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## **Recognizing Older Individuals: An Essay on Critical Gerontology, Robin Hood, and the COVID-19 Crisis**

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## Recognizing Older Individuals: An Essay on Critical Gerontology, Robin Hood, and the COVID-19 Crisis

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*Cockroach and bug infestations, seniors calling out repeatedly for help, rotting food, COVID-19-infected patients put in the same room with those who are healthy, missed meals, seniors left in soiled diapers and linens – these are just some of the things Canadian Armed Forces (CAF) personnel have seen while helping in five long-term care homes in Ontario.*

*The military, called in to help at some of Ontario's worst-hit long-term care homes during the COVID-19 pandemic, confirmed what caregivers and family members of those in the homes have been saying for years: there is a crisis in how we care for our seniors.*

Malek 2020

### Introduction

Sending Canadian soldiers into nursing homes in Ontario and Québec – where the lack of care resources and subsequent deaths caused by COVID-19 was much more pronounced than in other provinces – was a desperate last resort for saving nursing home residents and the image of Canada as a progressive, caring country. This image, often evoked when describing Canada's approach to health care as superior to the ultra-neoliberal US American system, was shattered with the revelation that – as the author of the article above pointed out – there was a crisis, something observers “have been saying for years.”

All scholars in aging studies – critical or not – agree on one point: the COVID-19 crisis laid bare structural and interpersonal factors of neglect which have been going on for a long time; and with that, catapulted older people out of their partial invisibility as has rarely happened before. The most vulnerable individuals became front page news around the world. Images of their tired, worried and sometimes lost expressions reminded readers on a daily basis of something central to critical gerontology: that living conditions for many older people, especially those in nursing homes, are too often inhuman. The frequently repeated statement that ‘COVID-19 *only* affects older people’ sharply reflects the lack of valorization of such lives, especially in Québec where the number of deaths in nursing homes was for a while one of the highest in the world (Paré 2020).

The kind of care prevalent in such living spaces, critical scholars argue, reduces older people to objects who do not receive much more than a basic management of needs – at least those individuals who don't have the means and resources allowing them to be recognized as *someone*.<sup>1</sup> Older people in nursing

homes, generally perceived as living in spaces of ‘bare life’ – a living space comparable to a “state of exception,” just like townships and prisons (cf. Mbembé and Meintjes 2003) – are at the core of critical gerontologists’ writings, including the more recent field of critical dementia studies. The focus on a lack of recognition of some older people as persons in dehumanizing living spaces is probably the reason why there is such an immense preoccupation on the part of critical scholars with questions around personhood and social citizenship. In a blog post on “What is the Next Stage in Critical Gerontology?” Mario Paris (2016) states that social recognition is at the core of the discipline. The “critical” therefore refers to an engagement with an individual who should not disappear in a homogenized group of ‘elderly,’ but who needs to be seen as someone beyond handicaps and frailty.

The COVID-19 crisis is forcing scholars, as well as the general population, to recognize the existence of a concrete link between the State, society and interpersonal relations – something that arguably is sometimes neglected in critical gerontology, in which, as Tom Kitwood (1997) once stated, the “person comes first.” A lot of critical gerontology studies (e.g., de Medeiros and Basting 2014) are rightly about interventions conceived as providing better, more human, more creative care and activities, rhetorically projected against the screen of neglect and social exclusion. However, by focusing on the older person-in-need-of-help, critical scholars ultimately reinforce dehumanizing practices, because without acknowledging (and changing) political and structural factors, interventions such as some person-centered approaches often only help to cope with insufficient care systems. Leibing (2020) in this regard, talks about the establishment of “momentary citizenship,” since unsuitable forms of living and a lack of recognition are only for a short period of time interrupted by such interventions. However, some forms of more radical ways of conceiving dementia care might provide solutions, for instance by rethinking architectural spaces (e.g., Lubczynski 2011) and by “queering dementia” – not only as a means to more inclusive practice regarding minorities, but also as a radical way of rethinking the normative ‘self’ in dementia (Foth and Leibing, submitted article).

Furthermore, the all-encompassing image of ‘frail older people’ overshadows nuance and becomes an ideology that turns researchers and care staff into sort of Robin Hoods. Hood, who himself is a liminal figure, nevertheless fights in a clearly divided world of good and bad, in which victim and oppressor – poor and rich people – are unquestioned categories. Just like some critical gerontologists who also position themselves, apparently, outside of norms of common dementia care practices, conceived as inhuman. And although this kind of positionality happens as a result of an admirable intention, it can make such scholars at least partly blind to nuance, in line with what Sartre once called ‘transcendent givens’ – values as independent of human subjectivity (see Collier 2003). As an example, Francis Vailles (2020b), a Quebec journalist and specialist in social epidemiology, recently reminded us that the generalized image portraying older people as endangered by COVID-19, but equally as a dangerous source of contagion – as “super-spreaders” – needs to be relativized or nuanced. Vailles (2020b), partly reacting to senior citizens being refused access to supermarkets at the beginning of the pandemic, showed that individuals living in nursing homes in Québec were at high risk of dying from the virus, and in urgent need of more resources and better organized care. However, older people living in the community were actually dying of COVID-19 at lower rates than adults under 65.<sup>2</sup> The protection of the ‘frail’ older person became here a category fallacy, since such a ‘Robin Hood activity’ did not resolve the urgent need of those who needed protection, while equally denying citizenship to older people who were neither frail nor in need of such a limitation of their liberty.

In the following I will give a short overview of the COVID-19 crisis in Québec in order to reflect on critical gerontology and, as I will argue, to draw attention to the need of also critically analysing critical gerontology. I will argue that accounting for different, complementary approaches in critical

gerontology might help avoid 'RobinHoodism' and provide more nuanced data about aging and the life course.

### Québec's COVID-19 crisis

Over the course of several weeks in spring 2020, newspapers and other media outputs published daily the map of Canada, in which the reader could find for each province the total number of COVID-19 cases, the number of new cases (within the last 24 hours), as well as the total number of accumulated deaths. On June 5, 2020, for example, the most western Canadian province, British Columbia, announced its numbers, which differed profoundly from those of Québec in eastern Canada – “as if we were living in two different countries,” anthropologist Stacy Pigg from Simon Fraser University in British Columbia commented (personal communication).

Until June 05, 2020	British Columbia	Québec
<b>All cases</b>	2632	52143
<b>New cases (24 hrs)</b>	9	259
<b>All deaths</b>	166	4885

Source: La Presse online, “Actualités” 2020.

But, if testing and analysis were following more or less the same protocol, why was there such an immense gap between the two provinces? In terms of numbers, Québec counts twice the number of older people of British Columbia, but that does not explain the great difference between the provinces. And even in Ontario, where *more* older people live than in Québec (respectively 2,292,790 versus 1,534,300 for the 65+; see Statista.com 2019), COVID-19 cases and deaths were lower than in Québec. Three principal explanations were provided by public health experts and – finally – discussed intensively in the media. First, in Québec more older people live in residences (for autonomous and semi-autonomous individuals) than in other Canadian provinces. These agglomerations are known for higher numbers of COVID-19 cases when compared to the general population, although still much less than in nursing homes. A Québec tax initiative seems to explain why many older people moved into private residences and so, as some critics remarked, private owners of residences were financed in a public health and social system (see Vailles 2020a).<sup>3</sup>

A second factor that is regularly mentioned by researchers and in the media is the administration of health care in Quebec, whose structure has been described as “monstrous,” “too big,” “too centralized,” “chaotic,” “detached from reality,” and so on (e.g., Lemay 2020). An example of the chaotic situation is that, although the catastrophic management of nursing home care was admitted to (especially the fact that nursing home staff were constantly moving between ‘hot’ and ‘cold’ zones and therefore contributed to contagion), now, in the fall of 2020, at a moment when a second wave is building up, this situation has not changed in Québec. British Columbia, on the other hand, was able to regulate staff movement between infection zones within one month (Chouinard 2020). Further, for a long time, Québec’s head of public health denied the need to wear masks for the general population, and even for health care professionals protective material was missing during the first weeks of the pandemic.

Finally, as elsewhere, staff shortages became increasingly dramatic as the pandemic unfolded, in a system that was already operating beyond its limits before the COVID-19 crisis. This, in combination with a chaotic and top-heavy administration imploded care work in Québec’s nursing homes and led to scandalous conditions and many preventable deaths. It led to what some called a “genocide in Québec’s nursing homes” (e.g., Patenaude 2020).

### *Two scandals*

Less perceivable and highly value-laden aspects of life are often revealed in major narrative changes (similar to what Paul Rabinow (2012) calls “chronicles of shift”); changes that carry the potential of transforming existing ways of thinking. Defined by the Merriam-Webster dictionary (n.d.) as “a circumstance or action that offends . . . established moral conceptions,” scandals are, because of their disruptive nature, an ideal way of getting closer to core values of a given society.

The first scandal of the COVID-19 crisis in Québec is obviously the extreme neglect of nursing home residents already mentioned in the introductory quote. The direct critique in the form of public outcry and indignation regarding conditions that had already been known for a long time, but that now, because of its extreme manifestation, could not be ignored, directly targeted the current, but also previous governments. As an example from Olson (2020):

Bedridden residents were lying in sheets stained brown up to their necks in excrement, so long had it been since their diapers had been changed. Some were dehydrated and unfed. "The conditions were disgusting. The patients were drenched in urine and feces," said Loredana Mule, a replacement nurse who worked that evening. . . . One LPN and two patient attendants were trying to care for 130 residents. Food trays had been placed on the floor, dishes untouched because residents with mobility issues couldn't reach them. At the end of that shift, the last remaining LPN on Herron's staff went home and never came back. No "hot zone" for infected patients was established — and residents known to have tested positive for COVID-19 were wandering around the floor. . . . One attendant described working from 3:30 p.m. until 7:30 a.m., to tend to the needs of the dozens of seniors on the floor.

Nursing homes generally have a very negative public image, and this is not only the case in Québec (Leibing, Guberman, and Wiles 2016). It is disturbing that, while at the core of critical gerontology's preoccupations, and regularly documented in the media, not much has changed regarding such living (or dying?) spaces. And as the author of the introductory quote remarked, “... it is a sad irony that it took the traditionally male-dominated military to get the attention of politicians when workers in the homes, most often racialized women, have been raising the same concerns for years” (Malek 2020).

A second scandal is related to the first one, but represents a different kind of critique. Again, a quote from the local media:

Quebec's *Confédération des syndicats nationaux* (CSN), which represents more than 30,000 caregivers in the province's beleaguered health-care system, is pushing back hard on recent comments made by the minister for the elderly, Marguerite Blais. The union thinks Blais . . . should be remembered as *the minister whose main contribution to Quebec's long-term-care centre network was “clowns” and “mechanical seals” rather than any genuine assistance to the elderly or those who attend to them.* As long ago as 2012, the CSN repeatedly put pressure on the provincial government to reduce the workload faced by caregivers or increase funding for CHSLDs [nursing homes]. “No one listened, there was no change,” said Gingras. Rather, said Gingras, Blais announced clowns and mechanical seals would be sent to the centres to entertain the residents, a move that drew criticism at the time. *Gingras said Blais felt “the elderly deserved a chance to smile” rather than ensure those residents had the necessary resources to be fed and bathed.* (Bergeron 2020; emphasis added)

In a way, this kind of media output is a critique of critique or: a critique of RobinHoodism, that has been taken for granted for a long time. The journalist not only challenges the governance of older peoples' lives in Quebec (as does the first scandal), the prescriptions found by the Minister, clowns and seals for older people – for many considered good practices in elder care (e.g., Warren and Spitzer 2011) – get now inversed. These interventions become inappropriate, even cynical, once the need of targeting structural factors becomes evident. In the concluding section I want to reflect a bit more on these two kinds of critique.

### **Critical aging/dementia studies 1.0 and 2.0**

The following discussion is the result of a certain discomfort caused by discussions with colleagues and students due to the glitchy definition of 'critique.' I felt that thinking critically about (COVID-19 and) aging needed to distinguish between kinds of critique – a need that in an earlier publication I attributed, at least partly, to the pitfalls of humanism as a predominant framework for thinking about care (Leibing 2019). In humanistic frameworks, as in my understanding of the first scandal, questions of responsibility are raised and a clear division between good and bad is established. Of course, several authors have mentioned similar blind spots within humanist kinds of caring for others that, as Didier Fassin (2012), in the context of international humanitarian work, describes as ideologically based on equality and inclusion, while practically reinforcing the "inequality of lives" as the "invisible foundation" of humanitarianism (242). Within this kind of framework, care work is deeply linked to empathy, which Fritz Breithaupt (2017) considers a dilemma. Empathy is positive, he argues: it makes us human and can lead to doing good, but can also be negative, since it is rarely acknowledged how empathy polarizes by engaging with only the victim, and in this way nuance is lost to one-sidedness. In a similar vein, Michael Ridge (2015) talks about "impassioned belief": he argues that normative judgments motivate people's action through affect. However, they turn actions, like care, into a "desire-like" and "belief-like" state, often expressed through "'ought'" and as unquestioned 'good'" (2015, 9).

Another argument stems from the point Miriam Ticktin (2011, 5) raises in the context of immigration activism in France. In some studies in critical gerontology older individuals – like Ticktin's immigrants – are reduced to the single category of "older people." Ticktin writes that "[r]egimes of care are grounded in a politics of universality . . . [However,] [i]mmigrants are stripped of their legal personas when identified solely as suffering bodies, . . . they are not liberated into full citizenship" (2011). Ticktin's argument is highly relevant here, because this is exactly what also often happens in care for older people. By engaging with nursing home residents, many of them with an advanced dementia, and by offering happiness in form of arts-based therapies for example, only "momentary citizenship" in the form of a partial we-ness is realized (Leibing 2018, 2020).

And finally, looking again directly at aging studies, Thomas Cole (1992, 233) writes that "[t]he fashionable positive stereotype of old age showed no more tolerance or respect for the intractable vicissitudes of aging than the old negative stereotype." The radicality of Cole's observation is important for reflecting on pitfalls of humanistic approaches to care for older people, which I tried to do by distinguishing between two kinds of critique (or scandals). Different from the first, the second scandal of the COVID-19 crisis in Québec is linked to a more radical conscientization that questions exactly what is close to the heart of critics of the first group: saving frail older people through humanist interventions. While therapeutic clowns were often presented as positive interventions in the local media, or as signs of ultimate humanity and researcher's 'equality' (Hendriks 2012; 2017), this also made the public aware of the need to root 'happiness' more deeply in structural problems, and without which laughter (and tenderness) resulting from clowns and mechanical seals couldn't be sustained.

In this sense, anthropologist Cheryl Mattingly's (2019) division of critical phenomenology into 1.0 and 2.0 might be helpful in rethinking critical gerontology, because she not only distinguishes between two kinds of critique, but also claims that *both* are necessary: the blind spots found in one do not mean that they are not both needed. "In anthropology," Mattingly (2019) writes,

... work that has been explicitly designated 'critical phenomenology' usually refers to approaches that bring together critical sociopolitical voices and scholarly traditions with phenomenological ones. For my purposes, I will refer to this as 'critical phenomenology 1.0.' But there is also a second sense in which phenomenology is critical: phenomenology as a project of concept critique. This speaks to the phenomenological insistence on destabilizing *all* concepts. When both these senses of critique are taken together, critical phenomenology emerges as a radical provocation to disquiet dominant sociopolitical concepts, including those we ourselves hold. This disquiet becomes part of our own political theorizing. Let's call this, for the moment, 'critical phenomenology 2.0.' (2-3)

Sociologist Thomas Lemke (2011) provides a similar analysis. He shows that Foucault, especially in his later work, bases critique on experience:

The notion comprises two seemingly contradictory dimensions. Experience is conceived of as dominant structure and transformative force, as existing background of practices and transcending event, as the object of theoretical inquiry and the objective of moving beyond historical limits (27).

This kind of argument could be linked to Mattingly's preoccupation with critical phenomenology, if we assume that experience is a central notion within phenomenological thinking (see also Rabinow and Rose 2003). Methodologically, experience can be captured by intensive engagement with lives, ours and others, as it is the case in some ethnographic approaches. However, ethnographers also sometimes look exclusively at the interpersonal dimension of care, in which victims and 'the bad' are firmly established from the beginning. Radical or 2.0 ethnographies would, after Mattingly, also destabilize this order of things. Such an approach would help to describe the deeply disturbing effect of COVID-19 on many lives, and especially older individuals' lives, and at the same time take this as an opportunity to rethink present landscapes of care (and the obscured position of both 'the elderly' and 'the carers' in this landscape). Both perspectives are needed: as Lemke remarks regarding Foucault's later understanding of critique: "There cannot be any critique without an idea of what is conceived as intolerable and unacceptable" (2011, 40).

However, studying the experience of the COVID-19 crisis is not only describing the horrific conditions older people were (and are) going through, as in the shocking quotes above. It would also mean, among many other possibilities, to follow closely those who want to help, nurses for example, and show how they face their own fears of getting sick and dying or of transmitting the virus to their children at home (and therefore quit). It would further mean creating a deep understanding of the multiple, sometimes unsurmountable hurdles these nurses experience on a daily basis in the chaotic Québec health care system. Finally, such an approach would make us wonder how, historically, such a neglectful system could come into existence and survive. Such an ideal ethnography would document, closely tied to experience, how such categories through which older people live and get perceived by themselves and others, are accepted, contested, embodied, and articulated in concrete lives, and not in pre-established models, even not if such models resemble well-meaning Robin Hood.

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## Notes

1. “Becoming someone” here relates to the argument, often made using Agamben’s (1998) concept of ‘bare life,’ that some people get marginalized and their lives banalized in a way that they are not considered worth caring for anymore (like some poor people with dementia, despite all discourses of inclusion made by gerontologists). However, bare life-like states can be facilitated by resources like financial means that are able to buy dignity to a certain degree and adapted environments of care or, the fact of being white (and therefore worth recognizing) – as opposed to being aboriginal, as Jiwani (2013) has shown in her study of missing women in Vancouver.
2. The following table is based on Vailles (2020b; published with the author’s authorization). The numbers refer to deaths per 10 000 in different living spaces in Quebec:

<b>CHSLD (long-term nursing home)</b>	<b>865</b>
Intermediate resources (semi-autonomous)	196
Residences, autonomous	62
At home, 65+	2
At home, 65 -	0.4
<b>Whole population</b>	<b>6</b>

Based on data published by INSPQ, MSSS, AQRA and ISQ (see Vailles 2020b).

3. Freeman (2020) explains why so many more Quebecers move into senior residencies than aging individuals in other provinces: “Thanks in part to a generous provincial tax credit for housekeeping and meals, Quebec is the capital of Canada’s senior housing business. According to the statistics for 2018, 17.9 per cent of Quebecers over the age of 75 were living in nursing homes and seniors’ residences compared with just 5.5 per cent in Ontario. And probably in part because of the subsidy, the average rental cost in Quebec per unit was just \$1,678 a month, half the cost in Ontario.”

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