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Beyond the evaluative lens: Contextual unpredictabilities of care

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ABSTRACT

Social science and gerontological research on care tends to focus on identifying practices that qualify as "good care" and promoting interventions that might produce it. In this article, we identify this approach to care as the "evaluative lens." We argue that while useful, an evaluative approach to studying care can limit scholars' abilities to attend to the complex and disorderly aspects of care in daily life. Drawing on long-term ethnographic research in three distinct contexts of elder care, we show the central role that contextual unpredictability plays in care experiences. In so doing, we argue for scholarship that recognizes care as a form of becoming, embedded in processual and historically contigent relations.

Introduction

A desire for "good care" undergirds the vast majority research on care as an object of inquiry and intervention. In the current historical moment of neoliberal rationalization, this desire often translates into actionable research and scholarly aims of identifying care activities, practices, dispositions, categorizing them as good or not, and then working–whether through theorization, deconstruction, or intervention–to replicate those seen as good and improve those deemed otherwise. There is an implicit understanding that ever-more granular articulations of care lead to opportunities for improvement–that there are discrete components of care that, once known, can be targeted for intervention. In this way, "good care" comes to mean that care that can be made predictable, that can be controlled and improved upon.

We argue that the implicit link between good care and predictability highlights a fallacy in evaluative understandings of care (Leibing, 2015). Practices of care are themselves complex, such that attempts to predict, control, or improve upon existing practices are necessarily partial. In this article, we acknowledge the productive nature of care scholarship that takes an evaluative approach, but shift our analytic lens to the complexity of care as it is lived and imagined. A key dimension of this complexity is unpredictability, which we illustrate at multiple scales: individual developmental trajectories, interpersonal care relations, social network trajectories in the context of a segregated city, and national sociopolitical change in the context of institutional care. We embrace these complexities in order to shed light on meaningful portions of the lived experiences of engaging in care.

As a theoretical stance, the evaluative approach to care contains implicit understandings of morality, meaning, and trajectories of care in late life. We posit that this evaluative approach to care has at least two effects. First, scholarship on care frequently theorizes care by considering how care is and becomes a social problem. In the context of elder care, scholars worry about the rising costs of care (Seshamani & Gray, 2004), the shortage of younger adults to provide care in aging populations (Sanderson & Scherbov, 2015), and the inadequate quality of care in different settings (Feng, Fennell, Tyler, Clark, & Mor, 2011). Care, read as social problem, becomes fixed within entities, something that happens between distinct nodes, something inherently individualized. In short, it becomes a phenomenon of actors and actions, with the focus of evaluations becoming those actors and actions. Exactly who these actors are can range across scales, with more or less distance from the instance of care – objects of care, such as the medication one ingests; those providing care (caregivers); clinics, hospitals, care facilities; communities, medical or otherwise; policy makers; governments – but they remain bounded and agentic, and the evaluation of care is aligned with and attached to them. In other words, care is evaluated as the result of actors who either perform care well and become exemplars, or fail to do so and become targets of intervention.

Understanding the social world as a set of bounded orderly units to be acted upon means that problems can be targeted discretely for intervention, which can genuinely improve patient outcomes and experiences. Although this approach has the benefit of bounded, intervenable orderliness, however, the second effect of an evaluative approach is that moments of chance and disarray–contextual

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unpredictability–that cannot be disciplined into the good-or-not dichotomy come to be marginalized, intentionally or not, as uncontrollable noise. That is, the aspects of care that fall outside the evaluative framework come to be ignored by practitioners and scholars alike, creating practical and theoretical blind spots. Instead, if we conceive of care as the generative basis for social and biological life, we see that it constantly exceeds any seemingly straightforward notion of intervenable action or practice. In other words, the fallacy we identify is not so much with observed care practices but with the limitations of common social scientific conceptualizations through which we often understand these practices. Our aim is to expand our analytical and practical engagements with the concept of care beyond the evaluative lens so as to recognize how care produces critical forms of social meaning and relations. This enables analysis of how care is interwoven with the complexities and disorderliness of everyday life, many of which resist amelioration through intentional action or policy.

In this article, we focus on moments from our fieldwork with families living with early-onset Alzheimer's disease, older adults receiving paid home care, and older adults in institutional care, in order to demonstrate how contextual unpredictability shapes care experiences. These unpredictable excesses of care defy clear categorization, but still infuse people's lived experiences, and are one strand of care experiences that the evaluative approach to care obscures. There are certainly others. Rather than being exhaustive in our own cataloguing of all that is obscured, our goal here is more modest: By acknowledging the contextual unpredictability of care, we hope to loosen care from the entities in which it becomes fixed and allow for care scholarship that can accommodate the disorder and messiness of real life.

The evaluative approach to care

The interdisciplinary scholarship on care often focuses on positive and negative aspects of the phenomenon. In a 2013 article, anthropologist Joel Robbins proposed an anthropology of the good, identifying care as one focus of this anthropological project. Indeed, care as an object of study has been taken up across disciplines, at least since the work of Carol Gilligan (1982) and Nel Noddings (1984), as a scholarly endeavor intended "to explore the different ways people organize their personal and collective lives in order to foster what they think of as good, and to study what it is like to live at least some of the time in light of such a project" (Robbins, 2013a: 457). Such endeavors have taken the shape of examinations into what constitutes good care; how good care can go awry, despite best intentions; what its counterpart (bad care?) looks like; and how care might be improved (which can take any number of forms depending on the positionality of those evaluating and the criteria of improvement). Despite differences in theoretical approach, method, and context, an evaluative approach to care is a unifying thread of much of this work. Underlying the work, often implicitly, is an ideology of optimization.

Medical anthropologists working at the intersections of humanistic theory, health care practice, and aging frequently conceptualize the constitutive components of care in terms of interaction and moral orientation. For example, Annemarie Mol and colleagues argue that care fundamentally has to do with negotiations over how different forms of the good, in a moral sense, might "coexist in a given, specific, local practice." To this extent, the "good" becomes "something to do, in practice, as care goes on" (Mol, Moser, and Pols, 2015, 13). Recognizing the shifting and complex social terrain in which care takes place, these authors come to describe good care as "persistent tinkering in a world full of complex ambivalence and shifting tensions" (Mol et al., 2015, 14). Similarly focused on the ways in which care can be understood as a form of moral practice, medical anthropologist Arthur Kleinman (2012) has written about the "moral face of caregiving" (2012, 1550), a visage that becomes visible through "core moral tasks": "[t]he laying on of hands, empathic witnessing, listening to the illness narrative, and providing moral solidarity through sustained engagement and responsibility over the course of chronic illness and in the terminal period" (1551). In this perspective, the practice of care consists of a moral striving for something that can be experienced or recognized as good, and which always contains the possibility of failure.

This focus on the morality of care is also evident in interdisciplinary research on care among older adults. For instance, care becomes a "moral imperative" (Higgs & Gilleard, 2016) that focuses attention on how practices toward older adults affect their personhood and sense of well-being. Within gerontological research, especially that concerned with caregiving and carework, good care often is embedded in projects of definition, classification, and intervention. Caregiving and carework come to be described, alternatively, as a series of tasks (Kemp, Ball, & Perkins, 2013), located within a relationship or relationships (Adams & Gardiner, 2005; Ryan, Nolan, Reid, & Enderby, 2008), engaged in for a period of time (Hainstock, Cloutier, & Penning, 2017), by a person who takes on care/giving as an identity or profession (Milligan & Morbey, 2016; Saarnio, Boström, Hedman, Gustavsson, & Öhlén, 2017). The work of care, described in terms of activities, tasks, practices, something done by someone to or for another, affects those involved, both those who do the work and those for whom it is done, sometimes negatively, sometimes positively, and most often a blend of both. Care is thus a practice that shapes the personhood and wellbeing of all involved in these relations of care.

Taken together, these diverse strands of research conceptualize care as resting at the intersection of what feminist scholar Joan Tronto has referred to as "practice and disposition" (1993). This perspective recognizes that relations of care are generative, even when difficult for its practitioners, and that interpersonal care practices can be experienced and recognized as good. However, this perspective also individualizes the stakes and practices of care. In this perspective, carers should and do strive to achieve good care. Thus, appropriate personal, analytic, and systemic attention to these moral strivings can solve the practice of care. Even if care does not become perfectly good, these more attuned moral practices should result in better care.

The implicit other suggested by these moral strivings for good care is bad or violent care. At the structural level, Angela Garcia (2010), Lisa Stevenson (2014) and Miriam Ticktin (2011) show how particular forms of state or public care (as action) that seek to address "problems" become violent to those who are objects of intervention. These texts demonstrate that it is not interpersonal care that will "solve" these problems but broader and deeper structural reforms that target the conditions produced by colonial and postcolonial violence. These scholars reframe practices that, without contextualization, could be seen as "good" care. By historicizing the forms of relations that come to produce violent care, these works expand the concept of care beyond the scope of interpersonal action and relations. In this way, the structural perspective has been both productive and still within the moral evaluative framework.

Although this is necessarily an incomplete survey of research on care given the breadth of literature on or referencing "care" as an on-the-ground ethnographic fact or as an analytic, the presence of the evaluative approach across care scholarship is evident. The evaluative approach casts care in moral terms, existing along a continuum from good to harmful. In this approach, care becomes fixed in individuals, organizations, or larger structural elements, and its morality becomes laminated to the entities within which it comes to be located. Whether concerned with intervention or not, the goal of evaluation is to broach the possibility of improvement. By identifying the evaluative approach and elucidating some of its contours, we do not mean to undercut its importance, but rather to highlight its existence and posit that there exist other, complementary ways of understanding and conceptualizing care.

In what follows, we offer three ethnographic portraits as an entree to another potential approach, one that seeks to avoid casting care as a social problem to be solved, and instead embraces the messy problematic of care work. In the first, we consider variation in the

presentation of Alzheimer's disease and how that influences the possibilities of caregiving. The second draws upon the life histories of two women to illustrate the growth of social support networks, whose embedded and often precarious tendrils often can elude calculation and projection. The third example considers how differing generational experiences of historical transformations can shape experiences of care. Taken together, these examples constitute an approach to understanding care that recognizes the excesses of contextual unpredictability, elements that, while they affect (often dramatically) the persons, relations, materials, practices, and possibilities of care, are less readily available to the evaluative approach, its terms of classification and desire for optimization.

Methods in context

Although our research projects have different origins and guiding questions, over the last decade we have conducted long-term ethnographic fieldwork in the urban and suburban Midwestern United States, and urban postsocialist Poland, with older adults and the people who provide care for them. One project focused on care work and those who perform it and receive it within the home care industry, tracing the generative labor of that work to create and sustain relations of care and inequality. Another examined family caregiving among spouses in the context of early-onset Alzheimer's disease, demonstrating the ways that, as families come to understand their domestic experiences through the medicalized lens of disease, they also make sense of Alzheimer's through the logics, relations, and materialities of family. The third explored how relations of care shape personhood among older Poles living in different kinds of long-term care institutions, comparing these practices to those of older Poles participating in third-age organizations, while tracking how these relate to the large-scale sociopolitical changes that have occurred during the lives of the oldest generations in Poland. Taken together, our research, conducted in the homes and daily lives of older adults, offers complementary perspectives on the different ways that care is shaped by unpredictable historical contingencies, contingencies that in some cases, even while they allow for necessary care supports to exist, would not be interventions or policies for which we would advocate. Analysis across ethnographic cases in which care is provided in the context of marital relations and market exchange enables us to check assumptions about the ways that the moral, affective, economic and organizational aspects of different care relations shape their trajectories. While popular discourse and scholarly research treats these as distinct if not opposite methods of providing care (Zelizer, 2005), our analysis shows that both kin and paid care relations have primarily been considered through forms of evaluative scholarship that obscures the role of unpredictable and contingent historical and social factors in shaping care relations and experiences.

Collectively, our research spans seven years of ethnography (Buch, 2006–2008; Robbins, 2008–2010; Seaman, 2011–2013), which involved participant observation and interviews, both semi-structured and informal conversation. Along with research in home care organizations (Buch), long-term care institutions run by the state and the church (Robbins), memory clinics, and support groups (Seaman), and other settings, observation of the practices and processes of care within people's homes and daily lives was central to our ethnographies, providing a perspectival center that rooted much of the analysis and theorization. With older adults and their home care workers or spouses, we spent time engaged in the rhythms and relationships, work and rest that composed their daily lives. We cleaned apartments and houses, bathrooms, kitchens, and living rooms; we cooked meals, helped serve, and sometimes shared them; we ran errands, shopping and refilling prescriptions; we sat and talked or listened to the radio, watched television, being co-present. The research was intimate spatially, relationally, and often materially as we worked alongside others, in their spaces and in their lives.

As we conducted fieldwork, we were witness to the unfolding of what people explicitly discussed as “care.” We watched these moments of care—the practices, materiality, and relationality that constituted them—accumulate both longitudinally within cases and across them, enabling us to recognize the many complex, diachronic, contingent dynamic aspects of care. In rare instances, this care went—in the estimation of those with whom we worked—well: smoothly and according to plan, producing outcomes that satisfied everyone. More frequently, however, it did not. From inconveniencing to life-altering, care sometimes fell short, failed in the estimation of those therein engaged. People felt disappointed, angry, or hurt. People could be left in a condition they felt was worse—more isolated, forced to move, their health compromised. Sometimes blame was attributed—to individuals, agencies, clinicians, policies, bodily fallibility. Many times, however, there was no attributable entity—individual or structural. The contingencies of relations, materiality, bodies, and life course were too thickly interwoven to deconstruct for the purposes of blame. Even with hindsight, there was no clear path to outcome-shifting intervention. People were left to make sense of what had transpired, regardless of outcome.

You know one: unpredictable pathologies and trajectories of illness

Late fall, and I (Seaman) was accompanying a group of people with Alzheimer's disease on an all-day field trip. The trips occurred twice monthly, organized and run by a local organization that provided a range of resources for older adults. Staff and volunteers would accompany participants on morning and afternoon activities, separated by a lunch. They toured museums, zoos, gardens, or other local attractions, did activities such as ‘make your own pizza’ lunches, attended performances.

That fall day, we'd spent the morning listening to a music program in the foyer of a local church, and we would spend the afternoon touring the state's Department of Transportation headquarters. Now, it was lunchtime, and the twelve of us—nine people with AD, one program staff member, one volunteer, and an anthropologist—were at a suburban Italian restaurant. The staff member passed out truncated menus with two main course options, a modification she made after the first few field trips, when she noted the process of ordering seemed to overwhelm the group. With limited options, group members got less frustrated, she had told me, and ordering went more smoothly. That afternoon, the options were a hamburger or a stuffed pasta, along with choice of soup or salad and a drink.

Several people whom I followed for my research attended the outings regularly. Four men—Alan, Jonathan, Kevin, and Joe—were especially close in my work. During fieldwork, I spent hundreds of hours with them and their families, in their homes, on social outings, in support groups, and at medical appointments. They and their wives had met at a support group, and the four families formed a smaller, biosocial cohort who, due to their similar diagnostic timing, felt they experienced living with AD together.

Often, the families would comment on the similarities between their experiences. All four had been diagnosed with early-onset Alzheimer's disease at approximately the same time, ranging in age from late 40s to early 50s when I met them. There were similarities in terms of where they lived, the kinds of jobs they held, their children. Their lives with Alzheimer's disease could also be seen as, in many ways, comparable. Especially in those early years when the condition often was most visible in missed belt loops, repeated stories, or the forgetting of well-worn commutes–indications everyone evinced–the similarities were foregrounded between the four men and what Alzheimer's disease was in their lives. Yet, during lunch that afternoon, I found myself attuned to the differences, perhaps for the first time.

Conversation moved organically between groups, and the four men participated, each in their own way. Joe never talked much during the time I knew him, and when he did, the conversation often followed the stream of his consciousness. Earlier at the music program, he had

enjoyed humming with the music and dancing. During lunch, he spoke little, spending much of the time prior to the meal making quiet buzzing noises. Despite little verbal participation, Joe has a ready smile and bright eyes; he often feels warmly engaged. He and an older woman, in her early 80s, have a lightly flirtatious relationship, and at one point on the bus ride over, she reached out and patted his hand, calling him her "long lost friend." The juxtaposition of the two is charming, as his ex-football player build contrasts with her small, grandmotherly frame. Years later, his strength and size would be challenging for his wife, as she struggled to keep him from waking and leaving the house in the middle of the night.

Alan and Kevin, whose jocular personalities made the texture of their contributions often feel similar, each played the role of comedic storyteller in their own way. Alan pulled from his stockpile of well-worn, humorous stories, which mostly centered around his trouble-maker childhood, a prankster who stayed right at the edges of real trouble whether in school or at home. His stories were well-crafted, his narrative and timing on point, even as they most often steered discussions off course. Over time, these traits would persist, even as his short-term memory—Alan's most visible expression of his AD—disrupted the recall and continuity of present moments. Alan's memory loss presented much as the American imaginary predicts, in repetition, lost trails of thought, and momentarily forgotten tasks. Over time, even as his trademark wit persisted, Alan increasingly sheltered himself from the stimulus of daily life, taking respite in quiet corners of the house, his garden, or the care facility where he eventually would spend time in an adult day program. He went to sleep early, a fatigue I attributed to the cognitive challenge of existing within and interacting with the world as short-term memory processes fade.

The wit of his comedy partner, Kevin, tended in a slightly different direction, more closely tied to the flow of others' conversation. At one point during the lunch, someone brought up the movie *Fear and Loathing in Las Vegas*, and Kevin described once seeing Hunter Thompson give a talk, during which, as the story went, the gonzo journalist drank an entire bottle of whiskey. Even when he couldn't quite remember the details, he told his stories with a confident gusto. As Kevin lived with Alzheimer's, in contrast to Alan, he and I would continue to talk and listen to music late into the evenings, often after his wife went to sleep. He was introspective and articulate about his diagnosis and how it affected his life and his relationships in a way that Alan was not willing or able to be. Where Alan withdrew, Kevin described being withdrawn, and sometimes he expressed anger at what he felt was his increasing inability to do, to interact. Once, during a support group meeting, he commented on increasingly "feeling invisible" as he drifted through the spaces of his house, surrounded by family involved in their own projects.

Jonathon, who sat to my left sipping coffee, was more reserved. His aphasia was pronounced, leaving him with few words and lengthy pauses. If you were patient, however, the integrity of his memory would assert itself. The Fukushima nuclear disaster had occurred earlier that year, and reports about the drift of radiation in the atmosphere and water made headlines throughout the summer and fall. As we talked, Jonathan brought up a recent one, and we carried on a lengthy, halting conversation about the environmental impact. Along with his aphasia, Jonathon experienced significant visuospatial difficulties. That afternoon, every time he went to set down his coffee cup, he would do so a bit farther to the right, until after two or three times, his cup was directly in front of me, his arm pushing me gently aside as he went to reach for it. I guided him back to his place setting, and the coffee cup dance began anew as Jonathon shifted to tell Kevin a story about his dog chasing deer in the woods. Kevin took the reference to 'antlers', rather than 'deer', and decided Jonathan was talking about the family's Halloween costume for their dog. And the lunch continued.

There is a saying that to know one person with Alzheimer's was to know one person with Alzheimer's. This nugget of folk wisdom was common throughout my research and, as a quick Google search reveals, circulates more broadly through the world of Alzheimer's care and advocacy.[1] The clinical staff, support group volunteers, and family members who used the saying described it to me as an articulation of what they felt was the individual nature of people's condition. For them, the saying acknowledged the variability of symptoms, how they progress, when they present and in what order, that people experience. In doing so, it gave voice to the uncertainty of the experience, the unknowability of life with Alzheimer's disease when taken out of the language of population level health sciences and embedded in the lives of individuals.

Trajectories of illness and people's understandings of those trajectories shape the experience of those illnesses (Becker & Kaufman, 1995; Corbin & Strauss, 1988). For those living with illness, futures loom both large and largely unknowable across multiple scales. Within our current anticipatory era of temporal logics and knowledge production (Adams, Murphy, & Clarke, 2009), both popular and biomedical orientations to dementia and Alzheimer's disease have become increasingly future-oriented. Those diagnosed with Alzheimer's disease and the people who live with and care for them must attend to the ways in which anticipation for the future shapes their experience.[2] While the terminal nature of Alzheimer's disease lends the experience a pervasive, overdetermined narrative of fatality, people living with Alzheimer's disease and those who live with and care for them must also contend with the day-to-day variability of the condition and how it progresses.

The differences between the Alzheimer's diseases that Alan, Kevin, Joe, and Jonathan demonstrated over lunch that afternoon unfolded in distinct and often unpredictable ways over time. Joe's physicality and verbal play, more characteristic almost of frontotemporal dementias, required a different care relation, attentiveness, and reaction than Alan's increasing fatigue and social withdrawal. Jonathan, Kevin, and their wives' lives came to be powerfully shaped by their continued awareness of, frustration with, and despair at the changes they experienced. The complexity of their pathologies–to say nothing of their personalities, histories, social and material relations–affected their and their families' lives in unpredictable ways that profoundly shape the possibilities for care and care relations.

Beyond planning: the indeterminacy of social support and community

On a survey, it would likely seem that Mrs. Meyers and Ms. Murphy had a great deal in common. Both were single and childless, had retired from decades long careers, one as a public servant and the other as a nurse. Both had lived in their apartments and neighborhoods for many decades before hiring home care workers. Both relied on their home care workers to enable them to stay in their homes as their respective health conditions – diabetes and painful kidney stones for Mrs. Meyers and rheumatoid arthritis for Ms. Murphy – made it ever more difficult for them to manage on their own. By the time I (Buch) met both women, neither felt comfortable leaving her apartment on her own, and both relied primarily on their home care workers to keep their pantries and refrigerators stocked, to keep their clothing laundered and their homes tidy. For quite a while before hiring home care workers, both women had relied on elaborate social networks of friends and neighbors to keep them company and help them with these tasks. And yet by the time I left Chicago, Ms. Murphy's network had broken down entirely,

[1] The saying's polysemic nature makes it particularly useful for caregivers, who can deploy it both to acknowledge variability among people with Alzheimer's and to deflect potential judgment of care decisions based on others' experiences.

[2] Anticipatory logics also have led to the dominance of those who might someday have Alzheimer's disease within political and research imagination, relegating people living with the condition as "too far gone" by the point of diagnosis (see Leibing, 2014, 2018, also Seaman, 2016).

facilitating her move to an Assisted Living facility. Mrs. Meyers managed to remain at home for at least a year longer, when she and I lost touch. Mrs. Meyers' ability to remain at home was clearly facilitated by the support of her friends and neighbors.

Of all the older adults I knew in Chicago, Mrs. Meyers and Ms. Murphy were the most socially outgoing and had nurtured the widest support networks across their lifetimes. To understand the circumstances by which Mrs. Meyers' network remained intact even as she received support from home care providers while Ms. Murphy's network fizzled out requires narrating the idiosyncrasies of each woman's history. This narrative reveals the ways that the actual duration and effects of social support cannot be easily calculated or planned for. While social scientists have long shown that strong social support networks have a significant and usually positive effects on experiences of aging (Antonucci & Akiyama, 1987), the actual construction and duration of such networks are difficult to predict. Most publicly-funded home care programs assess whether potential service recipients have available social support in determining their need for care and reduce the amount of services provided accordingly (see Buch, 2018). Social support networks directly save public programs money, and thus there are policy interests in helping older adults form and maintain such networks. Some measurable factors, including the intersections of race, neighborhood segregation and socioeconomic status played a role in the very different trajectories of Ms. Meyers' and Ms. Murphy's social networks. Yet it would be almost impossible, and certainly undesirable, to implement policies or social practices to change these trajectories.

Ms. Murphy arrived in Chicago a few years after the end of World War II. Raised as a foster child in rural Ireland, Ms. Murphy trained as a nurse in London but decided to leave the United Kingdom during the lead post-War years. Among several offers, she chose a hospital in Chicago. She quickly built a strong network of friends with whom she remained close for decades – other nurses, her landlord's family, distant relatives, friends from church and other Irish immigrants. Her networks changed shape when her friends married and had children. Though she never married, she spoke fondly of her role as honorary aunt and close friend to many of her friends' kids. Eventually, she settled in a second floor apartment in a leafy neighborhood on Chicago's north side, where she lived for decades.

There weren't as many years as Ms. Murphy had hoped between when she retired from nursing and when her arthritis made it difficult for her to manage living on her own. During those years, she continued to travel regularly to England and Ireland to visit her far-flung foster siblings, and had an active social life. She was never lonely. As her debility grew, she increasingly relied on her widespread network of friends to help her remain in her apartment – a few friends brought her groceries, another picked up her prescriptions. The daughter of her former landlord took her for her haircuts and doctor's appointments, and other friend's now-grown child helped her keep her banking straight. Yet as the years wore on, her network dispersed and became less capable of supporting her even as she found herself increasingly restricted to her second-floor apartment.

For all the help from her friends, Ms. Murphy eventually found herself unable manage the cooking and cleaning, and worried about falling in the shower. Having spent the end of her career as the nurse supervisor at a nursing home, Ms. Murphy knew a lot about the elder care terrain in Chicago. She first applied for home care services through Illinois' publicly-funded Community Care Program (CCP), which provides low/no cost home care to older adults with limited assets. It turned out Ms. Murphy's retirement savings were just a little too substantial to qualify. Instead, she hired a privately-funded home care agency, who sent Sally Middleton to be her home care worker. Ms. Murphy could only afford eight hours of care a week, and for awhile that was enough. Sally did not drive, which meant that Ms. Murphy continued to rely on friends to bring her groceries and take her to appointments. Then, several of her friends moved out to the suburbs or to distant cities to live nearer to their children. Other friends, also experiencing the bodily changes of aging, moved to assisted living facilities or stopped driving. Her friend's children found themselves preoccupied caring for their parents, and were unable to continue to provide the regular assistance she needed.

Around the same time, I fortuitously appeared in Ms. Murphy's life, a friendly and curious ethnographer happy to run small errands for the older adults with whom I worked. For a while, I picked up prescriptions and grabbed a few groceries from the corner store for Ms. Murphy. Over the course of a few months, the grocery lists grew longer and longer, as Ms. Murphy struggled to find other friends able to bring her food. Around the same time, Ms. Murphy was hospitalized for a week. Afterward, Sally stayed with Ms. Murphy round the clock for nearly a week, while the older woman continued to recover. Sally, who was only about fifteen years younger than her client, found that sleeping on Ms. Murphy's 1960s era sofa left her back so knotted she could barely walk. Ms. Murphy's mounting needs, driven in part by the dissolution of her social support network, had left Sally feeling that she was no longer physically capable of providing older adults with the care she believed they deserved.

Sally retired two weeks after Ms. Murphy was released from the hospital. Sally's retirement heralded the end of Ms. Murphy's ability to continue living in her apartment. The home care agency replaced Sally with another worker, but she never really clicked with Ms. Murphy. The agency also connected her with Meals-on-Wheels, improving her food security. Yet it soon became clear that Ms. Murphy needed more household support that she could afford to purchase. The agency supervisor managing her case helped Ms. Murphy find a spot in a nearby Assisted Living facility. Several months after Sally retired, Ms. Murphy moved out of the apartment she had inhabited for over thirty years.

Mrs. Meyers had lived in her far west side neighborhood for more than thirty years by the time we met. She was born in Alabama, and raised mostly by her grandmother as her mother died giving birth to her. Like many of the Black girls she grew up with, when she was not in school she worked as a maid for a wealthy White family. She fled Alabama for St. Louis after her employer's husband made sexual advances on her. She met her husband in St. Louis, and after a few years they migrated to Chicago as he sought better employment in his work as a butcher. They had two boys, and settled into a comfortable middle class life in what was at the time a middle class Black neighborhood. When the boys went to school, Mrs. Meyers found work as a Sheriff's deputy and became involved in local politics. She remembered those as good years, when she and her husband had enough money to eat out and travel.

Over time, her husband's health deteriorated and he began to drink more and more. He was diagnosed with a chronic disease that eventually cost him both his mobility and his sight. Mrs. Meyers cared for him at home as long as she could, but eventually decided to sell their home, place him in a nearby nursing home and move her and her younger son to an apartment in the neighborhood. She still lived in that second-floor apartment when we met. Her elder son was soon diagnosed with the same condition that afflicted his father, though the progression of his disease was much more precipitous. Her husband, then her son died within a few years of one another. She lived with her younger son for years, though he died young as well. Mrs. Meyers was reluctant to speak much about this son's passing, sharing mostly that it had happened very quickly and she had been caught by surprise. By the time I met Mrs. Meyers, she was living alone in her apartment, her son's bedroom untouched. Her only remaining family were an older sister and her nieces and nephews who lived in St. Louis. Once Mrs. Meyers stopped driving, she was rarely able to see them; they spoke frequently by phone but were not able to visit very often.

Mrs. Meyers' family life in old age was nothing like she expected. As her diabetes, kidney stones, arthritis and other ailments grew more debilitating, she found it more and more difficult to leave the house. When we met, she left only for doctors appointments. Her neighborhood had changed significantly since they moved in, the once middle-

class community fractured by growing poverty, lack of investment, and violence. Yet she was neither particularly lonely or alone. She constantly wove and rewove the social web in which she was embedded, nurturing relationships with neighbors and friends and weaving newcomers into the daily fabric of her life.

In the midst of these changes, Mrs. Meyers had grown into the matriarch of her building. When a young single mom moved into a apartment downstairs with her toddler-aged son, Mrs. Meyers adopted the pair, acting as a surrogate mother/grandmother. This neighbor drove Mrs. Meyers to the store and to doctors appointments. Similarly, her upstairs neighbor, a kind man in his forties or fifties, checked in on Mrs. Meyers several times a day. Whenever he left the building, he stopped to ask Mrs. Meyers if she needed him to pick up anything from the store. He called 911 when Mrs. Meyers had a severe diabetic episode and made the arrangements with the medical supply company when she returned from the hospital. For more than a decade, these and other neighbors provided Mrs. Meyers with both the critical instrumental support and warm companionship she craved.

After a hospitalization, the social worker organizing Mrs. Meyers' discharge planning referred her to the CCP for home care services. Mrs. Meyers was reluctant to hire a home care worker but agreed after realizing she would need more help than she was comfortable asking of her friends. Mrs. Meyers cycled through nearly a dozen CCP workers before deciding Loretta was a good enough housekeeper and cook to keep around. Loretta cleaned the apartment, did Mrs. Meyers' laundry, did regular grocery shopping and cooked Mrs. Meyers' hot meals during her twice-weekly visits. Mrs. Meyers did not entirely trust Loretta, and found Loretta somewhat unreliable. Because she could also rely on her neighbors if Loretta missed work, Mrs. Meyers decided that it was better to keep Loretta than to hope the CCP agency would send someone better. Together, Loretta and Mrs. Meyers' network of friends and neighbors made it possible for her to continue to live in her apartment, surrounded by objects that reminded her of her husband and sons.

Neither Ms. Murphy or Mrs. Meyers had a living spouse or children, or even nearby relatives. This meant that neither had could rely on kin to form what most research and elder care policies presume will form the stable core of an elder's social support network. Yet over decades, both women had developed extensive social networks of just the kind that research suggests enables aging in place and improves quality of life. Even though Mrs. Meyers had objectively fewer material resources and was in worse health than Ms. Murphy, in the end Mrs. Meyers' network proved better able to sustain her life at home. Contrary to common assumptions about low- income African American neighborhoods and social networks, the comparatively limited mobility and high levels of intergenerational reliance in Mrs. Meyers' neighborhood enabled her to receive more consistent levels of social support over time. The relatively greater economic, social, and geographic mobility of Ms. Murphy's middle class, and mostly White social network meant that it fragmented at nearly the same moment her need for support increased.

The interactions of class, race, and mobility on elders' social support networks are potentially measurable and predictable. However such findings might have limited ability to productively inform social policies aiming to strengthen older adults' social support networks. Social policy obviously could not promote the lack of mobility and resources that characterized Mrs. Meyers' network and contributed to its long-term stability. This network's success in sustaining Mrs. Meyers reflects the creativity and forms of mutual reliance that people develop to sustain life in the face of systemic poverty and oppression. These networks are sources of resilience in low-income communities, but given their basis in structural violence it would be profoundly exploitative to develop policies that encourage the expansion of under-resourced networks as a way of promoting aging-in-place or other forms of desired old age.

Across the divide: unknowable qualities of relations and care

In a rehabilitation center run by Catholic nuns in the southwestern Polish city of Wroclaw, most patients stayed for a period of weeks or months as they recovered from major surgeries, strokes, or other significant events that left them unable to care for themselves. The four-story building was located in the historic religious center of the city, just steps from the cathedral, bishops' offices and residences, and seminary. Patients came to the center from the city of Wroclaw itself, as well as from smaller towns and villages in the region, some of which lacked this kind of care facility. Additionally, this center had a reputation for good care, in part because of the excellent staff. Patients were tended to by doctors and nurses who were simultaneously stern and warm, and attended physical and occupational therapy according to their needs. Hot meals were brought to their rooms, which they shared with one to three other roommates, and the chapel was only an elevator ride away. The hallways and stairwells were decorated with plants and religious images; especially prominent were pictures of Pope John Paul II, adored by so many in Poland, a country where almost 90% of the population identifies as Catholic (*Główny Urząd Statystyczny [Central Statistical Office],* 2011). At the end of the hallway on each floor, a TV that was often tuned to the Catholic station *Trwam* (*I Persist*) invited patients to gather around it. The garden outside the building also served as communal space, when weather permitted.

Although the center was not specially designated for the care of older adults, almost all patients were over the age of 60. Some staff were over 50, but most often the care dynamics were that of a younger person caring for a person at least one decade, if not two or more, older than them. Sometimes these age differences were quite large, as when an occupational therapist in his twenties was leading music or art therapy session with patients in their late nineties. These seventy years of difference marked not only different life stages, but also different periods in the history of the Polish nation. For indeed, the very oldest patients were born before World War I, when Poland did not exist as a country, while staff in their twenties were only toddlers when state socialism ended in 1989. In between, Poles lived through two world wars and the imposition of state socialism by the Soviet Union, followed by the collapse of that system and Poland's membership in the European Union. These cataclysmic international and national events shaped the material conditions and imaginative horizons of millions of Poles, such that different generations lived in substantively and conceptually distinct worlds. These generational differences implicitly shape social relations in Poland, including relations of care. In certain moments, one of which is presented below, these implicit differences become explicit through everyday interactions between one patient, care staff, and the ethnographer.

One patient, pani Alicja,[3] was seen by staff as a figure that was both deserving of pity, but also as a frustrating patient. She had worked as a farmer in a nearby village until a massive stroke left her paralyzed on one side of her body. In her early 70s, pani Alicja was very talkative, often trying to engage her three roommates in conversation, and always glad to see the ethnographer. Her stories tended to combine a condemnation of the present with wistful remembrances of the past, including details about both her own life and that of her fellow farmers and Poles. Believing that Poland's membership in the European Union (EU) had negatively affected small farmers such as herself, pani Alicja contrasted this with the Soviet era, when there were guaranteed markets for the produce that she grew. She saw the EU as an outside force that unjustly controlled the Polish nation, as the latest in a series of such outside forces stretching back to the late 18th century, when Poland was conquered and divided up among the Prussian, Russian, and Austro-Hungarian empires (see Porter-Szücs, 2014 for an overview).

[3] *Pani* is the formal term of address for women; reflecting usage in the field, I include it here.

This link between the EU and past oppressors was not unique to pani Alicja, but rather was representative of particular right-wing nationalist groups in Poland, including the Catholic media network that the TV station was tuned to in the hallways. These views receive strong support among older generations, but are even stronger as stereotypes of generations that came of age and had adult lives during socialism (Robbins, 2013b). Pani Alicja's register of complaint thus marked her as a certain stereotype of an older Polish woman.

Whenever I (Robbins) spent time in pani Alicja's room, I noticed that staff could be short with her, not listening to all she had to say. This shortness sometimes bordered on dismissiveness, as when I inquired with a staff member as to her kin network. Pani Alicja often said "I'm an orphan," but also spoke of children and grandchildren who lived nearby and visited. The nurse sighed deeply and confirmed that indeed, her children and grandchildren did live nearby and did visit multiple times per week. This contrasted to other patients who had no relatives nearby to visit them, or whose kin did not visit. Thus, she was *not* an orphan. From the staff's perspective, pani Alicja was better off than some of her fellow patients. However, from pani Alicja's perspective, spending months in institutional care was a negative experience because it took her away from her home and her kin, the locally valued social context in which to receive care. A statement about pani Alicja's location within her kin relations, then, shifted based on the differing perspectives of staff and patient.

One incident makes clear these differences on expectations of social relations. One day, pani Alicja asked me for help in calling her granddaughter. Pani Alicja's room was on the third floor, while the one pay phone for the building was located on the ground floor (in 2008, not many residents yet had cell phones, and there were no phones in patient rooms). Because she could not use one side of her body, pani Alicja needed to be pushed in her wheelchair to the elevator, into and out of the elevator, and to the pay phone in the ground-floor stairwell. Staff did not have time for this task, especially as the line for elevator was often quite long. Happy to help, I pushed pani Alicja down to the phone, where she explained how to use the pay phone and her calling card. After several tries, for I was unfamiliar with this type of phone and card, we were able to determine that she did have credits on her card and were able get through to her granddaughter's voicemail, on which pani Alicja left a teary message saying that she missed and loved her granddaughter and would like to talk to her soon. We then returned to her room, as pani Alicja expressed her gratitude, through tears, for the chance to call her granddaughter.

When I told staff later about this call, they sighed and thanked me for helping out, although they felt that such calls were not truly necessary. Because they always already saw pani Alicja as a person whose complaints were not entirely valid, they did not see her desire for a lengthy trip to the pay phone as a legitimate form of care. Rather, as an older woman, as a former farmer from a village, pani Alicja was expected to engage in a mode of complaint. These expectations of complaints thus shaped staff members' understandings of her desires in the present.

In one sense, it seems as though this case falls prey to the "care as social problem" framework that the evaluative approach assumes. Within that framework, the problem here would seem to be one of a lack of intergenerational recognition, to which the solution could be a more aware, empathetic care workforce, that could perhaps be achieved by revising training for staff. However, if extended to its logical conclusion, it becomes clear that the situation is less straightforward than a problem to be resolved by educational interventions. Contingencies of social relations quickly spiral beyond the predictable or controllable. Current systems of professional care are structured such that, at some point, it is nigh on guaranteed that a professional caregiver and those they care for will not get along.

Moreover, this case raises the issue that care often demands knowing the truth of another person's feelings and thoughts. Was pani Alicja truly feeling isolated and in need of talking to her granddaughter, or was she perhaps feeling bored? For someone other than pani Alicja to answer that question requires one to make judgments about the authenticity of her statements. This judgment requires access to the inner states of others, a difficult problem to say the least. Such judgments are essential to many domains of care, yet the fundamental epistemological challenge involved means that they can never be eliminated, leaving care as a process that is bound to be fraught, messy, and complex.

Discussion

When we first began discussing this article among ourselves, we started with a shared observation: The moments from our fieldwork resulting in what would be recognized as a positive outcome appeared less frequently to be the product of carefully designed, proactive interventions than the result of unpredictable, for lack of a more precise term, happenstance. Less positive outcomes were no different, entwined with a set of historical, life-course contingencies that seemed to provide the contours for the possibilities of care and its potential to affect people's lives. The movement of Alzheimer's disease pathology through a particular brain with a particular history of growth, engagement, testing, and trauma; the development–and sometimes dissolution–of social networks and support across a lifetime in a city with a distinctly segregated social, political, and economic past; a unique nation-state history that left a generation of professional caregivers and the generation of those they cared for straddling a political divide that rendered the possibilities of one's interiority less readily accessible, that diminished the potential for divide-crossing empathy upon which the moral orientation of "good care" so often is staked. Through three very different examples, these three case studies begin to give a sense of the range of effects that contextual unpredictabilities can have on people's ability to engage in, sustain, receive, and offer care. Together, they demonstrate the limits of understanding care as a phenomenon to be evaluated and improved upon.

The evaluative approach to understanding care and aging is a useful, productive one, and the intent of this article is not to suggest otherwise. Rather, we seek to highlight the way that evaluation of care's "goodness" is but one analytic and theoretical stance, and that sometimes both we and our research participants, those with and for whom we work, would benefit from an alternative or complementary approach. All approaches to research and theory building necessarily draw boundaries to define and delimit their object of inquiry. Boundaries enable a kind of understanding of the object, while at the same time also producing a certain version of the object. In the process, some phenomena of the object-in-the-world are necessarily beyond the border. That which lies beyond is rendered noise, considered outside the scope of investigation and analysis.

Yet the noise, the contingencies which are always part of the lived experience, can be fruitful to examine. In the case of care, we advocate not for the elimination of the frame's borders, but for the utility of broadening or slightly shifting them, resulting in a frame through which the researcher, scholar, clinician, advocate can engage with the noise beyond "good care", what we here have called contextual unpredictability. The four men's differing presentations of Alzheimer's disease, Mrs. Meyers' and Ms. Murphy's divergent social networks, and pani Alicja's opaque intentions and frustrated care providers are experientially meaningful to the people involved. They are lived realities, shaped by contingencies embedded in biologies, social and structural relations, and personal and national histories, ones which have dramatic effects on the texture of care. The ethnographic moments, though brief, indicate the complexities of care and care relations and the often fallacious nature, acutely felt by those involved in care, of one's ability to embody and enact "good care".

Opening investigation and analysis to questions other than "the goodness of care" (Harbers, Mol, & Stollmeyer, 2002: 219) allows for the emergence of new questions and directions. How do people experience the messiness of care? What project beyond the moral do

people imagine as “care”? What happens when care fails, when the intention to care can go no farther? What do we, as scholars, researchers, and clinicians do with those moments? What do we do when there is no intervention to be made? How do we engage? How can we make space, a structural-individual spanning acknowledgement and accommodation of things as they are in a way that is different from acceptance, an individual-level, moralized, affective response to ‘things as they are’? We posit that making space can accommodate a range of emotional orientations and individual-level responses, as well as potentially structural-level interventions. It is about a recognition that, even as we attempt to more fully control the experience (hopefully to positive ends), that might not be possible and that inability does not fall outside the range of care as an experience, but is a crucial part of it.

Collectively, these three case studies also begin to outline our approach to the study of care. We conceptualize care as fundamentally and foremost relational and processual (Buch, 2013, 2015, 2018; Robbins, 2017, 2019; Seaman, 2018, 2019, in press). Care as relation encompasses not only social relations, but material, historical, and biological. These elements are inextricably bound up together, meaning that analyzing care must also mean analyzing these multiple forms of relations. Indeed, it is this multiplicity that makes care such a complex phenomenon. Care is also processual; the motion and dynamism of the relations that constitute it, that (re)produce it over time, are central to its nature. In our work, ethnography is the appropriate methodological approach to begin to trace care's contours. In this way, our approach fits alongside that of Harbers et al. (2002), who, in addition to advocating for an examination of care as “goodness,” also advocate for continued ethnographies “of the practicalities and materialities of daily care” (219). By embracing the “imponderabilia of everyday life” (Malinowski, 1961[1922]) as evident in experiences of care, we can develop a broader understanding of this fundamentally human practice that comes to the fore in late life.

Conclusion

In this article, we have pointed to a definitional and methodological fallacy intrinsic to the development of most any construct, not just care: that a construct can bound a phenomenon in a way that meaningfully captures and allows for the accommodation of its full, lived complexity. In the context of care, this fallacy of representation becomes apparent at the moments of care experience that interventions cannot reach but which nonetheless shape the lives of those involved, often dramatically. In order to expand our understanding of care as a practice that cannot be solely defined by an evaluative approach, we need to conceive of care not as an event, but rather as a kind of becoming. These processual relations are always embedded within and responsive to historical contingencies, and will necessarily have elements of the unpredictable and unruly. By acknowledging, embracing, and attending to the contingent, processual qualities of care, we can therefore avoid discussions of care that suggest care can be entirely planned for. Within this framework, care that goes “poorly” is not solely the fault of individuals, institutions, or structures, but part and parcel of the phenomenon of care itself. This is not to say, of course, that individuals, institutions, or structures can never contribute to poor care – for indeed this happens too frequently, and of course appropriate remedies should be sought. Rather, we are suggesting that there will always be some excess that can never be adequately controlled or managed. The complexities inherent in relationality mean that “good care” will never achieve its platonic ideal; conceiving otherwise would be a fallacy.

By embracing these complexities, care emerges as an empirical phenomenon that is inherently difficult, imperfect, and messy. Expanding our analytic perspective to include these elements of the phenomenon better aligns our analytic tools with the phenomenon being studied. This perspective works to overcome an inherent romanticism that sometimes shapes research on care, in which the analytic lens focuses primarily on care's positive elements (e.g., strengthening relationships, giving meaning) (see Edwards & Strathern, 2000 for a similar inherent bias in the anthropological study of kinship). Analysis of how care can be violent and cause harm still fits within this dichotomous moral framework. In order to move beyond this evaluative approach, we need to ask different questions. Such a shift in perspective is necessary in order to more fully understand the complex phenomenon of care itself.

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