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NO ROOM FOR ABUSE

In Canada, media reports on health care tend to focus on the high costs of the health care system; reporting privileges the economic aspects of this social service. In the Canadian system, long-term care or chronic care is a type of service that is situated within the health care system. Long-term care institutions typically house older individuals who have lost a significant amount of autonomy and require constant care. Until recently, the services dispensed within these institutions were unseen by the media, and thus the public did not reflect much on these services. The publication of the Report of the Royal Commission on the Future on Health Care in Canada in 2002 has fostered a growing public awareness of the vulnerability of older individuals and those with chronic illnesses, and their relationship with their care-givers. Although it may be the case that the typical care for such persons in these situations is now emerging from a zone of invisibility, it is uncertain that the media coverage accurately portrays the realities of institutionalized care-giving. This essay examines the care practices in long-term care institutions in order to understand the processes at work in an environment in which care is commodified. The 'area' in which this caring labour is located is an area where constant moral compromise can create a climate where abuse can become endemic. This paper considers these environments and the potential for abuse in them in relation to the concept of 'grey zone', first formulated by Primo Levi and later adapted by Giorgio Agamben and Claudia Card, as well as in relation to the related concept 'bare life', also formulated by Agamben. The author argues that the 'greyness' produced by care practices that are bound to a cost-effective and task-oriented framework create an environment that is not conducive to proper moral behaviour.

Keywords   long-term care; abuse; grey zone; bare life

In Canada, public scrutiny of health care services has been directed towards acute care, and media reports have, in the past, privileged this particular area of health care. In the Canadian system, long-term care or chronic care is a type of service that is situated within the health care system. Long-term care institutions typically house older individuals who have lost a significant amount of autonomy and require constant care. Until recently, the services dispensed within these institutions were unseen by the media, and thus the public did not reflect much on these services.

The publication of the Romanow Report in 2002, with its chapter on home-care, has fostered a growing public awareness of the vulnerability of older individuals and those with chronic illnesses, and their relationship with their care-givers (Romanow Commission, Report of the Royal Commission on the Future of Health Care in Canada 2002). Such individuals and the persons who care for them are now the focus of increased media attention. In 2003, reports of abuse of persons in long-term care institutions created a public outcry: in particular, the coverage of an incident of abuse at *Charles-Borromée* long-term care facility in Montréal was the focus of both local and national news coverage. Recent television programmes about institutionalization have highlighted the issues surrounding compromised adults (see, for example, *Rage Against the Darkness*, CBC, September 2004). Although it may be the case that caring for adults in long-term care facilities is now emerging from a zone of invisibility, it is uncertain that the media coverage accurately portrays the realities of institutionalized care-giving.

This essay examines the care practices in long-term care institutions in order to understand the processes at work in an environment in which care is commodified. I argue that although the space in which this caring labour is takes place may not be a 'grey area' or a 'grey zone', nonetheless the power differences between the agents in the care relationship, as well as the framework in which this care takes place often exacerbates these differences and this creates a climate of moral *laissez-faire*. Connecting these care practices to a cost-effective and task-oriented framework creates an environment that is not conducive to proper moral behaviour.

In order to examine the care practices in long-term care facilities in Canada, I will draw on Claudia Card and Giorgio Agamben's contrasting uses of Primo Levi's concept of the 'grey zone'. In particular, Card's understanding of 'grey areas' alerts us to the reality of stressful situations and the moral implications these situations may create. Of particular relevance is the way that Card points our attention to the mechanisms that produce such grey areas. Agamben is also useful for my analysis because he claims western society must, of necessity, produce such zones. Institutional practices amount to the regulation of 'bare life' and this causes both the devaluation of the care-receiver and the care-giver. My discussion of Card and Agamben should serve to elucidate some of the theoretical aspects of care-giving, and will also show how the practices of care are fragile and at risk in such institutional settings.

The paper will proceed as follows. I will first explain how care practices are regulated in an institutional setting. I argue that such practices devolve from a medical model of disability, and that under such a discourse potentially harmful situations can develop easily. Next, I discuss some media portrayals of institutional abuse in relation to Claudia Card's concept of 'grey area'. I argue that even though this is not an entirely accurate manner in which to describe

commodified care practices, it alerts us to the dangers inherent in commodifying care practices. Finally, by delineating Agamben's notion of 'bare life', I hope to show that commodified care practices are tied to a greater neo-liberal framework that needs to be questioned.

Institutionalized care

A person is placed in a long-term care facility when she can no longer perform the daily tasks of living without considerable help. In order to determine whether she has reached this point, the needs of the disabled individual are assessed and evaluated by a professional using a set of accepted standards, including whether the person can dress, feed and clean herself on her own or with some assistance, whether this assistance is in the form of a prosthesis or a person helping her with these chores. There may also be an evaluation of the person's mental capacity to see to her own affairs. Once it is established that the individual needs a substantial amount of help to accomplish all or most of her basic daily tasks, she will be placed in a long-term care facility. In this sense, long-term care institutions are an extension of home-care help. When home-care help is unavailable or becomes insufficient, institutionalization is deemed necessary.

Once in a long-term care institution, the individual is considered a resident of the particular facility. The language is important here as it is meant to emphasize the 'home-like' aspect of these institutions. Thus, the institutional literature usually refers to 'residents'; for example, the code of ethics of an institution will typically refer to 'residents' not 'clients'. Residents are thus labelled as individuals who will be living in a '*milieu de vie substitut*'. The French expression used in Québec conveys well the meaning of long-term care; it is a 'home' that is the substitute for the real thing. The individuals in long-term care acquire a new identity: they are residents of the institution, not disabled individuals. Their identity now becomes welded to that of the institution. This point is crucial as it calls our attention to the fact that the care practices are situated within a medical discourse and are shaped by that discourse.

Institutionalized persons lose a significant amount of their capabilities. They are candidates for long-term care either because home care is not available to them or because the amount of care required for them to stay in their homes has been deemed too great. There is an equivalence here between the use of the terms 'capabilities' and 'autonomy'. Because such individuals are unable to perform the daily tasks of living without assistance, they are not considered to be autonomous, whether or not they are mentally competent. In this sense, these individuals are classified as incapable and they must be removed from their homes and institutionalized. Inherent in this 'diagnosis' is an understanding of deficiency. This resonates well with the medical model of

disability. According to this model, a person who is disabled is a person who is sick and deficient in some way; the disability resides entirely in the person herself. This model has been subject to much criticism by many disability activists and scholars, who have developed and championed the social model of disability, in which disability is understood as resulting from an interaction between the person and her environment.

Because a long-term care institution is a health-care facility, the individuals living under its auspices are evaluated under a medicalized discourse. This medicalized discourse remains unchallenged within long-term care institutions in Canada, in part, because these institutions fall under the control of the health-care system. The resident is caught in a vicious circle where the predominant medical discourse cannot be avoided. This is in part because old age has become more and more medicalized and since long-term care institutions typically house aging adults, it follows that such facilities are seen as medical facilities primarily. Yet, the problem is not simply the predominance of the medical perspective in the encounter between the resident and the institution, but the fact that this is the only way in which the resident is seen. There is a tension emerging between the goal of seeing such facilities as a 'home' and, at the same time, having such facilities staffed by medical professionals.

Upon admission, the needs of the resident are evaluated systematically; that is, bodily functions, such as breathing, eating, eliminating, are evaluated. From this evaluation, a nursing plan is drafted in order to meet each resident's particular needs. The resident's medical stability is of foremost importance and the attending doctor and nurse will make sure the right medication is prescribed and then given and taken at the right times. The nursing plan places in hierarchical order the basic needs of the resident and ensures that her physical well-being is maintained by attending to those needs on a daily basis. There is a strict ordering of the importance of these needs as well as an appropriately planned response to each of these needs. Since the needs are the noteworthy feature of the residents, they are often the criteria by which the residents are identified. For example, if the person in Room 4 cannot eat by herself, she often will become known as the 'feeder in Room 4', and if another resident needs to be kept under surveillance she may be known as the 'wanderer'. Since it is the needs that are addressed by the staff, they soon become familiar with the particular requirements of a resident, and there is often a strong identification of a resident solely with her needs.

To understand this process more fully, Foucault's concept of bio-politics is helpful. The concept of biopolitics implies that the body of the individual becomes the objective of state intervention (Foucault 2004). If we understand the long-term care facility in Canada to be the regulatory body that puts into place the various interventions that will insure that a resident's needs are met, then we can see that the way in which these needs are addressed devolves from

a particular discourse. In this case, a medical discourse. In addition, as seen above, special emphasis is placed on understanding the individual through her needs. The regime of biopolitics facilitates the identification of the resident with her needs, and this serves to enclose her in an identity that easily reduces her subjectivity to that of her needs alone. Furthermore, the practices of care are subject to strict controls because these must respect the established hierarchy of needs. The regime of biopolitics, then, not only orders the needs of the residents, but it also dictates the manner in which these will be met. The 'how, when, and why' of the resident's needs falls under a disciplinary regime that is outside of the control of the individual herself. There might be some flexibility in the system, but it is restricted nonetheless. I will return to this disciplinary regime when I examine the economic aspects of care practices below.

The needs of the residents are addressed according to a set of practices. That is, the staff is trained on the basis of how to fulfil the resident's needs. This training involves, for example, how to feed a dysphasic individual, or how to re-position a person in bed without injuring one's back. There is an emphasis on how to meet the individual's needs appropriately and safely. However, there is also another consideration, that of cost effectiveness. Thus, the care-givers too are subjected to a disciplinary regime regarding their care-giving activities; not only are there rules for safety, there are also economic considerations. How important those considerations become directly affects how the care practices are administered. These considerations are subject to a discourse that is tied directly to governmental policies relating to health care services. Therefore, the care practices are regulated according to a particular discourse, and the system that frames these care practices is also regulated by a specific discourse. I will now examine this overarching system.

As Foucault has written, the notion of government is 'understood in the broad sense of techniques and procedures for directing human behavior' (Foucault 1997). The techniques of governmentality have been analysed in the case of disabled individuals (Tremain 2001), and Foucault's notion is also applicable for the case I am considering. In 'Breaking the boundaries of the broken body', Shildrick and Price look at the disciplinary practices that disabled persons must engage in order to get disability allowances and help under the Disability Living Allowance in the UK. The person who is disabled must report on the intimate details of her particular needs in order to qualify for benefits. Therefore, the confessional aspect and the disciplinary aspect combine to produce a subject who must willingly put herself through this self-scrutiny.

Shildrick and Price's analysis focuses on individuals outside of a formal institutional setting. These technologies at work on individuals outside institutions are also at work on individuals inside such facilities. However, there is another layer of governmentality, which is added when individuals are

in an institutional setting. How society views institutions and the individuals residing in them, and how funding and services are provided for these facilities are all subject to a regimentation and ordering which devolves from the manner in which a society understands care and those who need substantive care. In the case of Canada and many western nations, such institutions and those living in them are seen as marginal to society. Put differently, the institutions are subject to a discourse that sees such facilities as outside mainstream society. Thus any funding or services that these facilities require are not considered primary to society but are, rather, incidental to it.

Social attitudes are reflected in the type of media reporting which focuses on the aging population. Usually such reports invoke the cost to society of this future aging population, as if this future aging population is not part of society. Individuals who are perceived as unproductive are almost always portrayed as a burden on society to the point that the individuals themselves often will reiterate the claim that they do not wish to be 'burdens'. Nevertheless, such individuals often also feel they were once contributing members of society and thus have some entitlement to care provisions. Aronson and Neysmith explain this tension:

> Elderly people negotiate this complex terrain at a time when their relationship with the State is in flux, when . . . assurances of economic and social security are being reviewed and compromised. Unsurprisingly, this climate translates into a sense of disentitlement and instability for many older people.
>
> (Aronson and Neysmith 1991, p. 44)

If institutions that take care of unproductive individuals are not seen as an integral part of society, their funding will not be a priority for most citizens. On the one hand, Canadian citizens want to have access to health care; on the other hand, they are told they should accept a reduction in social services because these services are expensive. Meanwhile, long-term care facilities are left in a financially tenuous condition, as they have to manage a growing population in an atmosphere of neo-liberal fiscal restraint. This 'meta-discourse' of fiscal restraint directly affects the manner in which care practices are dispensed, as well as whether the labour involved in caring for compromised adults is valued or devalued.

Although some contend that governmental policies have shifted in Canada during the last decade to make way for a social investment state as opposed to a strictly neo-liberal one, funding priorities have predominantly been on education and acute health care (Dobrowolsky 2004). Long-term care institutions remain outside this social vision since they house persons who are not currently contributing members of society. They are necessarily left out of the social equation that privileges justice towards those who are

productive. If unproductive individuals are taken to have contributed to society, they may be eligible for some kind of care because of society's duty to people who have contributed to society in the past. Here the attitude towards the elderly is an attitude of charity or of mixed duty rather than an attitude of justice. Although it is somewhat outside the scope of this paper to examine the issue of political justice for persons who are not seen as contributing members of society, some scholars, such as Kittay in *Love's Labor*, have argued for a right to care for such individuals arising from political justice.

That such an issue is seen outside the concerns of the 'average citizen' helps explain in part why care practices within long-term care facilities have not been under much scrutiny. Another contributing factor to this neglect is that chronic institutionalization has not tended to be a subject considered worthy of theoretical attention; this was certainly the case for institutionalization in general until the seminal work of Foucault. To sum up, given the fact that the population in such long-term care centres is mostly one that is marginalized and cannot adequately voice its dissent, that such centres are costly, and that, furthermore, they are seen as a dead-end for most residents who are no longer contributing members of society, discussion about the practices of care within such centres has not elicited much public interest.

However, when cases of abuse make their way to the forefront of the media, this situation changes. Irritated and disgusted citizens may begin to note that such centres are a problematic site, and their ire is exacerbated even more if they think that perhaps their dear old grandmother could be the object of such seemingly cruel treatment and abuse.

It is important to see how this abuse is portrayed in the media, as such portrayals yield useful insights into the existing care practices. I will now turn to recent events that made headlines in Québec in the last few years in order to highlight what I see as some of the grey areas of care-giving.

Caring practices

A famous case of abuse in a long-term care facility in Montréal was brought to public awareness in November 2003 by the two sisters of a disabled woman who was living at the facility, *Centre hospitalier de soins de longue durée (CHSLD) Charles-Borromée*. The orderlies harassed the woman in question by making inappropriate jokes, telling her obvious lies, and calling her names. The abuse was verbal and was caught on cassette tape, which was then broadcast on the national news in Canada. In the months following this public case, a Canadian television network produced several specials on elder abuse; these reports incorporated taped video footage of physical abuse of elderly individuals residing in assisted living facilities. Long-term facilities such as *CHSLD Charles-Borromée* are government regulated health care facilities, whereas assisted living

facilities are not governmental facilities and may not be subject to the same regulations and scrutiny.

It is important to see how the abuse was portrayed in the media in order to understand the various elements at play. The media's typical portrait has been as follows: the nasty care-giver is seen as an all-powerful individual who takes out her frustrations on her poor helpless charge. For example, she enters the room while the resident is asleep and kicks the bed in order to wake the resident up. By analysing abuse in long-term care facilities, I am not contesting that abuse happens. However, the way in which abuse is depicted in these portraits makes it appear as if it is only the result of cruel orderlies, who are inherently abusive individuals just waiting to do evil to some helpless person. Such a portrait of abuse is limited because the abuse comes exclusively from an evil orderly. Responsibility is located in the actions or inactions of a single individual. What is shown is the one-sidedness of abuse that resides entirely in the evil orderly. There is no attempt to convey the atmosphere in which this type of abuse is likely to occur, nor is there any attempt to understand or question institutional practices.

I now want to examine more closely the way in which care practices are regulated and how care is dispensed; that is, I want to focus on the effects of the overarching governmentality of care practices. Within the neo-liberal or even the social investment state, care practices are classified as semi-skilled labour (Neysmith 1991, p. 237). Furthermore, care is labour that is identified as task oriented. Situating this labour within the confines of a resident's room, implies that caring for this resident means entering her room for the exact purpose of accomplishing some punctual task so that her particular need, and only that particular one, is met at that particular time. For example, when lunch is served to persons who cannot feed themselves, the orderly will enter a resident's room and feed her, then move on to another resident's room and do the same thing. The labour is regulated very much like factory work. Another example is the manner in which bedtime preparations are enacted. In order to make sure that the residents are comfortable and dry for the night, a round takes place at, say, 8pm and all the residents, one after another, are changed and repositioned so they can sleep. If someone has a need outside this time period, that need is seen to only if there is sufficient personnel to accommodate the special request. Thus, care becomes defined as a punctual intervention to be accomplished at a specific time and place and in an exact manner. However, as Neysmith and other writers have noted, caring is not really a task-oriented endeavour but rather one that requires the building of a relationship; care is relational work (Neysmith 1991, p. 238). Since the particular care I am looking at takes place in a medical facility, it becomes easily assimilated to the expert medical discourse dominant there. Care practices are seen as punctual events, much like taking a pill to relieve one's headache, and become reducible to a set of gestures that can be quantified.

This quantification implies that the care practices are a set of precise manoeuvres to be performed efficiently on a passive subject, which leads to the commodification of care practices. The commodification of care has many consequences. One obvious consequence is that this type of delivery is economically preferable in a financially limited system that endeavours to dispense care to compromised adults. The second is that the care-recipient is objectified. Because of the power differences between them, it is difficult for her to maintain an equal relationship with the care-giver. If she has cognitive impairments that make communication difficult for her, the objectification is exacerbated. Punctual interventions may prevent her from establishing rapport with her care-giver, other than one based on her passivity. But this expectation of passivity may have the opposite effect. For example, a person with dementia may behave more aggressively under such conditions; this may put the care-giver under more pressure to accomplish her task. The third consequence is that the care-giver becomes a worker who needs only to accomplish a punctual set of manoeuvres in an allotted time regardless of the resident's state of mind. This constantly positions the care-giver in a constrained structure of limited time and space.

The space where these care practices take place is much like a 'grey area' where moral behaviour can easily be transgressed. The media portrayals of abuse never question the space in which the abuse takes place. I want to bring this space into view here, by focusing on the room, since it is usually portrayed as the scene of the 'crime'. In most reports, the room is simply given as the background for the abuse. Yet, it is where the abuse takes place. This room is under the control of an institution mandated to promulgate care. How is it that such a site is turned into a zone of abuse? Why is this site the 'privileged' place of hurt and not care? What has gone wrong? The media reports locate the wrong in the worker only. Again, I do not question that abuse takes place. However, I believe that focusing solely on the worker is to misunderstand what is taking place in the room. The room, which serves as a metaphor for the institution, is central to our understanding of the type of abuse that happens. If the abuse was outside a care facility it might be seen as an act of aggression or even a hate crime against a person belonging to a particular group, in this case older individuals. Yet, this is not the case. The abuse is taking place within an institutional setting. If the care practices are being derogated from, is it a case of abusive individuals polluting the system or is it something endemic to these regulated care practices?

Grey areas

In order to focus on abuse within the particular space of a room in a long-term care facility, I will now examine Claudia Card's concept of 'grey area'. I want

to assess whether the regulations directing the care practices constitute a problematic area of action of the same type as Card delineates with her concept. An important point in Card's discussion of grey areas is that she recognizes different levels of oppression. Although it might be difficult to identify abusive behaviour in a zone of caring as coming from an extremely oppressive system, it is useful to examine closely how unacceptable behaviour can take place within a system of commodified care practices.

Card adapts her concept from Primo Levi's theorization of the grey zone, and so I briefly want to look at Levi's discussion before moving on to Card and Agamben's modifications of Levi's work. In the *Drowned and the Saved*, Levi discusses the 'collaboration' of some prisoners with the concentration camp authorities. His discussion centres on the *Sonderkommandos*, and he attempts to understand those who may have collaborated with the Nazis, those who did not, and those who survived in the camps. According to Levi, all these men and women were caught up within a complex system that is not easily decipherable. As Levi makes clear, it is difficult to lay blame on these 'collaborators' because they were also the intended victims of the Nazis. These 'collaborators' were both executioners and victims and Levi's point is that under such extreme circumstances one cannot hold such individuals responsible for their actions in any straightforward manner. Because the *Sonderkommandos* were chosen by the Nazis, their agency is not clearly demarcated. The 'grey zone' is just that, an ambiguous zone where one cannot judge so easily. As he explains, 'it is a grey zone, poorly defined, where two camps of masters and servants both diverge and converge. This grey zone possesses an incredibly complicated internal structure and contains within itself enough to confuse our need to judge' (Levi 1988, p. 42).

In *The Atrocity Paradigm*, Card further explores this notion of a grey zone where evil can occur and where it may be difficult for agents to distinguish right from wrong. She uses the term 'grey area' to point to that zone of ambiguity, but, at the same time, she is careful to state that the Holocaust is a particular form of evil that should not be appropriated lightly. She states:

> Like Levi, I understand grey zones more specifically to result from choices that are neither gratuitously nor willfully evil but that nevertheless implicate choosers who are themselves victims in perpetrating evils against others who are also themselves victims, paradigmatically victims of the same evils as the choosers.
>
> (Card 2002, p. 232)

This area of moral ambiguity is compelling for Card because it helps her understand situations that can be extremely stressful and have dire consequences for all of those involved. She summarizes Levi's concept as follows:

> Levi's grey zone has three striking features. First, its inhabitants are victims of evil. Second, these inhabitants are implicated through their choices in perpetrating some of the same or similar evils on others who are already victims like themselves. And third, inhabitants of the grey zone act under extraordinary stress. Many of them have lost everything and everyone, and they face the threat of immanent and horrible death.
>
> (Card 2002, p. 224)

For Card, the greyness of a particular situation may imply that it is unclear to what degree an agent is responsible for an action, which is certainly the point in Levi's original formulation of the concept. But it can also refer to the epistemological status of the choices facing the agent; that is, it may be unclear precisely which action needs to be taken. The important point of the grey area is that both victim and perpetrator are oppressed within it. In such conditions, moral choices become unclear and innocence is easily lost, as in the case of hostage victims who identify with the captors and commit crimes that they would have previously found morally repugnant. In this situation, the perpetrator may inflict the same kind of harm that she has been a victim of. Card also suggests that such an analysis might be applied to persons within systems that promulgate racism, misogyny, homophobia, and anti-semitism. According to Card,

> [c]onditions less extreme than those of the Holocaust can produce some of the ambiguities and complexities of greyness. They set up victims of oppression to pass along oppressive practices to the next generation. The evils of everyday misogyny, racism, homophobia, and anti-Semitism are not always imminent or looming in the form of well-defined events.
>
> (Card 2002, p. 233)

The other salient feature of Card's discussion is that she warns of casting grey areas so broadly that they become too wide to be effective in understanding the coercion that takes place in certain extreme situations. Not all situations of oppression are alike; some may involve extreme dehumanization and possible loss of life, whereas others may be easier to resist. If we appreciate the fact that a real, immanent and constant threat is a factor in how a moral agent chooses to act, and that both victims and perpetrators are victims of the same oppressions, could the conditions under which care-givers find themselves in long-term care be labelled a 'grey area'? Although these workers may be poorly paid and overworked, their lives are nonetheless not under threat in the care situation. If they physically abuse their charges, it is unlikely that it is because they are or might be physically abused themselves. It would seem that I am casting a net that is far too wide in order to encompass care practices. The risk here is that I am simply giving abusive individuals an easy excuse for their shameful behaviour.

Realizing that these are real concerns, I want to suggest that the care practices in long-term care are in an area of 'moral *laissez-faire*' rather than moral ambiguity, and that these practices can be conducive to moral apathy or worse. This, in turn, makes it easy for the care-givers to perpetrate acts which are shameful. They do so, not so much because they are in situations of extreme oppression, although they often work in conditions that are less than ideal, but because their care practices are conducive to the objectification of the person being cared-for. It can be countered that objectification does not necessarily create a moral *laissez-faire* attitude. However, it is the combined effect of objectification with the strict regulation of practices within a cost-effective framework that creates an area of danger in which it becomes easier for the care-givers to lose their moral innocence.

What is especially troubling about abuse in care-giving situations is that the intended purpose of the practice is the complete opposite of what is actually done. It is not only that the care-giver is not doing a good job, but that she, in fact, goes further than that and harms her charge. What is problematic here is that the parameters framing the care practices are not conducive to enhancing the care-giver's work. This, in turn, creates tension for the care-giver, and a 'slippery slope' situation can easily develop where shameful behaviour is just another step in the practice of 'un-caring'. This is not meant to excuse shameful acts of abuse but to help us understand how abuse occurs. The area of 'moral *laissez-faire*' is one where moral compromise is encountered; this occurs when the practices of caring do not encourage some kind of 'caring itself', but rather degrades the 'caring attitude'. Or, put differently, 'moral *laissez-faire*' occurs when 'caring for' is completely dissociated from 'caring about'.

The important feminist theorizing on care is relevant here. Since the work of Carol Gilligan, much has been written on care especially at it relates to moral theory. Joan Tronto has examined closely the concept of care, and she argues that, especially because it is an activity that is naturalized, it is in need of thorough conceptual analysis. For Tronto, care must be understood in nuanced ways, as more than just 'caring for' and 'caring about'. Care should also be understood as an important political ideal. The important point here is that she shows that care is both a practice and an attitude (Tronto 1993, p. 104). Simply put, the caring attitude is often not encouraged in an environment that regulates care practices within a strict regime of market labour and devalues the object of that care.

Eva Feder Kittay has examined the case of dependent individuals and those who care for them. In *Love's Labor*, she argues that theories of justice, Rawls' in particular, fail to accommodate those who are dependent and considered 'unproductive' as well as those who care for them. In her article 'Caring for the vulnerable by caring for the caregiver: the case of mental retardation', Kittay looks at cases of abuse of vulnerable individuals and argues that care-

givers, paid or not, need to be supported in their care work. For Kittay, this is a matter of political justice. Her point is that, unless workers are well supported, abuse is likely to happen. I agree with Kittay's point, and I would further add that the strict regulation of care practices under a market model can lead to abuse.

An atmosphere conducive to uncaring brings me to Card's next point, which concerns the production of grey zones. She notes that the '[m]oral conclusions to draw from the grey zone are not about its inhabitants but also about the very production of grey zones' (Card 2002, p. 234). She goes beyond analysing merely the situation of a grey zone to ask how it is that such situations can occur in the first place. If the practices of care are not conducive in helping the care-givers achieve their goal of care-giving, why are such practices produced, and, furthermore, why and how are they maintained? In order to answer this, I will now turn to Giorgio Agamben's treatment of grey zones.

Giorgio Agamben writes extensively on the concept of 'bare life', a concept he traces from its inception in Aristotle's work. In Aristotle, there are two meanings of 'life': *zoe* and *bios*. *Zoe* means general life, that is, what all living creatures share; Agamben refers to it as 'bare life'. *Bios* is the particular life of an individual. This distinction may provide a richer understanding of life, but it has had, according to Agamben, unfortunate political implications in western society. Foucault saw the regulation of bodies from the sixteenth century to the present as the power to 'make live'; put differently, the ancient sovereign power to 'take life' transforms into the power to 'make live' or biopower (Foucault 1990). However, Agamben understands this regulation, which he calls the exclusion of 'bare life', as emerging in Roman law. As Wynn writes in an article examining nursing and the concept of life in the case of neonates, 'Agamben's political project is to rethink this problematic separation of *zoe* from *bios* underlying all political formulations in the west' (Wynn 2002, p. 124). Although it deviates from Foucault's idea of biopolitics, Agamben's undertaking can be seen, nevertheless, as an extension of it. Contemporary western society, in all its facets, is the site of the politicization of 'bare life' (Agamben 1998). This politicization of 'bare life' produces 'grey zones' and these are inherently problematic.

From Primo Levi, Agamben takes the concept of the 'grey zone' and develops it as an ambiguous zone within which 'bare life' can be acted upon with impunity, even eradicated. Thus, the concept of the 'grey zone' is inserted into a theory of sovereign power over 'bare life'. According to this view, the Holocaust is an example of the annihilation of 'bare life'. The Nazis exemplify a sovereign power that acts with impunity over those it has rendered completely devoid of political significance. The crucial point to understand here is that the two notions – 'bare life' and the 'grey zone' – are intertwined in Agamben's work. I will now turn to Agamben's use of the 'grey zone',

keeping in mind the ways that Agamben deviates from Primo Levi's original purpose in introducing this concept.

In *Remnants of Auschwitz,* Agamben discusses Primo Levi's description of a soccer match, which took place between the *Sonderkommandos* and the SS at Auschwitz:

> This match might strike someone as a brief pause of humanity in the middle of an infinite horror. I, like the witnesses, instead view this match, this moment of normalcy, as the true horror of the camp. For we can perhaps think that the massacres are over − even if here and there they are repeated, not so far away from us. But that match is never over; it continues as if uninterrupted. It is the perfect and eternal cipher of the 'grey zone', which knows no time and is in every place.
>
> (Agamben 1999, p. 26)

Agamben uses this soccer match as an example of the ultimate 'grey zone'. It is a metaphor for the ambiguity of ordinary circumstances and it serves to show us how we are never far from a zone where radical evil can occur under seemingly ordinary circumstances. There always lurks the potential for evil. This zone of ambiguity is where victim and executioner can mix, and where radical evil can become benign. 'A grey, incessant alchemy in which good and evil and, along with them, all the metals of traditional ethics reach their point of fusion' (Agamben 1999, p. 21). However, in his discussion, Agamben enlarges the idea of the grey zone to one that can exist anywhere and at any time. If we accept Agamben's concept of the grey zone, any area can potentially develop into this zone of moral unclarity and, eventually, evil. It is important to understand that, for him, this is an inherent feature of western society. It is necessarily so because '[w]estern politics first constitutes itself through an exclusion (which is simultaneously an inclusion) of bare life' (Agamben 1998, p. 7).

I think the concept of a grey zone is quite powerful, and if we look at the media portrayals of abuse in care facilities, long-term care can indeed be seen as an ambiguous zone. It is tempting even to view these sites as an instantiation of a grey zone. In the case of abuse at *Charles-Borromée*, the resident was powerless to defend herself when the orderly verbally abused her. Located within this system of care are individuals who have very little or no agency and who depend on others for their survival. In the media reporting, the orderly or care-giver has all the agency, while the resident has none. Both are situated in a room or a zone where evil acts can occur, where seemingly benign individuals commit acts of cruelty. In this particular zone, therefore, we are in the presence of workers who, because they are oppressed, in turn, abuse their charges. It would seem that Agamben's understanding of 'grey zones', unlike Card's, would permit such a conclusion.

Nevertheless, as seen above, the situation of the care-giver is not one that is extreme enough to qualify as a grey zone or area because the worker is not under any immanent threat. Agamben extends the idea of a grey zone in such a way that is ultimately not very helpful for understanding why agents may be at risk in certain situations but not in others. So, for our moral considerations, Agamben seems to lead us to excuse all abusive behaviour. However, we need to shift from moral considerations, which were the prime concern of both Levi and Card and focus our attention on the political significance of grey zones, that is the production of such zones. By doing this we can better grasp what is at stake. Just as Card draws our attention to the production of grey areas, Agamben helps us investigate the production of 'bare life'.

The system in which long-term care takes place is not conducive to supporting the care-giver's goal. The worker often finds herself in a conflicting situation. She knows care-giving is a multi-faceted endeavour involving a human being and that this endeavour is not solely task-oriented. However, she is not in a system that helps her attain that goal. The care-givers are giving care within a system that politicizes 'bare life'. In Agamben's formulation of the term, 'bare life' is the raw existence of individuals who have no political agency, no place in political society. A person can become predominantly 'bare life' because of an illness or an accident, because of a criminal act or even by a political decree. Indeed, in his own delineation of the term, Agamben refers to the situation of persons in deep comas (Agamben 1998). Such individuals have been excluded, yet remain within the system; for Agamben, they are examples of the 'included exclusion'.

In many ways, the individuals in long-term care have also been excluded. They are living in a special place; these institutions are marginal to society. Furthermore, the agency of the residents is quite limited. Even if they are mentally competent, they are placed within a rigid bureaucratic system, and, if they have wishes that fall outside the prescribed provisions, they must battle the regime that is in place. The raw stuff of their existence is regulated according to considerations of efficiency, that is, in terms of time and money constraints. Caring reified under a medicalized discourse becomes a series of tasks classified as semi-skilled labour aimed at meeting needs efficiently. This priority of efficiency coupled with a market model of care labour implies that the bodies of the persons in long-term care are subjected to the policies that direct long-term care. To save money care practices can become compromised. One of the consequences of this atmosphere of fiscal restraint is that the individuality of the person is lost in the midst of these care practices. This is a good example of the regimentation of 'bare life'. Put differently, care practices are directly tied to governmental policies that regulate compromised adults. The care-receiver's situation is tenuous from the perspective of institutional policies and the care practices themselves and, furthermore, because her individuality is practically annihilated.

We cannot forget that care practices are necessary for the survival of the residents; this distinguishes long-term care from other ambiguous zones. Nevertheless, if the care practices do not take into consideration the whole person who is being cared for as well as the fact that the labour of care-giving is one that is not exactly quantifiable, then we are left with a system that treats human beings as a task to be done. Moreover, the workers involved in this task will not only be poorly valued, they will also be put into a situation where some amount of compromise will always be part of their work. If one deals with compromise on a daily basis, one may become used to being morally compromised. Thus, moral innocence is more easily lost and shameful behaviour is just another step along the journey.

A system that classifies individuals as non-productive entities to be attended to in a carefully regimented manner, will not be a system that fosters the moral well-being of those requiring care and those giving care. Attempting to carefully pry apart 'caring for' and 'caring about' in order to make the task of caring into a manageable and quantifiable task can only cause moral compromise for some and lead others to more shameful acts. If care work is to be understood as the complex labour that it is, it must be divorced from a system that politicizes, regulates and subjects life to financial priorities.

Conclusion: when care is work

The media reports of abuse would have us locate the abuse solely in the evil care-giver. This obscures the space in which the abuse is taking place. I do not suggest that such a space is a 'grey zone' in the sense that Levi used it. In most instances it is not even a 'grey area', since the agents are not under extremely difficult moral circumstances. However, if we shift our attention from the moral dimensions of grey zones or areas to the political dimensions of such areas, then we can see why such spaces are problematic. If moral behaviour is lacking in these spaces of 'greyness', we must strive to understand what is going on. For this reason, Agamben's concept of 'bare life' is useful; it forces us to shift our gaze to the implications of institutionalization.

The discourse of long-term care institutions does two things: first, it places the resident into a role that she cannot contest, and second, she becomes objectified as a set of needs. Institutionalization insures that her identity is now closely linked to that of the institution and its practices. The resident now has a new identity that is both permanent and problematic. Moreover, the medical discourse that shapes her life paints her as a deficient individual having precise needs that must be met in order to promote her well-being defined in narrow terms. Therefore, she exists at the edges of a system that looks upon her as 'bare life' only. When framed in this way, it is easy to see caring labour as a

task to be done. Furthermore, the caring encounter is one that becomes punctual and delivered on the clock. If this is obviously problematic for the resident, it is also problematic for the care-giver since this reduces her multi-faceted task of care-giving to one that is quantifiable and then easily commodified. In this type of care-giving, relationships are of primary importance; however, they cannot be acknowledged in care practices that are regulated according to a model of efficiency. Claudia Card and Giorgio Agamben help us situate the production of care practices within a system that devalues certain individuals, in this case, institutionalized adults in need of care. The end result is the regulation of care practices that do not support the care worker and place her in a constant space of moral compromise.

An important point about these considerations of care is that, ideally, care is a practice that enables. The purpose of care, in fact, is to allow the person being cared for to thrive. Moreover, care is a practice that binds individuals to each other. Persons who need a lot of assistance are at risk of being isolated. Caring practices, even if they are viewed as instrumental, can break this isolation, as disability activists have shown. If we look at the care practices in long-term care, we can see that these caring practices tend to isolate people. In the first place, these care practices must take place within an institution which groups together individuals according to a level of need. The care practices also imply that care is parceled in specific ways within a tight regime that medicalizes and commodifies it. Therefore, both care-receiver and care-giver are seen in only one dimension and ultimately are isolated from each other and from themselves by this practice. The current institutional discourse of care requires a reductionist ontology. The care-receiver's dignity is always assaulted within such a system because she is rendered 'bare life' only; and, furthermore, the care practices are unidirectional actions aimed at a passive recipient. These institutional care practices are what mediate the relationship between care-receiver and care-giver. In this scenario, therefore, cases of abuse should not surprise us given the way in which care has become a rigid practice to be performed on individuals who are devalued.

Acknowledgements

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