INTRODUCTION

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For my part I would rather not be old so long than be old before my time. The weakness of childhood, the impetuosity of youth, the seriousness of middle life, the maturity of old age – each bears some of Nature's fruit, which must be garnered in its own season.
—Cicero, 44 BC

In the last few decades, the care of frail older people within UK society has been highlighted as careering from one crisis to another due to the cost of provision of social services and nursing care. These crises, drawn attention to in the media and in academic research, have become heightened since the global financial recession of 2008. National government cutbacks resulted in a decline in public funding by local authorities, the National Health Service (NHS) and social services for frail and sick older people receiving care in the community. During the process of identifying the need for anthropological research in this area, I concentrated on combining my background in nursing with that of my training as an anthropologist. The convergence of these two disciplines resulted in anthropological research being undertaken where health professionals and health auxiliaries were at work. Aware of a task-focused culture within nursing, I also wished to see if this was evident within nursing home practice in the UK. It had been apparent during my years working as a nurse in developing countries, as well as within the nursing profession in England, especially and notably while training in nursing and midwifery. According to Menzies' (1970) early study in a large hospital that endeavoured to develop new methods of performing tasks within nursing, 'ritual task-performance' exists to spare staff the anxiety of making decisions. Over forty years later, the process is still being debated within nursing, centring on the need to move from task-oriented to science-based practice. Ten years working as a part-time staff nurse commencing in 2000 at the

Oxford University Hospitals NHS Trust (OUH), a world-renowned centre of clinical excellence and one of the largest NHS teaching trusts in the UK, enabled me to see whether or not this ideology was put into practice.

In the early 1990s, after finishing an MSc degree in medical anthropology and then a Master of Studies in social anthropology, and before undertaking doctoral studies, I worked for a nurse employment agency across the county and was willing to perform weekend night shifts in either residential nursing homes, the children's hospital or industry. Because of persistent staff shortages in many nursing homes, work was readily offered and accepted as my ideas for research in such a setting began to formulate. It was during many shifts in the nursing homes that the need to conduct anthropological research in such institutions became evident and, in particular, the need to analyse the minutiae of life within these homes. Anthropological study within care homes could inform as to the presence or absence of a quality of life both for residents and employees. The term 'quality of life' is used in guidelines for managers and staff of residential nursing homes (Residential Forum 1996; Philpot 2008; DEMOS 2014) as well as studies among older people, as will be shown later. The home studied was chosen because of its size, with over seventy residents, thirty staff and a large enough suite of buildings for the researcher to be able to conduct a study involving participant observation, without being too intrusive. Managers at the nursing home as well as the owners gave their permission, and approval was gained from the Local Authority Ethics Committee. Subsequent research undertaken with colleagues in the Oxford University Hospitals NHS Trust highlighted the recurring delays in the discharge of older patients, particularly when the media took up the descriptive but derogatory terms of 'bed-blockers' and 'bed-blocking'. This research into delayed discharge from hospital resulted in publications illustrating the use of a new (to the UK) measure of function and cognitive assessment of independence of older patients known as the Alpha FIM (Hinkle et al. 2010). What was so significant in the use of this score/measure by health professionals was the ability to use the results to determine cognition or its lack in the older patient and thus make predictions of admission/discharge outcomes.

In recent decades, newspaper articles have consistently highlighted a growing discontent within British society regarding its treatment of older people, and particularly the frail and sick person in need of social services and nursing care. These newspaper stories criticised the various governments, especially the Conservative government of the 1990s and 2000s, for the continuous cutbacks in funding for social service and health service provision. The suspicion of rationing care and treatment for older people is never far from the surface of these reports in the daily press. In order to set the social context and climate for the study conducted within the nursing

home, a summary of newspaper articles from the past twenty years is presented by way of introduction to the public's perceptions of treatment and care management of older people, namely sick and frail elders within British society. The newspaper headlines selected are as follows.

'Where do I want to live when I'm old? – unless we start a national debate now, our own old age could be bleak'. The photograph with this article shows a staff member and resident sitting in a home for older people; the photo caption says 'good homes are hard to find' (Aslet, *The Times* 1994).

'Home Sweet Home' – caring for the elderly is big business where fortunes have already been made (Kane and Waples, *The Sunday Times* 1994).

'Families given warning on costs of care' – old people and the chronic sick are not entitled to long-term care under the NHS may result in patients being forced into private nursing homes (Laurance, *The Times* 1995).

'Scheme helps elderly stay put' (Editor, *Oxford Mail* 1995). An Oxfordshire district council, with social services and a housing trust, plan to enable older people to stay in their homes by offering advice and practical help with repairs and improvements.

'Granny flats to be charged council tax' – court blow for the elderly (Horsnell, *The Times* 1995). This front-page news story followed the High Court's ruling that families providing 'granny flats' for relatives would have to pay two council tax bills. Anticipated public outrage was addressed in an Editorial entitled 'A tax on caring – keeping the elderly at home should not be penalised' (Editorial, *The Times* 1995). Within the same edition of the newspaper, the political correspondent wrote of the Labour government's plan for a Royal Commission to report on care of the elderly and other vulnerable groups (Sherman and Frean, *The Times* 1995).

'Community Care Act forces ailing pensioners to spend life-savings on health fees – woman aged 79 has paid £100,000 for husband's nursing'. She kept a pamphlet dated 1948, describing the launch of the NHS, and on spending their savings stressed that her 'contract' had been broken even though they paid tax all their lives (Cox, *The Times* 1995). This example was included with similar case histories, in light of the government's decision to introduce harsh means-testing for pensioners, the front-page headlines reading: 'Battle to stop elderly losing their homes. Major aims to end penalty for thrift' (Murray and Wood, *The Times* 1995).

'Nursing home operators look for healthier future'. Pending government proposals for people to insure themselves for ageing and long-term care, the top ten public companies providing residential care for older people are highlighted (Suzman and Rich, *Financial Times* 1996).

'Gently, gingerly… asks how rehabilitation services can be revitalised for elderly patients hustled out of hospital'. As wards and hospitals for older people in need of rehabilitation close down, more people who could be discharged back to their homes are being discharged permanently to residential care homes (Rickford, *The Guardian* 1997).

'What the eyes don't see. By institutionalising our loved ones, are we surrendering them to the enemy within?' Grant writes of the guilt felt at placing her mother in a residential home and the worry over the possibility of abuse (Grant, *The Guardian* 1997).

'Protection for the elderly' was written after *The Sunday Times* posed the question, 'Who cares for the plight of Britain's elderly people?' Sack loads of mail, e-mail messages and telephone calls told of neglect and poor care in many nursing homes and residential homes around Britain (Editorial, *The Sunday Times* 1997).

'Elderly must wait on care'. In light of the Royal Commission on funding for long-term care of elderly people, this article highlights the response. The overall recommendation is that long-term nursing care for older people should be free as it is in the NHS. The government is criticised for conniving to delay any legislation until 2001, while an editorial in the same newspaper suggests that the conclusions of the report will bankrupt the nation (Sherman and Frean, *The Times* 1999; Editorial, *The Times* 1995).

'Let the old eat what they want, says Leith'. Urging nursing homes 'to adopt a more flexible approach to meal times', Prue Leith emphasised 'the social significance of communal eating', giving an example of a ninety-year-old woman who was miserable at meal times. She was given poached eggs on wholemeal toast by a twenty-year-old staff member whereas all her long life she had eaten fry-ups and white bread. Leith gave a 'spirited defence' for the woman to choose what she wanted (Frean, *The Times* 1999).

'Garden where memories grow'. A nursing home garden in Scotland planned to 'unlock patients with dementia from their secret world'. Staff found that a physically fit man in his eighties with dementia had been a keen gardener, so they created a vegetable garden for him whereupon he 'instinctively' knew

what to do when gardening which drew him back to a familiar world, giving his life new meaning (Elliott, *The Times* 1999).

'NHS has failed elderly, says damning report' (Abraham, *The Times* 2011).

'Care for the elderly is a casualty of over-pressed nursing' (Letters to the Editor, *The Times* 2011).

'Without care – poor financial management is not all that is wrong with British care homes' (Editorial, *The Times* 2011).

'Strategic vision won't fix a leaky lavatory – you can't run a care home on diktats from head office. Bring in the micro-managers and restore some pride' (Purves, *The Times* 2011).

'Midlifers caught between worlds – Sandwich generation cares for parents and children' (Ford, *The Times* 2011).

'Spending on care for the elderly falls by a fifth' (Savage, *The Times* 2011).

'Music offers a path back to reality for dementia sufferers' (Maclean, *The Times* 2012).

'Councils still measuring elderly care in minutes – clock watchers: how councils measure out care in minutes' (Barrow and Coates, *The Times* 2012).

'Dutch approach to dementia is encouraging' (Letters to the Editor, *The Times* 2012a).

'Stop sending patients home late at night, hospitals told' (Smyth, *The Times* 2012).

'The elderly are not bed blockers they are patients' (Bauley, *The Times* 2012).

'Reality of caring for elderly relatives in 21st-century Britain' (Letters to the Editor, *The Times* 2012b).

'Transform care for the elderly, urge charities – final plea to No. 10 to prevent families "picking up pieces"' (Bennett, *The Times* 2012a).

'No. 10 sits on "urgent" care reforms – campaigners are angry after plan to cap costs is delayed' (Bennett, *The Times* 2012b).

'What shall we do with Mother? As the Social Care Bill looks at ways to cope with an ageing society, the strain isn't just about money. What if your elderly parent drives you mad?' (Scott, *The Times* 2012).

'Elderly would rather lose fuel cash than bus passes' (Moody, *The Times* 2012).

'250,000 elderly Britons alone and lonely at Christmas' (Bennett, *The Times* 2012c).

'Put your parents out to grass in hi-tech garden shed – welcome to the granny pod' (Blakeley, *The Times* 2012).

'Care home measures may not halt crisis – the cost of caring for the elderly is now being addressed – but is it too late?' (Editor, *The Times* 2013).

'Cruel short visits deprive elderly of dignity and care – more Councils tell staff to stay just 15 minutes' (Smyth, *The Times* 2013a).

'Overstretched care workers "put elderly in danger"' (Bennett, *The Times* 2013).

'Who will look after you when you are old? To avoid loneliness in later years, don't look to the penniless State – start planning now' (Thompson, *The Times* 2013).

'Plenty of reasons to laugh in this happy, loving home – an Abbeyfield Society residence for the elderly that offers friendly care and banishes boredom' (Law, *The Times* 2013).

'Heston helps older patients get a healthy appetite back' (Smyth, *The Times* 2013b).

'Barely legal – Britain's approach to caring for the elderly is a national disgrace' (Editorial, *The Times* 2014).

'Old people turn to "lonely" care homes only as a final resort' (Bennett, *The Times* 2014).

'It's horrible to say, but dementia is a writer's gift'. Emma Healey won the Costa First Novel award with a mystery about memory loss (Wilson, *The Times* 2015).

'Elderly care home residents auctioned off by councils on "eBay-style" website'. Care homes in the area are invited to bid to offer the older person a home (Editorial, *Daily Telegraph* 2015).

'Woman cannot find care home after allegations of ill treatment'. A daughter claimed that complaints she made about her mother's treatment in care homes and hospitals made it difficult to find a residential home willing to take her in (Lay, *The Times* 2016).

With these illustrative articles in mind, I turn to a historical overview of the allocation of residential care in British society and the measures to reform care therein.

Reconsidering Residential Care

Long-term residential care for older people is not a recent initiative; from the late 1940s until the 1980s, long-term residential care for older people was provided for at the foundation of the NHS in 1948. The 'chronic-sick' prior to this were housed in public assistance institutions that were integrated into the newly formed NHS. The earlier institutions have their origins in the Poor Relief Act of 1601, where all parishes were responsible for housing the poor, the sick and older people in 'custodial institutions'. The act distanced itself from the more recognisable forms of punishing paupers in the Tudor system and aimed for methods of correction. The characteristics of these 'workhouses' live on in people's memories, especially for some of the very old residents in this study. Buildings survive that are commonly referred to as the 'workhouse', even though the NHS was instigated over sixty years ago. Prior to the Poor Relief Act, and before the dissolution of the monasteries, hospitals, which included care for the elderly, were run by religious institutions, which in the third and fourth centuries were known as '*gerontochia*', established by the Church to care for elderly people (Townsend 1964). What is significant about residential homes in the late twentieth and early twenty-first centuries compared to earlier eras, however, is that they are not seen as custodial. Also, although some state-run homes still exist, an increasing number from the 1990s onwards are business ventures first, in that they are privately run and emerged in the push for privatisation by successive UK governments.

Coinciding with this development is the changing demography of the client group and the increasing incidence of dementia within that group. The Community Care Act was the catalyst for this process of change. It generated significant players under these reforms, involving the voluntary

and private sectors in the delivery of that care (Department of Health 1990). The narratives of the care assistants who worked in the home also mention this change in emphasis, consistently describing their workload as becoming 'heavier' even though residents are increasingly more frail. Population statistics for England and Wales highlight a change in the age of people in residential care. Although 16% of people aged over eighty-five in the UK live in care homes, the resident care home population is ageing – in 2011, people aged over eighty-five represented 59.2% of the older care home population compared to 56.5% in 2001 (Age UK 2015: 14).

Some of the earlier newspaper articles above were published during the implementation of the National Health Service and Community Care Act 1990, enacted in 1993 (Department of Health 1990), within which the aim of community care was to give people the opportunity to live as independently as possible in their own homes or in other 'home' settings such as sheltered housing or care/nursing homes.

During the years of planning for the introduction of the Care Act Reforms, which became the Care Act (Local Government Association 2014), there was a continued need to reiterate that care and entitlement to care be clarified and strengthened to safeguard the social care needs for older people as well as the prioritised nursing care. A significant aspect of care of people in the community, either in their own homes or in residential homes, is 'needs assessment', considered by many families to be harsh and intrusive. The social services appointed care managers to undertake these assessments upon implementation of the Community Care Act in 1990 (personal communication with Sally Brodhurst, Joint Commissioning Manager, Oxford Social Services and Health Authority) and it is this aspect of care and its service provision that is highlighted by journalists. The Care Act aimed to implement 'the most significant reform of care and support in more than 60 years', placing the people, their relatives and their carers in command of their own care and provision. The Care Act claims: 'For the first time, the Act will put a limit on the amount anyone will have to pay towards the costs of their care' (Lamb 2014), though relatives stress this is not always true in reality.

Residential care in the decades prior to the 1990s was provided by local authorities and social services departments, and had its origins in the 1948 National Assistance Act, under which terms the local authorities had to provide a residential place for anyone who because of age, illness or other reasons was seen to be in need of care and attention. What was hoped for, and in some ways achieved, was the replacing of the old workhouses with modern purpose-built residential homes. Like others since Townsend's major study, *The Last Refuge*, this research continues in the footsteps of his major investigation of long-term residential care published in the 1950s. One of his observations was that due to postwar austerity and the lack of financial

capital, many of the planned residential homes were not built. Around the country, former workhouses modified to modern social needs continued in the provision of residential care for older, sick people. In Townsend's study, some of the residents within these homes were seen to be able-bodied and it was Townsend's work that did much to highlight their plight. Today, a care home, once termed a nursing home, can be registered to accept both people needing residential care as well as those needing nursing care, meaning there are able-bodied as well as frail, sick residents. The home in this study is dual registered and is popular with people seeking residential care and especially with relatives because nursing care can be provided if and when needed in the future. However, it was observed that the majority of residents admitted to the home were in need of some nursing care.

In the planning stages between the Community Care Act 1990 and its implementation in 1993, I was one of the researchers conducting a study to assess the need for a greater understanding of the role of housing agencies in community care and their interaction with other providers (Arnold et al. 1993). Acknowledging the importance of adequate housing within community care, the findings suggested that if hidden housing requirements had been adequately addressed, then the situation of countless people ending up in institutional care could have been prevented. My component included researching the housing and community care needs of Bangladeshi elders living in Oxford. The aims were to consider their perceptions of the housing situation as well as their access to social services, and the forward planning for future care needs including the inevitable ups and downs in family and community support.

These research findings showed that the majority of elders wanted their families to care for them, as some were already doing. However, some had doubts that their family would or should provide care at home, even though all totally rejected the idea of residential care, not even considering it as a 'last resort', but did express a need to know what facilities and services existed in order to plan for future short-term respite residential care. With the implementation of care in the community, the older Bangladeshis fulfilled their wish of being cared for by family members with statutory services in their own homes, as borne out by the findings here. No residents were members of any ethnic minority group.

Rural Riverside Setting of the Nursing Home

The nursing home in this study is set in large grounds leading down to the River Thames, located in a tiny hamlet of houses and bungalows, with one public house and a farm, but no shops. Although it is on a country bus

route served from a market town less than six miles from the home and another market town eight miles away, the direct bus service is infrequent. A sprawling village on the river nearby is a tourist spot, but the home's greatest contact is with a village that contains a large housing estate and schools one mile from the nursing home.

Many of the staff working at the home live on this housing estate. Although only a mile away from the large housing estate, there is a sense of isolation about the setting of the home, off a main road with extensive grounds leading down to the river. It is this sense of isolation that leads me to describe the home as remote. The setting of the home and isolation from active mainstream life render a remoteness about it, in stark contrast to the busy urban areas and market towns where many of the residents had once lived.

Until the late 1960s, the main building was home to a family who owned and ran a jeweller's shop in a nearby town. It was converted into a residential home for older people run by a doctor and after ten years bought by entrepreneurs who provided larger premises run as a family venture. After two extra wings were added and nursing care was introduced, it was sold to a large nursing home group in the 1980s. This public company was once one of the top ten companies listed in the country (Suzman and Rich 1996). The manager of the home describes it as being a 'home from home' for the residents and their families, and this phrase features in the promotional material. At full capacity, the home takes seventy-four residents, usually around seventeen men and fifty-five women. It is divided into three wings, each with its own sitting rooms, while two have a dining area. One of the wings houses the area where hairdressing and services such as chiropody take place, which therefore serves as a focal point during weekdays. This focal area, which forms an extended dining area, is also close to the manager's office. In the three main lounges of the three wings, there are television sets with the usual choice of channels. In the dining area of one lounge, there is an upright piano. Two of the five lounges have radios, but near the end of the study, with a change of management, a system of piped music to all the sitting areas was installed. One lounge has a large window overlooking the garden and river, and another lounge with eighteen chairs has a glimpse of the garden from one window, where three chairs are located, meaning that the fifteen other chairs only have a view from a window overlooking a narrow alleyway that runs from the garden to an entrance, which visitors use. A third lounge has a long window (along its length) with views to shrubs and part of the main garden. However, this view is only seen by those residents sitting in the chairs facing the window, and not from the six chairs that have their backs to it. A fourth small sitting room with no window was allocated to two residents who smoke cigarettes.

In what was the original building, most of the upstairs rooms have a good view of the grounds, whereas others have only a limited view. Downstairs there are newer single and shared rooms built along what was the front of the original house, and these face the view down to the river. No room in the main house had an en-suite bathroom and toilet, but all had wash-basins and commodes. In two newer extensions, single rooms built with en-suite facilities are allocated predominantly to private, rather than state-funded residents. However, there is a design fault with access to the en-suite bathrooms, in that there is no room to manoeuvre a wheelchair. On looking at the building from the outside, one can distinctly observe a change of purpose from a family home to a residential institution with a change of layout, namely not using what was the house's original main entrance. The kitchen and utility rooms, which would once have been at the back of the house, are now housed along the side. These utility rooms face the main entrance and the drive leading from the main road, but are not observed from the road as two cottages within the property lie alongside. In the design and building of new residential homes, emphasis is now placed on user-friendliness for the residents. This emphasis obviously arose out of trial and error in some of the earlier homes, which added extensively and haphazardly to the original buildings.

Although a private nursing/care home, and belonging at the time of the initial study to a large group of nursing homes, this home cared for residents funded by social services, as well as those self-funded. There are three main sectors providing long-term care in the UK, namely the state-run services such as the local authority or the NHS; the private sector, such as business concerns; and the voluntary sector such as the Church or those for retired musicians/actors. Local authority provision expects residents to contribute to the cost of their care, if they are able, while NHS provision is free at the point of entry (evidence on care of elders to The Royal Commission in Royal College of Nursing 1998; personal communication Maura Buchannan, President, RCN, 2014). It is this that led to the setting up of the Royal Commission to look at the funding for long-term care of the elderly. Its conclusions recommended that nursing care costs should cease to be the responsibility of the resident (Royal Commission on Long Term Care for the Elderly 1999). Over a decade later, Dilnot, Warner and Williams (2011) addressed similar issues of funding long-term care within their phrase 'fairer care funding'.

Demographically, the home is made up of residents aged from sixty-five years to their late nineties. They are predominantly female, representing the English working class and lower middle classes, with one or two exceptions. Many of the care assistants, who come from the nearby housing estate, are also representatives of the English working class. The ratio within the home

of women to men is addressed within the study, as is the ratio of female to male carers. Furthermore, the issues of untrained, low-paid care workers are addressed, and how they impact on the daily practices of life in a residential nursing home in the modern era. All the data and analyses arise from the anthropologist's 'thick description' of the multi-faceted make-up of such an institution.

Anthropology at Home

During the year of fieldwork in the nursing home in rural Oxfordshire, a sixteen-mile drive from my home, I often experienced a sense of geographical isolation and distance from the community at large. Yes, I was doing anthropology at home and no, I did not have to learn another language or wear different clothes to those normally worn. However, a different 'language' was spoken by the employees and residents. Clothes that I wore were commented upon by residents and staff alike, whether it was 'Doc Marten boots' worn with a skirt, or black jacket and 'heels' worn for a funeral. In order to meet care assistants on their own ground, I would occasionally sit in the staff room, which was always thick with the 'smog' of cigarette smoke. Like Okely, I found that 'I unlearned my private school accent, changed clothing and body movements' (1996: 23) and could never get my demeanour quite right. On one occasion, a nephew of a wealthy resident could not believe that I was a law-abiding researcher, rather than some official 'checking up on her finances'. These finances were bequeathed to him in his aunt's will, which no doubt accounted for his sensitivity, but it made me realise that I did indeed look suspicious in that setting, no matter what I wore or how I spoke.

That many of the residents and staff became friends is seen not only in the descriptive chapters below, but also in the fact that they continued to expect me to visit the home, even in subsequent years. This in-depth period and the ensuing time are defined and described in the interpretation of the detailed patterns of life as found in the term 'thick description' attributed to Geertz (1973: 6) when describing the ethnography of an anthropologist:

> From one point of view, that of the textbook, doing ethnography is establishing rapport, selecting informants, transcribing texts, taking genealogies, mapping fields, keeping a diary and so on. But it is not these things that define the enterprise. What defines it is the kind of intellectual effort it is: an elaborate venture in … 'thick description'.

Within the following chapters, we will see evidence of 'thick description', showing aspects of the view Geertz describes, for example how rapport was

established with both residents and care assistants. Issues and ideas emerging in the course of the research are addressed according to various arguments in the literature on ageing, philosophy and the quality of life. I concentrate on the social and personal implications of dementia and its impact upon the quality of life for the resident as well as the employee. The use of ethnography and formulation from the Greek ἔθνος *ethnos*, meaning 'folk, people or nation', and γράφω *grapho*, meaning 'writing', results in this description of the social discourse.

Subsequent chapters show the results of observations in the fieldwork, with one describing the care assistants at work with the residents; another detailing the case histories of people with dementia, and the social and behavioural aspects of their condition; and another emphasising the practicalities of social organisation within the nursing home, such as meal times and activities sessions. The discussion in the conclusion brings together the themes and ideas arising throughout, with regard to institutionalisation for both staff and residents, and the elusive theme of the 'quality of life', centring on routine and order within the notion of the institution as a 'home from home'.

If there is a culture within the nursing home itself, then this research endeavours to show the 'culture' wherever possible and where in particular it was enforced, both on residents and staff, especially with the manager's insistence on each individual classing it as their 'home from home'. Evidence of the use of the term 'home from home' in other parts of Europe is seen in the promotional literature for a large nursing home in Mallorca. The title of the information pack is 'Live as in your own home', inscribed in both Catalan and Spanish as early as the 1990s (Ministerio de Asuntos Sociales 1996). As will be seen here, the idea was not always a lived reality for the resident. The use of the word 'culture' here reflects the way in which it can be defined as referring to the care home's systems of values and accepted behaviour, often connected to one's social, regional or cultural heritage. In this context, it applies to a culture within institutions as well as the culture of the individual care home itself.

Both employees and residents as well as relatives were interested in the way that events within the social discourse of the nursing home would be written down. Relatives were quick to say how they hoped that memories of their family member would live on long after their death. This ethnography acknowledges my participation in the social discourse, as heard and observed, understood through participant observation and ultimately my ability to access and share in the ingredients, constituents and meaning of the discourse, both spoken and unspoken. This active participation is highlighted by the representation of the social discourse and social actions in the

thumbnail sketches of 'thick description' as interpretation throughout the ethnography.

The many voices included here will show the anthropologist's assessment of the author's interpretation as being second-hand. However, as the study was that of 'anthropology at home', and as I was familiar with working in residential homes and au fait with the culture of nursing generally, I hope that the voices coming through are those of the residents and staff, and not only that of the researcher. The emphasis throughout the study is of it taking place within a nursing home, even in the areas where the most intimate tasks were undertaken, such as in bathrooms and bedrooms, and what took place there at any given time during the year, formed part of the social discourse and dialogue.

If the description is thick, this implies many and varied layers, which in turn represent voices, both of the people in the home and those associated with it: residents, carers, all manner of employees, managers, relatives and visitors. Within the voices interpreted here, the author's voice and her interpretation of how she heard those voices are present. Another deeper layer represents the observed, though unspoken layer, committed to paper as interpreted observations, written from the author's perceptions of what took place on a daily basis within the nursing home. That year, with its annual cycle of calendar events, such as the celebrations of Easter, Christmas and New Year, and the greeted onset of new seasons of spring and autumn, also revealed the dreaded onset of winter and its association with death. Moreover, those individual celebrations within the year, namely the birthdays of residents and staff, the acknowledgement of the deaths both of residents and their family members and staff, as well as the turnover of staff, including management, added to the intimate detail of everyday life as lived in the home.

Within the often unspoken nitty-gritty of my description lie even deeper issues, such as the confrontation of multiple losses: loss of spouse; loss of home; loss of friends; loss of pets; loss of possessions; loss of privacy; loss of identity; loss of good health; loss of way of life; and possible loss of a reason for living. These overall losses serve to inform the larger issue of the presence or lack of quality of life within the nursing home, both for the resident and the employee. Likewise, the gains found on moving into such an institution are described, as these too form some of the layers, all of which ultimately compose the larger picture, this culture; this experience of life and ultimate death.

As each chapter develops, the overall concerns of the quality of life within a care/nursing home are prioritised, such as privacy, the feminisation and the medicalisation of old age and the loss of independence, all addressed within the lived reality as portrayed. Other concerns that arise, such as boredom

and the lack of choice, are considered with brief reference to philosophical works such as Foucault's 'On Power' (1988). Goffman's 1950s identification of 'total institution' is also reflected upon within the inherent need for members of society and their families to place relatives suffering from dementia and other illnesses in a 'safe' environment.

> The handling of many human needs by the bureaucratic organisation of whole blocks of people – whether or not this is a necessary or effective means of social organisation in the circumstances – is the key fact of total institutions. (Goffman 1961: 18)

In the 'total institution' described by Goffman, residents in a twenty-first-century institution such as a care home may find themselves in a place of controlled dependency and bureaucracy, which can in turn lead to helplessness. How this impacts on other residents who are lucid is also considered and the various reactions illustrated.

Foner's account of life in a residential nursing home in America in 1994, neatly entitled *The Caregiving Dilemma*, acknowledged that a nursing home life was equally that of the workers and their worlds as of the residents, revealing the institutional requirement for bureaucracy, resultant tensions and even the depersonalisation of staff. The following chapters stress how this occurs for patients in present-day long-term institutions. What is seen is a tendency, if not checked, for this to happen to staff in particular and also to residents. Depersonalisation results from the conflict between individuality and an invasive bureaucracy. When the institution itself is large, and when management is perceived to be both aloof and at a geographical distance, issues about the quality of life are at stake.

With its accent on the life experienced within the home, such an institution can inform our understanding of the social construction of old age and the treatment of frail older people well into the twenty-first century. This type of research resulting from oral narrative, case notes and discussions within the nursing home setting can inform staff, managers, families and residents, and may ultimately lead to an ideal of care for sick and frail older people. The emphasis on defining the group of residents as sick elderly people is central to residential living and its predictable institutional control. Within the following chapters, questions of independent or assisted living are addressed, while acknowledging the increasing immobility and cognitive decline of the residents.

The issue of marginalisation is encountered not only by the residents themselves but also by those who care for them, namely the low-earning, non-qualified women. The geographical location and isolation of the home, already mentioned, can contribute to marginalisation, especially when

family members and friends, themselves older people, are unable to visit unless they have access to private transport. If such an institution is poorly served by public transport and if, as is evident, it is not surrounded by the usual societal infrastructure of shops, schools, churches, banks and public houses, the geographical isolation so easily results in marginalisation from society. For staff and management to get to work, all needed transport, though some carers were close enough to cycle in good weather. When this type of isolation is added to an already felt detachment such as the loneliness and the losses associated with old age, it becomes likely that emotions such as depression and dejection emerge. Rarely were exhilaration and joy observed, although there was always evidence of humour and laughter, however flippant. The encounter with death that both staff and residents face, often on a daily basis and always during that 'dreaded onset' of winter, may well account for the dependency on humour to deal with such sensitive and heart-felt concerns. The in-depth description used throughout will refer to these emotions, even though such subjective issues are not easy to describe.

Cicero, writing as Cato Major around 44 BC in his treatise *Cato Maior de Senectute*, 'On Old Age', was challenged by the retort, 'perhaps someone may reply that old age seems more tolerable to you because of your resources, means and social position' (Cicero 1923: 17). As wealth, and the accumulated wealth or the resource-rich ownership of one's own house in particular, is tied up with social position, then to be poor and old is a double bind, as compared to being old and financially secure. Add to this the loss of good health, and the double bind becomes a triple one of many and varied experiences of ageing. This is shown here in the narrative of *Living before Dying*, and the quality of a lived life within this residential home and its wider community, and as described in the poignant leitmotif, 'Imagining and Remembering Home'.