than viewing and categorizing someone as a 'demented patient' and abandoning her to isolation, here I borrow from a perhaps unlikely source: a radical *children's* pedagogy, 'the hundred languages of children,' which originated in Reggio Emilia, Italy.[141] This pedagogy is a multidimensional model of learning. One important principle recognizes variation in children's skills and *types* of intelligence; rather than casting and relegating children to binary categories that become ossified such as smart/dumb, withdrawn/outgoing, athletic/uncoordinated, and the like, teachers understand all children as having different knowledges and talents, and they encourage children to learn from each other while celebrating

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[138] L. Mehl-Madrona, *Narrative Medicine* (Rochester, VT: Bear and Company, 2007). See also D.S. Cloutier, A. Martin-Matthews, K. Byrne, and F. Wolse, "The Space Between," *Social and Cultural Geography*, vol. 16 (2015), 764-782. https://doi.org/10.1080/14649365.2015.1020336; T.M. Kitwood, *Dementia Reconsidered: The Person Comes First* (Philadelphia: Open University Press, 1997); S.G. Post, *The Moral Challenge of Alzheimer's Disease* (Baltimore: Johns Hopkins University Press, 1995).

[139] For example, M. Brady, "Ethnographies of Neoliberal Governmentalities," *Foucault Studies*, vol. 18 (2014), 11-33; T. Li, "Fixing Non-Market Subjects," *Foucault Studies*, vol. 18 (2014), 34-48;
R.K. Lippert, "Neo-liberalism, Police, and the Governance of Little Urban Things," *Foucault Studies*, vol. 18 (2014), 49-65. https://doi.org/10.22439/fs.v0i18.4651.

[140] Kitwood.

[141] C. Edwards, L. Gandini, G. Forman (eds.), *The Hundred Languages of Children* (Santa Barbara, CA: Praeger, 2012).

such interaction and nurturing respect among children for each other. This is instructive for eldercare. Treatment based on capabilities requires a locational reordering of space in nursing homes to recognize and, moreover, harness variation in peoples' capabilities as a tool for enriching everyday life through meaningful interaction among residents, without exclusions. Whereas Eden-like approaches to exposing long-term residents to novelty and social diversity center on once-in-a-while events that bring children, for example, into nursing homes to interact with the elderly, attention here is directed not to discrete events, but rather to the construction of sociality as integral to everyday life. In this context, the recording of personal health narratives for medical treatment would extend to the recording of life histories to give voice to memories while creating regular *forums* in public spaces for exchanging such memories, thereby inserting practices of memory-sharing into the rhythms of daily routines. An integrationist approach opens avenues of social relations that access each person's memories and values, encourages sharing, and crucially, the capacity of individuals to learn from one another – a source of novelty and excitement that should not be reserved exclusively for children and young adults. This dynamic understanding of life and health recognizes that everyone, including old people, can and *should* have opportunities to grow.

The critical goal is to shed the bare and medicalized business of nursing homes to reproduce these 'facilities' as *homes* – places of familiarity, not alienation, where people live and continue to learn about life through the prism of unfolding social relations while receiving requisite care. The new truths to be produced are humanist, embracing *health* (Gesler and Kearns 2002), which can connect with, but not be driven by, science. The normative interest is with a regime of health that encompasses limitations, but treats them through capabilities.

Summary and discussion: analytics of resistance to nursing home governmentalities

Analysis of nursing-home governmentalities permits the delineation of mechanisms or techniques of resistance to counter existing techniques of biopower and disciplinary power, in turn to engender new, alternative regimes of practices that can cultivate new mentalities or truths and associated discourses. **Table 1** schematically summarizes the analytics of resistance discussed in the preceding sections relative to existing governmentalities.

Table 1. Schematic representation of analytics of resistance to governmentalities of eldercare. Dotted lines reflect interrelation among dynamics represented in different cells. Solid, horizontal lines distinguish analytical components. Arrows reflect direction of influence among the analytical components. Note the unidirectional influence in resistance, which must be constructed via the design (techniques of power) of new practices; in existing governmentalities, excepting the relation between mentality and discourse in which the latter communicates the former, the directions of influence are bidirectional whereby practices, which are grounded by techniques of power, both produce and are governed by a mentality. Techniques of resistance target techniques of biopower.

problem	long-term residents in nursing homes starve for social relations; alienation; psychological devastation			
conduct: regimes of practices	treatment of resident-patients: re: physical limitations - focus on bodies, not persons (nurses dispense pills; aides treat bodies) re: cognitive limitations - locational treatment; segregation	staff time spent filling out forms	profit-producing practices: doctors increase volume of patients across nursing homes to earn more $$ nursing homes/property flipped for profit	cost-cutting practices: insufficient staffing cheap, unappealing meals; lack of fresh food cost-cutting in construction
mentality, 'truth'	modernization,science/medicine – fix problems via limitations	neoliberalism; rendering nursing homes economically productive; shifting downward responsibilities of cost		
discourse	efficiency		profitability	efficiency
techs of power	medicalization of treatment staff training based on people's limitations (physical and cognitive)	regulatory framework: economies of documentation – forms, & the disciplining of staff bureaucracy -- standards, certification, licensing; PPS	nursing homes as investment vehicle targeting the real estate (separate from nursing home operations) via construction loans, public funding schemes, REITs, LBOs	cost cutting in nursing homes; PPS
mechanisms: techs of resistance	*relational approaches:* focus on physical/cognitive capabilities staff trained and evaluated on basis of *narrative medicine* integrationist approach to people with different levels of capabilities ('the 100 languages of residents') dedication of space to public forums	documentation of relation between personal narratives and treatment on the part of nurses and doctors	staff: break rules to engage residents personally upport nursing homes as nsibility campaign situated geographies to personalize environment to brokers of funds + media support	
counter-conduct: new regime of practices	recording, sharing of personal health narrative practice narrative medicine/holistic medicine residents with different levels/ranges of capabilities interact with/ help one another; sociality as routine		doctors, nurses spend more time with patients, practicing holistic medicine expenditures on new built form (new nursing homes refurbish existing ones) to value private and public space owners take part in activities; decisions rendered based on participation and observation – *experience*	
new discourse	nursing homes as *homes*, places of social comfort, familiarity; sociality; learning, growing			
new mentality, 'truth'	humanist perspective, health; engage problems via people's capabilities			

Analysis begins with the problem, namely the alienation and psychological devastation felt by resident-patients in nursing homes. The initial task is to identify the regimes of practices that deliver the problem. Reading down the first column of the table, resident-patients are treated in terms of their limitations via routine practices on the part of nursing-home staff. These practices both produce and are governed by a mentality of modern, western science, which connects with a discourse of efficiency and is grounded by the medicalization of treatment via training of staff in 'scientific' methods. The medicalization of treatment and associated practices and discourse interface with a neoliberal mentality (second column), which both governs and is produced by a regime of practices whereby nursing-home staff spend enormous amounts of time filling out forms, and consequently have little or no time to spend with resident-patients. These practices, which also interface with a discourse of efficiency, reflect a neoliberal mentality insofar as they render social problems (infirmity in old age) a matter of economic opportunity in the context of a regulatory framework of licensing, certification, standards, and forms for everything – all of which represent specific tactics in strategies of biopower for public funding. The neoliberalization of administration, resulting in cumbersome bureaucratic practices that consume staff time, therefore interfaces with profit-producing practices (column three) insofar as public funding, undergirded by economies of documentation, enables the perpetuation of nursing homes as businesses. Nursing homes are a source of profit for individuals such as doctors as well as other firms. Doctors, who spend most of their visits to nursing homes re/prescribing medications, sign on as internists to multiple nursing homes to increase their income, further siphoning time away from resident-patients in any one nursing home. Nursing homes themselves as economic units are bought and sold like trading chips by other firms, which are attracted to them by guaranteed government funding as well as a steadily increasing market guaranteed by an aging society. Other firms, disconnected from the care business, mine the monetary value of nursing homes, which is fixed in the real estate in which they are situated. Biopower to ground the mentality of transforming care of the infirm elderly into profit through real estate, reinforced by discourses of profitability ('hot' investments), has entailed a variety of tactics over time, including government-backed construction loans, public-funding schemes, REITs, and LBOs. The flow of profits away from nursing homes, and further, the responsibility of nursing homes to pay the debt incurred by their own acquisition, in turn interfaces with another regime of practices within nursing homes: cost cutting. In this way, neoliberalism, which entails the devolution of responsibilities to individuals and organizations dealing with on-the-ground problems in the everyday, shifts the burden of cost from firms that buy and sell nursing homes to nursing homes themselves, and disciplines nursing-home management in cost-minimization. Moving from the terrain of inter-firm relations to dynamics within nursing homes, nursing-home administrative practices become bound up, then, in cutting a variety of costs, from mundane items such as food, resulting in lower- quality meals to reducing staff and shifting employment to lower-skilled and thus lower-waged personnel (column four). The discourse of efficiency legitimizes cost minimization while casting eldercare as an economic problem requiring economic resolution. Understaffing combines with both bureaucratic practices that disassociate staff from residents as *people*. The regime of cost cutting also interfaces with bureaucratic culture as PPS regulates funding to increase payments

with increasing levels of sickness, thereby rendering the sickest the most productive. PPS also underestimates costs and thus lacks coverage of many costs, in turn connecting with other constraints that prompt cost cutting.[142]

Techniques of resistance must identify and target techniques of power to produce new, alternative regimes of practices that can engender a new mentality or 'truth' and related discourses. This view counters modernist notions on the right and left alike that people will change their thoughts and practices if only "the Truth" were revealed, prompting a mostly discursive approach to change. Per Foucault, practices produce a new mentality, not the other way around. Barbara Cruickshank[143] pursued this logic to explain that 'welfare queens' as a discourse evolved from regimes of practices. *Proactively* making use of this logic, a new mentality follows from new, on-the-ground practices enacted not as discrete events, but rather mundanely in the rhythms of everyday life. Such new practices or counter-conduct are not inevitable, and therefore require design by mechanisms, techniques of resistance, which directly counter techniques of biopower in existing governmentalities.

The techniques of resistance I have discussed, reading down the first column of Table 1, include relational approaches to treatment that are directed to residents' capabilities to counter techniques of power that focus on limitations; these techniques of resistance include narrative medicine, an integrationist approach to difference, and dedication of spaces in nursing homes to discussion and sharing of thoughts and feelings about life, knowledges, and relations in the past, present, and future; further, these strategies ultimately would entail training of staff in relational approaches to ensure meaningful applications. Relatedly, targeting techniques of power associated with the regulatory framework (second column), techniques of resistance would also engage alternative modes of documentation and evaluation of staff, specifically a focus on the *relation* between treatment and personal narratives to ensure that narratives are used actively and constructively. Relational mechanisms are intended to produce new, alternative regimes of practices – counter conduct – on a daily basis. Practices of narrative medicine would entail routine recording and sharing of personal narratives and interaction among residents of all levels of capability. Recognizing that change is a bottom-up process, one crucial question is how such strategies can be deployed *in advance of* changes at the scale of regulatory framework of the US government regarding public funding of nursing homes. The answer in nursing homes: *break the rules* to engage residents and implement treatment relationally. As indicated, such rule breaking occurs, but on an individual basis and covertly in the shadows of medicalized and neoliberal mentalities, discourses, strategies, and practices among staff who, in Foucauldian terms, critique the system and choose to engage in counter-conduct as an ethical act to spend meaningful time with residents; these covertly radical staff figure out elements of holistic treatment independently to engage in little acts of courage. Scaling up would require connection and support among staff who recognize problems and are willing

[142] L.-W. Chen and D.G. Shea, "Does Prospective Payment Really Contain Nursing Home Costs?", *Health Services Research*, vol. 37 (2002), 251-271. https://doi.org/10.1111/1475-6773.022.
[143] Cruikshank.

to engage in counter-conduct – an activist network approach that could evolve among staff and/or facilitated by researcher-activists. Media attention to problems and possibilities in nursing homes would be helpful regarding general communication, and further, to develop a public frame of critique to which nursing-home staff could relate to assuage potential feelings of alienation – an omnipresent challenge for those engaged in critique.[144]

A complementary technique of resistance would target the corporate sector that has ravaged nursing homes for the value of their real estate. The idea is to make use of these firms in the realm of corporate social responsibility campaigns that could benefit them as well as nursing homes – a tall order that would require personalization of the nursing-home environment in an experiential approach, possibly enrolling media support. In this scenario decisions about nursing homes on the part of corporate agents would be based on situated experience to contribute to the production of a regime of practices that might include funding for new or modified construction to provide spaces for social interaction as well as privacy, new food acquisition and meal/snack planning, and hiring more staff specifically to engage in alternative practices to enable a more social environment. The overall goal: produce a new, humanist mentality of health, conveying a sense of 'home' and familiarity by way of the above-stated techniques of resistance and resultant regimes of practices. Sickness and death indeed are common in nursing homes, but surely these inevitabilities of life should not foreclose possibilities among the living for enacting capabilities and sharing lives, thoughts and feelings, growing and learning.

Conclusion

Drawing from Foucault's engagement with governance through his work on ethics, my concern in this paper has been to conceptualize an approach to resisting entrenched problems in nursing homes from a bottom up perspective, consistent with Foucault's point that significant change occurs at the outset informally in civil society, and only later becomes crystallized in policy. Ultimately the agenda is to achieve system-wide change by targeting regimes of practices to produce new mentalities rather than the other way around. Thorough change is unlikely; the critical point is to set an agenda and conceptualize a strategy to avoid current and past problems to move in appropriate directions.[145]

Effective resistance requires critique not just of existing practices, but more holistically of existing governmentalities that deliver problems. Disentangling the various components of existing governmentalities and their relations helps direct attention to what, precisely, requires counter measures. By 'analytics' I refer to designing strategies and tactics to counter directly existing techniques of power, the mechanisms that ground existing mentalities in problematic regimes of practices. The construction of such counter-governmentalities aims to effect change based on knowledges of the production of on-the-ground problems.

[144] See for example Foucault's comments about alienation in Truth and Power, 130.

[145] Foucault, Hermeneutics.

Directing resistance to governmentalities means that designs aim not at targeting particular individuals or groups in specific positions in a hierarchy (e.g. government, corporate actors, nursing-home staff), but rather the construction of strategies, techniques of resistance, that would enroll all actors in counter-conduct and alternative governmentalities. Whether the challenge is eldercare or problems in another societal sector, aiming to punish actors committing oppressive acts may satisfy justice, but ultimately the punishment of individuals and groups, per Foucault, will likely produce increased, not decreased, activity on the part of this group of actors. [146] The position of this paper supports justice, including punishment of actors across societal sectors committing oppressive acts, from corporate actors to brutal police, corrupt government officials, and terrorists, and also supports short-term measures such as government policies that reign in the activities of perpetrators of injustice directly via disincentives and/or indirectly via incentives. However, juridical actions leave unattended the governmentalities that produce oppressive practices. Justice complements but cannot substitute resistance. The critical normative approach developed here frames a long-term agenda by treating analysis of governmentalities as an instrument[147] by which to design techniques of resistance to produce regimes of counter-conduct, in turn to cultivate new mentalities and discourses on a path to alternative governmentalities.

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[146] I refer here to Foucault's view of power as productive in critical response to the 'repressive hypothesis;' see Foucault, *The History of Sexuality*, vol I.
[147] Foucault, Questions of Method, 236.