Instituting Care: A Dementia Unit in Mainland China

Lillian Prueher

A dissertation

submitted in partial fulfillment of the

requirements for the degree of

Doctor of Philosophy

University of Washington

2021

Reading Committee:

Janelle Taylor, Chair

Stevan Harrell

Sasha Welland

Program Authorized to Offer Degree:

Anthropology Department

University of Washington

Abstract

Instituting Care: A Dementia Unit in Mainland China

Lillian Prueher

Chair of the Supervisory Committee:

Janelle Taylor

Department of Anthropology

As China's population ages, its government and medical marketplace are developing new forms of institutional, non-family-based eldercare and dementia care. This dissertation explores one such site, providing an organizational ethnography of a private dementia care unit in Sichuan, China. Conclusions drawn in this dissertation are based upon 16 months of ethnographic fieldwork carried out in Sichuan between 2015 and 2019 (primarily during the 2017-2018 academic year), including observations and semi-structured and/or unstructured interviews with dementia care staff, administrators, residents, family members, and scholars. This dissertation centers on interactions between different groups of participants within the dementia care unit – residents, family members, staff and administrators at different levels, and the author – to explore how these groups ultimately come together to shape care practices.

This dissertation considers how institutional care fundamentally operates as care for institutions, where interpersonal care practices must also be understood in relation to the tremendous investments of time, attention, and resources needed to create and sustain

institutional care settings. This approach shows the primary research site as a flexible institution – a place where there are simultaneously institutional norms and standards shaping what is possible for the care and labor environments within its walls and a constant negotiating and stretching of those institutional boundaries. This dissertation also contributes to discussions around what "care" or "good care" means in practice, and how relationality shapes dementia care not only in interpersonal relationships between caregivers and care receivers, but also in terms of relationality among caregiving staff within an institutional setting. In exploring complicated care practices such as the use of physical restraints, this research considers what such practices reveal about how needs are understood for people living with dementia, their families, the staff who care for them, and the institutions where they live.

Table of Contents

Acknowledgements

I owe the greatest debt of gratitude to the families, staff, and residents I met at Summit Care. They welcomed me into their facility and into their lives, and the stories and experiences they shared have forever changed my thinking. Without their generosity and openness, this research would not exist. I particularly thank the Director of Summit Care and the leaders of its Unit 1 dementia care ward for being so supportive of my research.

I have benefited immeasurably from the advice and guidance of mentors. I particularly owe thanks to Janelle Taylor for her years of thoughtful, thorough, and encouraging feedback. Working with her helped me to grow as a student, as a researcher, and as a teacher, and she has deeply shaped this research. I am especially grateful to her for opening so many doors while always keeping me grounded in the wisdom of "never put life on hold." I thank Stevan Harrell for connecting me to China Studies at the University of Washington, for the many scholars and friends he introduced me to in Sichuan, and for the way his stories, readings, and insightful comments added to this research. I also thank Sasha Welland and my wonderful GSR, Priti Ramamurthy, for their incisive questions, generative reading suggestions, and thoughtful engagement. I thank Yang Laoshi for her advice and for the academic home base she gave me in China. And, heartfelt thanks to Sarah Pinto and Elizabeth Remick for their help with making my first research trip to China in 2011 a reality and for their advice and guidance in the years since.

For conversations that clarified my thinking and for enriching my fieldwork in China, I especially thank Pat Tietgens, Michelle Zhang, Wendy, Monica, Circle, Victoria, Chelsea, "Da Nei," Claudia Huang, and for a crucially timed visit, Jenni Young and Demetrius Marcoulides. For joining my first visit to Summit Care to discuss this project, I especially thank Gao Mingyue.

I am grateful to colleagues at the University of Washington for the many ways they shaped this research and added to my graduate experience, including Marieke van Eijk, Jenna Grant, and the wonderful ANTH writing group for their years of inspiration and feedback: Marlaine Figueroa Gray, Anna Zogas, Leah Isquith-Dicker, Stephanie Cruz, Leyla Savloff, Lily Shapiro, and Shanna Scherbinske. I also thank Catherine Zeigler and John Cady for shepherding me through the university's many bureaucracies with such kindness and Zhijia Shen for connecting me to oral history work so early in my graduate studies.

For warm, intellectually nourishing conversations at the University of Copenhagen and beyond, I thank Mette Nordahl Svendsen, Iben Mundbjerg Gjødsbøl, Laura Emdal Navne, Mie Seest Dam, Ayo Wahlberg, Jieun Lee, Anja Marie Bornø Jensen, and Singe Lindgård Andersen.

For deepening my understanding of eldercare in the United States and helping me bring new questions and perspectives to my fieldwork, I thank Lesley Steinman and the fantastic group at Horizon House: George Counts, Andy Gordon, Nancy Robinson, Nancy Edquist, Margaret Burke, Sam Dworkin, and Lauri Warfield-Larson. I am especially grateful to Paul Wiesner.

I am profoundly thankful to the friends and family who have shared their wisdom and support during and beyond my graduate studies, especially Jamie Von Roenn, Pamela and Buddy Farmer, Elizabeth and Erik Jensen, Stephen Prueher, Ellen and Jim VanDeLaarschot, the Davis family, the Doernberger family, SiauXi Goh, Nadia Nibbs-Kohl, Jordan King, Sharmaine Oh, Jenna Liang, Ben Perlstein, Sarah Stansfield and Matt Richards, Alee Perkins, Andrew Friedland, Shantrice Anderson, Christina Garrity, Brett Jette, Steve Carlson and Jen Knight, and Breanne Shuster and Robbie Sepler. I particularly thank Isabelle Dienstag – I cannot imagine where I would be if we had not met all those years ago. I also especially thank Jessi Prueher and our parents, Judy Prueher, Chimera D'Andres, and Margaret Browning – I am so grateful for

their love, their confidence in me, their steadfast advice and encouragement, and the appreciation they instilled in me for “big ideas” and questions without answers. I also owe special thanks to Adam VanDeLaarschot for fighting through red-eyes and Skype calls to make the past six years so memorable, for being a constant sounding board, and for helping me to live more spherically – he has added so much to this research and to my life along the way.

Finally, I am grateful to the funders who supported this research, including the China and Inner Asia Council of the Association for Asian Studies (CIAC)/Chiang Ching-Kuo Foundation (CCKF), the National Science Foundation Graduate Research Fellowship Program (grant no. DGE-1256082), the Confucius China Studies Program Research PhD Fellowship, the Henry Luce Foundation/ACLS Program in China Studies Pre-dissertation Summer Travel Grant, the Thomas Francis, Jr. Global Health Fellowship, and the Gordon C. Culp-Jackson Fellowship in China Studies.

EPIGRAPH

"The voices of the ill are easy to ignore, because these voices are often faltering in tone and mixed in message, particularly in their spoken form before some editor has rendered them fit for reading by the healthy. These voices bespeak conditions of embodiment that most of us would rather forget our own vulnerability to." (Frank 2013 [1995], 25)

INTRODUCTION

"Care provides physical traces of larger social forces." (Aulino 2019, 115)

Two months into my long-term fieldwork in China, I sat in a luxurious dementia care facility in London fighting the urge to laugh. It was the first day of a 4-day course in Dementia Care Mapping (DCM)[1] run through the University of Bradford. Having flown in from Sichuan less than 48 hours before, I wondered if jet lag was not at least partially to blame for my struggle to keep from laughing. I had come to London because I was hopeful that DCM could offer both a more concrete way of communicating with Chinese dementia care providers, and potentially a framework I could use to translate my qualitative research into more tangible care recommendations and outputs for those working at my main research site, a private dementia care unit in Sichuan. I was inspired by person-centered care approaches after reading Tom Kitwood's seminal work, *Dementia Reconsidered* (1997), and I was eager to learn from the DCM instructor, who worked at the institution where Kitwood had established his career decades earlier.

And yet, as the class discussed what person-centered care looked like in practice, the examples cited began to seem absurd. In an exchange between one student and our instructor, an animated back-and-forth developed around plate ware. It began with considerations of biological changes to the occipital lobe that often accompany dementia and how those changes might make it easier for a person with dementia to see and identify food on a white plate as opposed to a more colorful plate. Then another classmate brought up an example from her care site where a

[1] "DCM™ as an observational framework translates the philosophy of person-centered care into observable and measurable actions. It provides a framework to record the lived experience of people living with dementia in care settings and the extent to which person-centered care is being provided" (McIntosh et al. 2012).

woman accustomed to drinking out of bone china was upset at receiving liquids in one of her facility's standard ceramic cups. This led the instructor to emphasize the importance of meeting each resident's needs and supporting them as individuals. As she put it, "If we have that blanket approach, it kind of goes against individualized care, because it [e.g. standardized drinkware] may not be something everyone needs" (copied from fieldnotes).

The seriousness with which that example got discussed left me dumbfounded. Of the dozen or so people in the room, everyone was a dementia care administrator, clinician, or researcher. How could standardized plates and cups be the burning example on their minds of unmet individual needs in a dementia care site? I was the only person connected to a dementia care institution outside Europe, but I could not believe that my classmates' sites were so idyllic that discussing the relationship between personhood and bone china could seem anything but comical. At my primary research site in China – like, I would imagine, at any dementia care site in Europe – there were countless examples of what seemed like more pressing and universal challenges to meeting residents' individual needs and respecting them as full persons. What about the ethics of keeping dementia wards locked in the first place? What about the challenges of creating a supportive environment where staff are familiar with residents' life stories and preferences even despite staff turnover? What about maintaining staffing levels that are high enough to support meaningful interpersonal connections between staff and residents in the first place without making dementia care prohibitively expensive? "It kind of goes against individualized care," our instructor said. I wondered, "How much individualization and control must residents have over their environments for plates and cups to be genuine concerns for staff? How will this ever be useful back at my site?"

Three years earlier when I began formulating my dissertation project, I could not have imagined how disconnected my primary research site would feel from the ones discussed in that DCM training. I had set out to understand contemporary dementia care in urban China from several perspectives: (1) the role of family members in an institutional care site; (2) how resource availabilities and policy landscapes shaped expectations and practices of care among all participants (people with dementia, their families, and paid clinician caregivers); and (3) how economic, cultural, and psychological values get negotiated and defined within elder care institutions. To explore these topics, I originally designed a multi-site ethnography. My goal was to identify a private eldercare facility, a public eldercare facility, and an NGO providing community-based support for older adults and their families so I could compare dementia care perceptions and practices across all three. I chose to focus my study in Sichuan because I had connections to researchers there via my adviser, because Sichuan is home to a higher percentage of older adults per capita than many provinces[2] and therefore supported a wide variety of eldercare services, because it was less highly researched and less highly resourced than coastal cities like Beijing and Shanghai, and because it seemed like a pleasant place to live during fieldwork.

Though I ultimately ended up focusing my study on a private hospital[3] that I refer to here as "Summit Care"[4], and its dementia care ward, "Unit 1," I visited 13 care sites around Sichuan

[2] Sichuan was reportedly one of five provinces designated as "*shendu laolinghua*" (深度老龄化, deep aging) in 2018 (每日经济新闻 2019)

[3] In addition to the private hospital that ultimately became my primary research site, I also identified a publically run site with a director who seemed eager to collaborate and an NGO providing community-based care at the end of my first pilot research trip to Sichuan in 2015. Unfortunately, with each subsequent trip, I found increased difficulties at the public and NGO sites. Leadership at the public site became increasingly concerned about partnering with a visibly foreign researcher and my main contact at the NGO site eventually moved on a different job (though she remained a key contact of mine as I continued my long-term research and heard about her work in community-based eldercare settings in Sichuan and elsewhere).

[4] "Summit Care" and "Unit 1" are both pseudonyms, as are all names of people connected with these sites.

as part of selecting and contextualizing that primary research site. In total, I conducted 16 months of fieldwork in Sichuan between 2015 and 2019, including 6.5 months of pilot research carried out over the course of three trips[5], two 4.5-month "long-term fieldwork" trips (effectively the 2017-2018 academic year), and 2 weeks of follow-up research in the fall of 2019. Once it became clear that I would not be able to connect with a public care site or an NGO providing eldercare, I began to approach my project as an organizational ethnography, with my research activities based primarily at Summit Care and focused on understanding its daily operations and the people connected to it as much as possible. I did this primarily through semi-structured and unstructured interviews with staff, residents, families, researchers, and local health officials, as well as by regularly spending time in Unit 1 observing and participating in daily care within the ward.

When I left for London, I had already been visiting dementia care sites around Sichuan for over 7 months. Though I left that training excited about its tools for "achieving and embedding person-centered care for people with dementia" into institutional care settings (University of Bradford 2021), I ended up only conducting a few days of DCM observations back in the Unit 1 ward. The DCM techniques were highly labor intensive, and there was no sustainable way for findings gleaned through such observations to be incorporated into staff's regular care work.

[5] These trips included two months in the summer of 2015, 6 weeks in the winter of 2016/2017, and three months in the spring of 2017. I visited Summit Care during each trip. The first time, I was tagging along with a large group of researchers touring care sites to make recommendations to the provincial government about eldercare insurance reimbursement rates. The second time, I went with an undergraduate research assistant who worked at the center where I was based in Sichuan and we met with the Director to discuss my project in-depth. The third time, I went alone and set up an observation schedule with the Director to begin collecting preliminary data in Unit 1.

Reflecting back on my experiences of the DCM training, I ultimately saw an irony to my initial sense of disbelief during the discussion about drinkware. In Unit 1, residents' cups were actually among their most personalized objects. Though some residents drank from the collection of plastic cups, sippy cups, and novelty mugs the ward had accumulated into its general supply, many had a personal metal mug or thermos that their families had brought from home. Staff and residents alike kept close tabs on these pieces of drinkware, and experienced staff generally knew which one belonged to each resident by sight. A discussion about whether or not the facility should offer residents the option of bone china would have been absurd, but if a family member brought in a special thermos, it was accepted that steps should be taken to ensure that resident alone had access to it.

Like the DCM framework, gerontological and anthropological literature I had read about care in preparation for fieldwork was also feeling disconnected from my observations of daily practices at Summit Care by the time I was in London for DCM training. In this dissertation, I trace connections that emerged over time and explore implications my observations at Summit Care might have for medical anthropologists and for elder care providers. I argue that this work destabilizes understandings of who – or what – is cared for in institutional dementia care. Specifically, I consider how institutional care fundamentally operates as care for institutions, where interpersonal care practices must also be understood in relation to the tremendous investments of time, attention, and resources needed to create and sustain their institutional settings. This approach helps me to see Summit Care as a flexible institution – a place where there are simultaneously institutional norms and standards shaping what is possible for the care and labor environments within its walls and a constant negotiating and stretching of those institutional boundaries. This dissertation also contributes to discussions around what "care" or

"good care" means in practice, and how relationality shapes dementia care not only in interpersonal relationships between caregivers and care receivers, but also in terms of relationality among caregiving staff within an institutional setting. In exploring complicated care practices such as the use of physical restraints, I consider what these practices can tell us about how needs are understood for people living with dementia, their families, the staff who care for them, and the institutions where they live. For eldercare providers, this dissertation underlines the importance of asking fundamental ethical questions: how do you balance safety with quality of life? How do you engage family members in residents' care (particularly as a source of continuity in the face of staff turnover)? Are institutions losing something important in their push for increased specialization and professionalization of care? Though these questions could be applied to any elder care setting, understanding them in relation to Summit Care requires attending to the particularities of China's constantly changing eldercare landscape.

Population aging in China

The United Nations predicts that by the year 2050, roughly one quarter of the Chinese population, or 366 million people, will be aged 65 or older (Mather 2020). For reference, the total US population is currently approximately 331 million people (Jarmin 2021). This demographic shift is related to many factors. Life expectancy in China rose from just 43.7 years in 1960 to 76.7 years in 2018 (The World Bank Group 2021a), in part due to infant mortality rates dropping from 83.1 per 1000 live births in 1969 to just 6.8 per 1000 live births in 2019 (The World Bank 2019). The so-called "One-Child Policy" also played a role, although the degree to which China's population aging was caused by this family planning policy is debated. Not only was there a dramatic drop in China's total fertility rate from 6.5 in 1952 to just 2.75 in 1979

before the policy ever went into effect (Potts 2006, 361), but "fertility levels fluctuated in China after the policy was launched; and most of the further decline in fertility since 1980 can be attributed to economic development, not coercive enforcement of birth limits" (Whyte, Feng, and Cai 2015, 144). As these demographic shifts occurred, "4:2:1" families became increasingly common, where two working adults are expected to support four aging parents and one child (Greenhalgh 2008, 182).

These changing family structures are also coinciding with changing understandings of morality (Kleinman et al. 2011) and impacting everything from the increased expectations parents place on only children (Fong 2004), to shifts in family resource allocations. Some scholars even argue that there is now "a new and flexible form of family structure, [where] family resources of all sorts flow downward, and, most important, the focus of the existential meanings of life has shifted from the ancestors to the grandchildren" (Yan 2016, 245)[6]. These changes, combined with families being more spread out geographically as middle-age and young adults engage in migrant labor (Chan 2013) and pursue career opportunities in other cities and other countries, make it increasingly difficult for families to address elder care needs at home.

Financing care: Shifting state and family responsibilities

While eldercare in China generally has been "considered a domestic issue" rather than a place for State intervention (Y. Zhang 2020, 52), state policies around pensions and social welfare support have had significant impacts on the degree of eldercare that families are able to offer their loved ones. As Shea explains, State support was fairly robust in the mid-twentieth century. She writes:

[6] This interpretation is highly debated, and some scholars argue that familial respect and valuing of older adults is simply taking new forms in contemporary Chinese society (Keimig 2021; H. Zhang 2017).

> During the Maoist era up through the late 1970s…[urban areas were] providing non-means-based support for the aged via pensions, rations, subsidized housing, and health care benefits provided to retirees by state-owned enterprises and government employers known as "work units." Beyond that, local government administrative units (street committees, residents' committees) gave some limited support to those few urban seniors who lacked both familial support and work unit affiliation and the ability to take care of themselves. (Shea 2019, 335)

Over time, however, these supports changed. Pensions, for example, initially were intended to provide state support for aging workers[7]. As Fu explains:

> China's pension programs were established with the introduction of Regulations on Labor Insurance in 1951, which provided the frame for the provision of various benefits based on the principle of lifetime employment and association with a state owned enterprise (SOE)...Pension payments were set at a comparatively high level: roughly 80-90 percent of the workers' salaries at retirement. (Fu 2008, 216)

Though some pension funds were "reallocated for other purposes" during the Cultural Revolution, the pension system remained largely stable until SOEs were forced by the Central government to pay urban workers' pensions on their own in the 1980s (Fu 2008, 217). Once this happened, some workers were persuaded to forfeit their pensions altogether with "lump sum" retirement buyouts (ibid), and the replacement ratio decreased[8]. The result, as Fong explains, is that economic reforms in the 1990's deeply destabilized people's abilities to financially care for themselves in old age[9], particularly for urbanites. She writes, "By enforcing mandatory

[7] State policies are dramatically different in rural and urban areas of China. Because my primary research site was in an urban area catering to urban clientele, my discussions of State policies and programs are focused on those affecting urban settings unless otherwise specified.

[8] During the 1990s, the economic benefits of "lower replacement ratios," or paying retirees smaller and smaller percentages of their pre-retirement salaries, became clear. The 1995-1997 pension reform system that first introduced these declining ratios was thus expanded and officially implemented by the end of 2007, making the "total replacement ratio" decrease from 75% to 58.5% (Feng, He, and Sato 2011, 470).

[9] While government spending on pensions has steadily increased since the 1990's (Frazier 2010, 3), closer analysis reveals that investment actually "appears to have exacerbated inequality" rather than shrink it (Frazier 2010, 5). This is true between rural and urban areas, as well as between rich and poor households within urban areas, where participants in the "minimum income guarantee program (*dibao*) [established] in the late 1990's" received payments in 2007 that "represented a little more than one-tenth of the average pension" at that time (ibid).

retirement[10] while leaving retirees without the means for economic self-sufficiency, the Chinese state practically guaranteed that most people would spend the final decades of their lives dependent on their children" (Fong 2004, 128).

Given the high and increasing costs associated with long-term care (F. Li and Otani 2018), the state has employed a range of strategies for supporting older adults[11] and their families without assuming sole financial responsibility for that care. These include "gradually establishing a [Long-Term Care] Insurance (LTCI) system" since 2013 (ibid: 480), implementing pilot programs for funding care sites (ibid), and for community-based elder care programs (Z. Feng et al. 2012), and incentivizing and directly investing in the expansion of China's eldercare infrastructure in the form of community programs and care facilities (Chu and Chi 2008; F. Li and Otani 2018).

The state has also put forward legislation to help older adults secure elder care support from their families. Though more recent mandates like the "*Chang Hui Jia Kan Kan Fa*" (常回家看看法, literally, the "Go Home to Visit Frequently Law") received significant press in Chinese media when first introduced, they, much like eldercare provisions in the Chinese

[10] It is important to note that there are currently discussions about incrementally raising the retirement age in China in order to respond to "the current average life expectancy, the increasing aging population, and a labor force shortage" (Cheng 2021).

[11] Following current Euro-American gerontology conventions, I use the term "older adults" throughout this dissertation even the Chinese the terms, *laonian ren* (老年人) or *lao ren* (老人) translate directly as "old-age people" or "old person." I argue that the level of respect "older adults" connotes in English is fairly similar to the level of respect conveyed by *lao ren* or "old people" in Chinese. Both are more respectful than some options (e.g. "old people" or "patients" in English or "*bingren*" (病人, patients) or the extremely colloquial "*lao tou*" (老头, old man) in Chinese). Both are also less respectful than some options (e.g. "elder" or the more commercialized "client" or "customer" in English or "*zhang zhe*" (长者, elder) in Chinese). While staff in my primary research setting often referred to individual residents with faux-familial terms (e.g. [last name] *popo/yeye/*etc. ([last name]婆婆/爷爷 , Grandma/Grandpa [last name]), when referring to the residents as a group or in the abstract, the most common word that staff, families, and even residents themselves used was: *lao ren* (老人, old people).

constitution and other legal documents[12], remain extremely difficult to enforce. Some legislative tools, such as "Family Support Agreements" (FSAs)[13], seem easier to administer, but remain not widely adopted in urban areas. Overall, these laws seem to sketch out an aspirational, albeit vague, outline of what facilities and families should provide older adults, but the state oversight mechanisms that would be needed to administer them are still being negotiated and created (Glinskaya and Feng 2018, 34). The result at my primary research site was that families became largely responsible for overseeing and evaluating care. Because family members could (and did) demand retribution if their loved ones were injured in the facility[14], the institution needed to be vigilant about legally protecting itself from family complaints[15].

[12] Chou provides a useful summary of this body of eldercare legislation as it relates to Family Support Agreements (FSAs) in China when she writes, "According to Article 49 of the Chinese Constitution, 'Parents have the duty to rear and educate their children who are minors; and children who have come of age have the duty to support and assist their parents' (National People's Congress of the People's Republic of China, 1982). Articles 20, 21, and 22 of the Marriage Law further extend the duty of mutual support from between parents and children to between adoptive, foster, or stepparents and children and between grandparents and grandchildren (National People's Congress of the People's Republic of China, 2001). Chapter 2 of the People's Republic of China Law on Protection of the Rights and Interests of Older Persons provides additional guidelines on the legal responsibilities of family members in providing economic support, housing, care in daily living, medical care and expenses, and emotional support for adults aged 60 or older (National People's Congress of the People's Republic of China, 1996). Although these articles and chapters pertain to elder support in general and do not specifically focus on the FSA, they do provide the legal foundation for the FSA" (Chou 2011, 8).

[13] Explaining the history and function of FSAs, Chou writes: "To ensure parental support, the Family Support Agreement (FSA) emerged from a local community in the mid-1980s. Since then, the FSA has been promoted and monitored by the government. By the end of 2005, FSAs had been signed by more than 13 million rural families across China and is now finding its way into cities. A voluntary contract between older parents and adult children concerning parental provisions, the FSA represents an innovation to help meet the challenge of providing elder support. Although the FSA's moral persuasion is based on filial piety, violations of the FSA are subject to penalties by law" (Chou 2011, 3).

[14] In recent decades, there have been regular news stories about *yinao* (医闹, medical malpractice), where family members of patients in hospitals sued care facilities for wrongful death or other issues (T. Hu 2017; H. Li et al. 2014; Liebman 2013). Such cases also occurred periodically at Summit Care.

[15] One important way in which they did this was by requiring residents' family members to sign release forms either allowing staff to use restraints if they deemed necessary or taking full responsibility for any negative consequences that might ensue if they refused to allow restraints. If their family member fell and got injured, the facility could no longer be held legally responsible.

"Supply-side investments": State efforts to expand eldercare infrastructure and investment

One of the largest ways in which policy directives from the Chinese state have impacted eldercare is the pace and scale of institutional eldercare development. The "90-7-3" model, for example, was initially put forward in Shanghai, and versions of it[16] are now being expanded nationally (中国新闻网 2017; J. Wang 2018) as cities and provinces aim to increase their institutional eldercare capacity. According to this model, 90% of older adults should receive care at home, 7% should receive community-based eldercare, and 3% should receive institutional eldercare (ibid). This care model is directly related to ambitious state targets for increasing the number of eldercare beds available in China for over a decade. As Glinskaya and Feng describe:

> Overall, the development of home- and community-based services has been limited, while residential care facilities are booming. This trend may have been induced by the targets set by the government to increase residential care capacity to at least 30 beds per 1,000 elderly people (age 60 and above) by 2015 (target met, per current government statistics). (Glinskaya and Feng 2018, 24)

Put another way, the number of beds for eldercare in China at urban institutions[17] nearly doubled in less than 5 years, increasing from 493,000 in 2009 to 971,000 in 2013 (ibid, 26).

While these "supply side" investments and government incentives (ibid) have been critical drivers of China's expanding institutional eldercare infrastructure, the state continues to make fairly limited direct financial investments in eldercare expansion. As of 2018, Glinskaya and Feng calculated that the Chinese government "spends about 0.02-0.04 percent of its GDP on elderly care, and this limited public financing is mainly geared toward subsidies for the construction of residential care facilities" (ibid, 35). Though the saying "China has gotten old

[16] In some places, the ratios are adjusted to 90-6-4 (Fang 2018, 138).
[17] Nationwide across all types of care sites (urban, rural, social welfare homes, and community institutions) there was a similar trend with the total number of eldercare beds increasing from 2,890,000 in 2009 to 4,937,000 in 2013 (Glinskaya and Feng 2018, 24).

before getting rich" (Keimig 2021, 4) is commonly used among scholars to describe the Chinese eldercare landscape, there is no denying China's tremendous economic growth over the past several decades. The general sense in China that economic conditions have been improving is reflected in statistics that show, "Since China began to open up and reform its economy in 1978, GDP growth has averaged almost 10 percent a year, and more than 850 million people have been lifted out of poverty" (The World Bank Group 2021b).

Both in China and abroad, a growing Chinese economy coupled with an aging population has made the Chinese eldercare industry seem ripe for generating economic profits. Though it is unclear who the real investors in China's eldercare market might be, throughout my research, I heard them described as individual private investors or private companies both in China and abroad. Though I periodically came across U.S.-based consulting firms that seemed to promise U.S.-based investors a profitable inroad into the Chinese eldercare market (see Figure 1), whether, for whom, and to what extent those endeavors actually were profitable was difficult to ascertain.

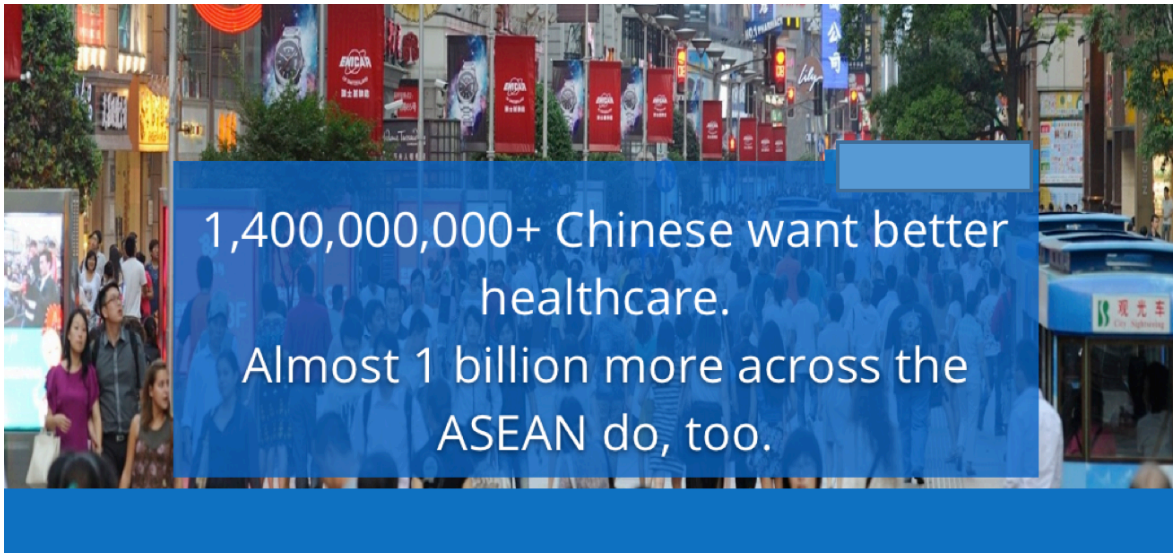

Figure 1: The banner image on the homepage of a U.S.-based consulting firm advertising the scale of the Chinese eldercare market to potential investors ("Rubicon Strategy Group" 2016).

Hu et al. give a sense of the range of companies and organizations investing in the Chinese eldercare landscape when they describe those interested specifically in continuing care retirement communities (CCRCs) in China. They write:

> The development of the Chinese CCRC sector is in its infancy, and its development is currently receiving increasing attention from investors, which can be grouped into real estate corporations (e.g., Poly Real Estate and Vanke), senior service institutions (e.g., Qinheyuan Corporation and Starcastle), insurance companies (e.g., Taikang Life, Union Life and China Life) and other investment institutions (e.g., HKING Group) (Deloitte, 2014). (X. Hu et al. 2019, 110)

Despite so much development interest, the reality is that the upfront and ongoing investments needed to create and sustain an institutional eldercare site often make it difficult for such sites to be highly profitable. According to the 2015 *Research Report on the Development of Eldercare Institutions in China* from the National Office of Aging Issues, "of the 257 eldercare institutions interviewed, 48.1% were breaking even, while 32.5% were making losses. Only 19.4% of the institutions interviewed were turning operational profits" (Fang 2018, 141). This resonates with what I observed at Summit Care. Though no one shared financial information about the site with me, the sense I got from facility leadership was that Summit Care was financially making ends meet despite being in a somewhat precarious position when it came to covering operational costs while also investing in facility growth.

Care in an increasingly commercialized market

For institutions trying to make ends meet or (ideally) even produce enough revenue to expand their services in an increasingly competitive eldercare market, attention must be paid to creating and maintaining a strong, positive reputation for the care site. This kind of institutional

branding goes hand-in-hand with the broader commercialization of eldercare and, as Hong Zhang documents, even a commercialization of filial piety in contemporary China (H. Zhang 2017). Specifically, Zhang traces the emergence of advertisements for long-term care insurance and institutional eldercare that are geared towards older adults' children. These advertisements promise "modern" and financial means for children to express filial love and eldercare support without parents "becoming a burden" or adult children needing to sacrifice their independence to provide eldercare directly (H. Zhang 2017, 242). She explains:

> In this new realignment of state, family, and market interests, what has emerged is a "modernized filial piety" that not only reinvigorates the filial tradition in a new form but also spawns new practices. Ideologically, the new formulation of filial piety is no longer associated with the traditional notion of "subordination of the young to parental authority" but is modified and reembraced as compatible with the changing times…In its modern form, this new filial piety is appealing to the state, because it not only carries on the cultural tradition but also helps stabilize the family and society at large. It is also appealing to parents and children alike. Parents feel that they are neither being abandoned by their children nor becoming a burden to them, while children feel that they can pursue their careers and personal lives without compromising their filial obligations. (H. Zhang 2017, 249)

For eldercare institutions like the ones I visited, finding ways to present their work in positive terms like this was critically important. As Zhang observes, eldercare institutions in China are commonly seen as sites of abandonment and, "To mitigate this public anxiety…residential care is repackaged as a way of both helping busy and career-oriented children fulfill their filial duty by purchasing care at elder homes and helping parents and families reconcile the moral dilemma posed by modern, competitive life by purchasing a solution to their elder-care needs" (H. Zhang 2017, 247).

At the same time as they try to attract new residents and families, eldercare institutions must also constantly grapple with staffing challenges in a competitive eldercare market. There is a shortage of professionally trained caregiving staff in China, with "an estimated 300,000

registered long-term care workers nationwide and over 40 million older people with disabilities who need care (much of that care is provided by family caregivers at present)" (Z. Feng et al. 2020, 1365). While government efforts to address this by "developing professional educational programmes" has increased the number of "educational (mostly vocational) programmes directly related to long-term care" from 86 nationwide in 2015 to 186 in 2018, enrollment in these programs remains low (ibid). As Feng et al. explain, this is likely due to "unattractive career prospects, such as unfavourable social attitudes towards long-term care workers, low wages with few benefits, demanding work conditions, shortage of opportunities for career development, and low job satisfaction" (ibid). For sites like Summit Care, where staff have been successfully recruited into caregiving roles, policy changes like the incremental relaxation of China's family planning policy since 2013 (F. Wang, Gu, and Cai 2016) have created new challenges. Now, young female doctors, nurses, nurse's aides, and administrators may go on maternity leave or even leave the workforce altogether to have another child[18] when it had previously been assumed these women would only have one child.

For eldercare institutions and the eldercare system more broadly, daily care practices must be understood in connection to these demographic, economic, and social changes. Contemporary institutional eldercare and dementia care are emerging in the context of these dramatic and ongoing shifts in Chinese society.

[18] Although "by May, 2015, only 1.45 millions (13.2%) of 11 million eligible couples applied for permission to have a second child" (Zeng and Hesketh 2016), at Summit Care, the Director discussed staff going on leave to have second children as a serious concern, particularly as he we trying to recruit increasingly young and more highly trained staff to his facility. In May 2021, the policy was further relaxed to allow families to have up to three children, though it remains to be seen how many families will actually choose to have more children (McDonell 2021).

Understanding dementia and social science approaches to studying dementia care

Under the heading "About dementia," the Alzheimer's Association writes:

> Dementia is not a single disease; it's an overall term — like heart disease — that covers a wide range of specific medical conditions, including Alzheimer's disease. Disorders grouped under the general term "dementia" are caused by abnormal brain changes. These changes trigger a decline in thinking skills, also known as cognitive abilities, severe enough to impair daily life and independent function. They also affect behavior, feelings and relationships. (Alzheimer's Association 2021b)

This definition covers several key points: "dementia" is actually a catchall term for a range of medical conditions; dementia is caused by physiological changes in the brain; dementia is often marked by changes in people's abilities to function independently and in how they interact with others. Though it can be difficult to determine which kind of dementia a person has, there are a range of tests available for diagnosing the presence and severity of dementia, including neurological exams, depression and mood assessments, brain imaging, and/or mental cognitive status tests.

In the social sciences, studies of dementia care institutions can be understood as part of studies of healthcare institutions more broadly. From Foucault's study of the medical gaze (1973), to Goffman's discussion of all-encompassing "total institutions" (1961), social scientists have studied healthcare institutions from many angles. Here I am interested in how care practices in Unit 1 happened in particular ways as a result of occurring within that institutional setting. Anthropologists have examined one facet of this through studies of institutional bureaucracies and how the structures they offer ultimately produce or undermine particular care practices (Hull 2012; Rhodes 1991). This insight that institutional systems should be studied both in their own right and in relation to daily care practices is directly related to my analysis in this dissertation. For residents, families, and staff, I am interested in what the Unit 1 dementia care ward claimed

to offer, what it offered in practice, and, why stated ideals sometimes seemed to diverge from daily practices.

In studying dementia care institutions, in particular, medical anthropologists have focused on daily care practices as a way of surfacing and understanding underlying values and assumptions about "good care" (Kontos 2006; Pols 2005; Moser 2010) and family members' roles in dementia care (Cohen 1998; J. Lee 2019; Hellström, Nolan, and Lundh 2005). In my research, I took to heart Pols' reminder to "attend to [elders'] performativity even when there is no language" (Pols 2005, 210). Informed by rich debates within anthropology regarding personhood (Bird-David and Israeli 2010; Buch 2013; Kontos 2006; Lamb 2014) and "a life worth living" (Gjødsbøl, Koch, and Svendsen 2017; Svendsen et al. 2018), I also tried to stay cognizant of how claims to personhood and value (for residents, families, and staff) were or were not supported, or "recognized" (Taylor 2010), within Summit Care.

Summit Care

Summit Care is located on the outskirts of a large city in Sichuan. Its fairly accessible location was among the reasons family members cited when explaining why they had chosen to bring their loved ones to Summit Care as opposed to less expensive, or more beautiful care sites in rural areas outside the city. A major expressway and bus stops for multiple city bus routes connected the facility to the urban center, in addition to the many cab drivers and rideshare services that frequented the area. There was a partially covered marketplace next to the hospital selling fresh meat and produce, as well as small stores or stands providing everything from toiletries, to clothing, to printing services and photo developing, along with a handful of small

restaurants and stalls selling food to staff and visitors to Summit Care and those living in the surrounding area.

Summit Care was architecturally fairly unremarkable. The hospital had four three- or four-story buildings that contained a lush garden courtyard at their center. Like many eldercare sites, it had a guard posted at each entrance to keep track of visitors and make sure no residents left unescorted. The facility had departments for nutrition, rehabilitation, Traditional Chinese Medicine, surgery, intensive care, general wards where residents with fewer medical needs[19] could stay, and Unit 1 for dementia care[20]. Toward the end of my fieldwork, the facility also opened a VIP ward in a newly renovated part of the building where more inclusive services were provided in addition to the highest staff-to-resident ratio in the facility. Although Unit 1 was the most high-end ward in Summit Care prior to the opening of the VIP ward, families of residents in Unit 1 still were expected to contribute to their loved ones' care by bringing daily necessities like tissues and adult diapers to the ward on a regular basis. In the VIP ward, by contrast, the facility provided all items necessary for daily bodily care as part of residents' monthly fees. Beyond the newly refurbished VIP ward, Summit Care's facility seemed clean and well maintained, but it was clear that it had not been newly built. Laminate and tile floors were chipped or peeling in some areas. Paint was sometimes cracked on the walls. Despite cleaning staff dusting handrails, window sills, and furniture surfaces almost constantly, the facility's inner

[19] In addition to lower staff-to-residents ratios, these wards were also less expensive than the more medically focused wards, so sometimes patients ended up there for financial reasons.

[20] Some have claimed that there are "no specialized facilities for people with dementia in China" (Keimig 2021, 62). Though staff in Unit 1 certainly wrestled with how best to support older adults with dementia, reflecting the fact that "public understanding of their specialized care needs was limited" (Shea and Zhang 2016; Y. Zhang 2020 *in* Keimig 2021, 62), it is significant that Unit 1 was presented to staff, residents, and families as a "specialized" facility for providing dementia care.

and outer walls could not help but accumulate a dusty coating from the frequently polluted city air.

Unit 1 was located on the top floor of one of the hospital's four main buildings. Gender-segregated, 3- or 4-patient rooms[21], an office for the doctors and unit leaders, the nursing station, and two small staff rooms[22] branched off one side of a long hallway, with barred windows[23] looking onto the courtyard below and letting in fresh air and natural light along the other side. At the end of the hall on one side were two small activity rooms, a few bathroom stalls (which were cleaned regularly but still had a heavy odor and staff repeatedly told me to avoid them[24]), and a locked storage room. At the other end of the long hallway was *dating* (大厅, the main activity room), and a small cluster of additional patient rooms. The *dating* was the heart of patient life in the ward. That was where meals happened for all but the most severely incapacitated residents, where activities were often held (or where residents returned to after attending activities in the small activity rooms), and where residents had their favorite spots along the large tables in the room or the collection of sofas and chairs around its periphery.

[21] Some were effectively double rooms that connected in the middle with 3-4 beds on either side of a door to the hallway. Some rooms had a small bathroom and shower area for the residents who lived there. Others only had a commode chair that had to be manually emptied by nurse's aides when it was full.

[22] One of these rooms had a single bunkbed with some storage lockers and was primarily used by the doctors on staff and the head nurse. When I was on night shift rotations, this was the set of bunkbeds staff insisted that I use. The other room had two sets of bunkbeds and additional hooks, lockers, and a shoe rack and was where nurses and nurse's aides changed out of the work uniforms they put over their street cloths, stored their belongings, napped during lunch or other breaks, and sometimes crouched together to share food if the chairs and stools by the nurse's station were already occupied. Nurse's aides also sometimes napped in the small activity rooms during their breaks.

[23] Barred windows were fairly common architectural features in the area.

[24] I used the staff bathroom which was accessed by taking a key from the nurse's station to unlock a doorway to a staircase. At the top of the stairs was a sink and a small bathroom. The bathroom had a large window that was always left open, a small garbage bin, and a squat toilet. Because the staircase continued on to the Summit Care roof and because spare wheelchairs were often piled on its landing, this area was supposed to be kept locked at all times unless someone was using the bathroom.

With each visit to the site, I came to appreciate Summit Care's fairly unique role in the local eldercare landscape. It was a privately run hospital, but it operated as a nonprofit[25], which meant a heavy reliance on both government subsidies and patient fees in order to keep its doors open. As a site with a reputation for providing *yiyang jiehe* (医养结合, integrated medical and elder care)[26] Summit Care accepted older adults with widely varying medical needs. This was distinctly different from many newly opened private care sites in the area, whose largely non-medical staff catered almost exclusively to independent living residents. In Unit 1, while the majority of residents seemed to have moderate dementia, staff told me that some scored within the "normal" range on their MMSE[27] while others had dementia so advanced that they could no longer communicate verbally. Some residents spent their days walking up and down the ward's long hallway without getting tired, while others were too physically weak to even sit up

[25] As others have noted, the "private aged care services sector in China consists of two types of organizations: nonprofit organizations (NPOs) and commercial for-profit organizations" (Glinskaya and Feng 2018, 29). NPOs "tend to provide affordable services and earn modest financial returns. They usually target the lower-middle and low end of the market and serve seniors who can make modest payments. In contrast, for-profit commercial organizations tend to target the mid- to high-end price range of the market, with the goal of earning substantial financial returns on their investments while striving to provide high-quality services" (ibid). Although Summit Care was technically an NPO, it catered to families spanning the lower-middle-end to the high-end of the eldercare market by offering different services and care environments for different fees. Its role as a private, non-profit facility should thus be understood as related to the fact that "virtually all private sector residential care facilities in China are currently registered as non-profit, non-enterprise entities," regardless of their target client market(s) (ibid).

[26] As explained on the facility's website, "The hospital took the lead in proposing and establishing a…medical and elderly care service model in China" (translated from Chinese by the author on 3/9/2021).

[27] The Mini-Mental State Exam (MMSE) and mini-cog are frequently used mental cognitive status tests, and a translated version of the MMSE was administered in Chinese to all incoming residents at Unit 1. A translated version of the mini-cog test was also administered periodically to residents within the ward. As the Alzheimer's Association explains: "During the MMSE, a health professional asks a patient a series of questions designed to test a range of everyday mental skills. The maximum MMSE score is 30 points. A score of 20 to 24 suggests mild dementia, 13 to 20 suggests moderate dementia, and less than 12 indicates severe dementia. On average, the MMSE score of a person with Alzheimer's declines about two to four points each year. During the Mini-Cog, a person is asked to complete two tasks:

1. Remember and a few minutes later repeat the names of three common objects.
2. Draw a face of a clock showing all 12 numbers in the right places and a time specified by the examiner.

The results of this brief test can help a physician determine if further evaluation is needed" (Alzheimer's Association 2021a).

independently in a chair. For a dementia care ward, it was striking that not all residents seemed to have cognitive impairment. Some were in Unit 1 because physical impairments due to medical events like strokes or chronic health conditions like diabetes required more intensive support than their families could offer at home. Some residents were there because they did not have family members to look after their needs. Most were there because their families had tried to care for them at home for as long as possible before reaching a breaking point and seeking institutional care settings to offer additional support[28]. Because of the relatively high staff-to-resident ratio[29] the dementia care ward offered, some families brought their loved ones there to receive care even if dementia support was not their main concern.

While many eldercare institutions I visited during my pilot research had fewer than 50% of their beds occupied, as scholars have observed elsewhere (Glinskaya and Feng 2018, 29), at Summit Care, and particularly in Unit 1, there was often a waitlist of families trying to get their loved ones a space in the facility[30]. Some of this seemed to be because of the facility's monthly fees. According to what the Director told me, Summit Care offered beds for as little as 3,000 RMB per month in its general wards, approximately 5,000-6,000 RMB per month in its Unit 1 dementia ward, and 8,000-13,000RMB per month in its VIP ward. Prices varied depending on a

[28] Stories of families finally deciding to bring a loved one to Summit Care after weeks of sleepless nights spent trying to managing night-time wandering and incontinence were not uncommon.

[29] For approximately 45 residents, daytime shifts in this ward usually included 2-3 doctors, approximately 6 nurses, and up to 6 nurse's aides (plus occasional interns or trainees) at any given time. Up until the final months of my fieldwork, this ward had the highest staff-to-resident ratios in the whole hospital.

[30] Though many families expected their loved ones to stay in Unit 1 after they entered it, residents also left for a variety of reasons. Some residents died of an acute illness or injury in the ward or after brief stays in an ICU within Summit Care or another hospital. Some residents left Unit 1 for less expensive wards in Summit Care or for the facility's VIP ward depending on the resources available to support their care. Some residents were moved to other hospitals in an effort for their families or (in the case of several wards of the State) the State to save money on their care. Some residents were moved to other care facilities so that they would be closer to family members who wanted to visit them more regularly. On rare occasion, some residents were even moved back home because their families felt they had improved so much within Unit 1 that they could now be effectively cared for by their loved ones.

particular residents' health needs and could become even higher if families wanted special meals prepared in the hospital's nutrition department (as opposed to those made by its general cafeteria), or if they want special services like rehabilitation sessions or Traditional Chinese Medicine services. Some families were able to negotiate lower rates on a case-by-case basis, but that was rare. In any case, the rates at Summit Care were generally less than those at some high-end, newly built facilities[31]. Summit Care also attracted residents and families because it was one of relatively few private sites that could provide care to older adults with more serious medical needs. For example, some care sites I visited during my pilot research only had a nurse on staff several days a week, and could not offer acute medical care beyond getting residents transferred to a nearby hospital if an urgent medical issue arose.

In our second extended meeting about my research, the Director of Summit Care described his hopes for his facility. He explained that he was trying to get Summit Care to become a center for research, particularly related to *fuwu* (服务, care services) and *peixun* (培训, training). He connected this aim to his efforts to hire young, more educated nurse's aides. These women had received 1-2 years of professional training at local programs, unlike the vast majority of elder care sites I visited in the area that relied solely on middle-age (usually female) nurse's aides with middle-school education or less to staff their wards. While Summit Care employed many of these older nurse's aides in its wards, during my research nearly all of the nurse's aides in Unit 1 and the VIP ward were young graduates of these more professional programs.

Summit Care was also constantly changing as an institution. As long-term staff explained to me, a decade before my research began, Summit Care housed just over 140 patients. At that

[31] Fees at newly built, high-end, private facilities can be well over 10,000RMB per month (Glinskaya and Feng 2018, 29).

time, more specialized wards like Unit 1, the VIP ward, and even the Intensive Care Unit did not exist. There was no operating room or surgery department, no nutrition department, and no fancy medical equipment like the CT scanner. Over time, the facility attracted more patients, which provided the resources necessary to slowly expand and specialize, hiring more skilled staff, and thereby attracting still more patients and revenue. Though this institutional development happened slowly initially, staff told me that it had accelerated in the years before my long-term fieldwork began in 2017. This change also occurred alongside "cultivating talent" efforts as Summit Care administrators increasingly sent staff to attend trainings within and beyond the facility and began to establish partnerships with local schools for training young nurse's aides in order to facilitate their own recruitment of these young women. Summit Care was also in the midst of expansion efforts and attempts by the Director to secure external, private investment that would allow him to construct a whole new building for the facility. While such expansion would have doubled the facility's size, at time of my research there were approximately 400 beds in Summit Care, and just under 300 of them were authorized to provide "medical" care under the state health insurance reimbursement system. The Director told me that, not including cafeteria staff, Summit Care employed around 260 people, including over 30 doctors, over 80 nurses, and approximately 65 nurse's aides. The remaining staff members were primarily in administrative roles. Although the Director acknowledged that this put the number of staff below government standards (which he said required, for example, 0.6 nurses per patient), he explained that staffing levels like the ones at Summit Care were common in all non-publically-run facilities.

Methods

Positionality

As the child of older parents and older grandparents – one of whom had dementia that progressed throughout my childhood – I brought a genuine concern and baseline understanding to discussions with eldercare providers, to family members trying to come to terms with loved ones' illnesses, and to interactions with older adults experiencing varying degrees of impairment. As someone who had pursued pre-med coursework as an undergraduate and spent dozens of hours volunteering in hospitals and observing in hospice wards during high school, I was comfortable in medical settings and in thinking about the care that medical settings might offer when they could no longer provide cures. As a White American who had grown up in an upper-middleclass suburb with highly educated parents, I had been privileged to go to a public high school that offered Mandarin, I had taken courses about China and Mandarin throughout college, and I had studied abroad in China at some of the best intensive Mandarin programs available. Throughout college and graduate school, I was mentored, encouraged, and supported by educational institutions and academic systems that ultimately allowed me to pursue and fund this research.

Thinking back on my experiences in China, interactions with cab drivers offer some of the best snapshots for capturing ways in which aspects of my positionality may have impacted people's responses to me and my research. In drivers' references to the Opium Wars, I heard reminders that my Whiteness not only made me a visible foreigner, but also implicitly tied me to histories of Imperialism and China's efforts to resist European colonization and regain the global influence it had held for millennia before the political unrest of the 19th and 20th centuries. In their questions about whether or not I was married and their stories about eligible young sons, I

was reminded of the social capital that came with being a young, White, American (and therefore frequently presumed wealthy) woman when the phrase *baifumei* (白富美, White, rich, beautiful) was a catchall for describing the ideal female partner. In their periodic calls to "be careful" because I was traveling alone, I heard reminders that being a young woman sometimes meant being seen as without power. I noticed Chinese nationalism building over the course of my research when drivers' questions about the United States changed from "How much money does an average person make in the US?" to "Which is better: living in the US or living in China?" to discussions about trade wars, whether it really felt unsafe in the US given all the mass shootings, and whether democracy made sense at all following the 2016 Presidential election. And yet, when they asked where I had studied Chinese, and I answered, "All over. In the US, in Harbin, in Taipei, and in Xi'An," we often found common ground. Sometimes their hometowns were near one of the cities I mentioned. More often, my answer became a way for us to start discussing travel more generally. Whether they were from outlying towns and cities or from other provinces altogether, I passed many car rides exchanging stories about favorite restaurants, parks, and tourist destinations – in the city where we were and in the ones we had each left. Sometimes on long rides these discussions of other places and far away homes led to discussions about our families. Sometimes we hardly talked at all.

I was lucky to work with people who made me feel like my positionality was a strength rather than a liability. At the local university, I was relieved to find an academic mentor who was an older woman who had spent most of her career abroad and understood what it meant when I said I was doing "qualitative research." At Summit Care, I was relieved that the Director was a married man with a family who had traveled extensively abroad, and always treated me with professionalism. Like leadership in Unit 1, he seemed interested in me and my work because he

hoped it could help further strengthen the facility. In Unit 1, though I tended to be more guarded with the handful of male nurses and nurse's aides that were present at different points during my fieldwork, I found it easy to socialize with the young female staff[32] outside the ward. When interacting with residents and their families, my status as a foreigner seemed most salient, and I frequently got questions about where I was from, how I had learned to speak Chinese, and how the care in Unit 1 compared to care in the United States. Like the young female nurse's aides, I suspect that people often thought of me as filling a compassionate, caregiving role because of my youth and gender (and, particularly in my case, because I frequently had unstructured time to spend simply sitting and interacting with those in the ward, unlike the nurse's aides who were often busy with their institutional workloads).

I tried to use my positionality to connect with the staff, residents, and families when I could. When I was invited to weddings and family events by the staff, I did my best to attend and play the part of the well-mannered foreigner – smiling for pictures, answering questions about the United States, eating whatever food was offered to me, and trying to at least make a passable showing at group activities like karaoke and mahjong. At the ward, I offered a free English class to any staff who were interested in attending. When I learned that the staff enjoyed baked goods I had made, I started inviting small groups to my apartment for cooking lessons and walked them through cornbread and banana bread recipes. On rare occasion, I hosted dinners with staff or administrators at my apartment and made "Western"-style meals to celebrate a birthday or other event. I helped organize a Christmas party at the ward, complete with multiple kinds of cookies and hand-made decorations. I joined groups of young, female staff for meals near the hospital

[32] The young female nurses and nurse's aides tended to socialize in all female groups unless they were attending social events organized through the hospital or unless any men in the group were their romantic partners or relatives.

and in the city. I went on weekend trips with some groups. I exchanged photos and updates with some over the course of years and quickly lost touch with others when I returned home.

Qualitative interviews and observations

As part of this project, I conducted over 40 hours of audio-recorded interviews with care providers and families connected to Unit 1, along with dozens of hours of semi-structured interviews with participants who preferred not to be audio-recorded – including doctors and administrators at Summit Care, additional family members of residents, local health officials, and other scholars whose work related to eldercare in Sichuan. Though I tailored my interview guide for each kind of participant – staff in Unit 1, leaders or administrators in Unit 1 or Summit Care, residents' family members, specialists outside Unit 1, etc. – my semi-structured interviews all explored several general topics. These included (1) questions about the participant's background; (2) questions about how the participant interacted with other kinds of participants in Unit 1 (e.g. how staff perceived and interacted with family members of residents, how family members perceived the Unit 1 staff and their loved ones' overall experiences living in the Unit 1 ward) and general perceptions of the ward overall; (3) questions about how the participants perceived dementia and how they perceived what it meant to live "a good life in old age;"[33] (4) questions about care practices I had observed in the ward, including participants' views about the use of physical restraints, safety, and what kinds of issues they felt could or could not be resolved through care in the ward; and (5) bigger picture questions about how they understood abstract concepts like what it meant to be a "professional" caregiver, the meaning of *xiao* (孝,

[33] As described in Chapter 1, this became a proxy for understanding how participants thought about what "good care" meant in institutional eldercare.

filiality or filial piety), and how they felt about the institution's future. Throughout, I asked participants to reflect on what they felt older adults' experiences of care in Unit 1 were like, and where they felt responsibility lay for addressing care issues.

I also spent over 500 hours in Unit 1 observing and, as possible, participating in daily life in the ward. During this time, I had countless unstructured conversations and interactions with Summit Care residents, families, and staff at all levels. While observing, I took notes by hand that I then tried to type up and flesh out in the evenings and on days when I did not visit Summit Care. In my observations, I focused on understanding what activities happened in the ward, how different types of participants interacted with one another versus how they behaved when only residents and I were present, ways in which different groups of participants seemed to create and deviate from caregiving norms within the site, and how and to what extent they physically engaged with the institutional space in their care practices. These unstructured conversations and observations helped me see the state's impact on care, as I listened for when those in Unit 1 mentioned the state and watched for traces of the state in the ward's physical care environment (e.g. through paperwork, banners and placards on the facility's walls, staff members studying to pass state certification exams on their breaks, etc.). I asked those around me how they perceived particular care interactions I had observed and encouraged them to imagine how they might feel in one another's roles (e.g. family as staff, staff as family, caregivers as care recipients).

Participating and observing: Ethnography in Unit 1

My research involved what others have referred to as an "awkward union of participation and observation" (Seim 2021). My lack of medical training significantly limited the degree to which I could be an "observant participant" in the ward as opposed to a "participant observer"

(ibid), and my participation was frequently therefore closest to that of the residents sitting around and responding to staff activities and schedules. At the same time, I tried to do what I could to support staff, as well. I kept residents company. I joined in for group exercises and clapped along when staff organized resident-led group songs. I helped "keep an eye" on the main activity room when staff had to step out for a moment. When asked by administrators, I gave PowerPoint presentations on elder care in Denmark and China. I also tried to advocate for residents whenever I could. I called the doctor over when residents told me they had questions about a health issue or treatment they were having. If residents said they were thirsty, I refilled their cups with hot water using the large thermoses staff filled from a boiled water tap each day. I occasionally helped spoon blended food into unsteady mouths (with what I immediately realized was my untrained hand). I regularly went for looped walks up and down the ward's hallway with residents who wanted to stretch their legs. I sometimes joined residents for (often fruitless) searches for misplaced objects in their rooms. I tried to offer more humanizing explanations for behaviors staff found frustrating.

And yet, particularly early on in my fieldwork, I had a difficult time navigating what my role was in the site. As the "American doctoral student," I was regularly asked what I thought should be changed in Unit 1, how care could be improved, and how eldercare was practiced back in the United States. I responded by reminding people that I was not a gerontologist, that I was just a student, and that anthropological methods were particularly slow – I would not know what my "findings" were until I had collected and analyzed my data. I was careful about giving advice or sharing my views on things in the ward or on Chinese politics more generally (another favorite topic that people raised with me). At the very end of my main fieldwork in 2018, I put

together (very American) preliminary recommendations based on what I had been told and what I had observed and experienced in Unit 1.

Uncertainty around my own role was also a byproduct and benefit of engaging in participant observation, which allows researchers to be more "mobile" within a given social environment (Seim 2021). As an ethnographer, I had access to residents, administrators, and families (at least those I got to know during their visits to the ward), as well as to social events with staff and their families outside of work. In the hierarchical and socially structured world of Unit 1, I could move between attending staff meetings, sitting with residents, eating lunch in the cafeteria with family members, having snacks with staff back in the ward, or talking with the Director one-on-one[34]. As a result, I built friendships with administrators, as well as family members, doctors, nurses, and nurse's aides connected to Unit 1, and I met with them and their families for meals, coffee chats, outings, and celebrations far away from the daily routines at Summit Care. When asked, I shared stories about my life in the United States. I tried to reassure the 18-to-22-year-old nurse's aides that there was time enough for them to have their own lives and have families; that it was worth thinking about (and then to whatever extent possible pursuing) work that they thought would make them happy. I tried (and sometimes failed) to keep names straight and to check in with people. I hoped that a "happy birthday," "how's your pregnancy going?" "Did you get to visit your infant this month?" or simply a well-timed homemade snack would help me become a more normal part of people's lives.

I also attempted to set and maintain respectful boundaries with my observations in Unit 1. When leadership in the ward asked me to avoid coming to the site on weekends because that was when the majority of family visits occurred and the ward would be especially crowded, I agreed

[34] While staff generally described the Director in positive terms, nurse's aides tended to be especially intimidated by him and even nurses sometimes told me the idea of meeting with him one-on-one seemed daunting to them.

without hesitation. When staff told me I could go with them on their rounds as they helped residents go to the bathroom or get ready in their rooms, I declined[35]. Staff might have been comfortable having me observe in those situations, but it felt important to respect residents' privacy and keep my observations to common areas in the ward unless residents themselves invited me into their rooms.

Because I was worried people might feel coerced by facility leadership to participate in my study, I was careful to let staff and families connected to Unit 1 know that I was conducting this project (e.g. by introducing myself and my work in staff meetings and whenever visiting family members in the ward approached me, were introduced to me by another family member or person on staff, or simply made eye contact often enough that I introduced myself to them), and then invite people who were interested in participating in the project to reach out to me if they wanted to set up an interview. Once an individual "opted in" to be interviewed, then I was able to recruit through a snowball sampling method, asking each interviewee if there was anyone else they would recommend I invite to be interviewed. In this way, I was able to broaden my interview base.

Over time, my relationships with people connected to Unit 1 evolved and changed. Some of the people I became closest to left the ward. Residents' families decided to relocate them to another care site, and staff found jobs elsewhere or left to start families of their own. Some stayed and seemed to deteriorate overtime. Residents' physical and language abilities sometimes slipped away, staff and family morale sometimes dipped (or maybe they just got more honest about how they had felt all along?), leadership grew (or admitted to being?) slightly more

[35] Even so, I still ended up turning my head to avoid seeing diapers changed when staff, sometimes rushing to help many residents after a meal, would ask them to stand and quickly pull off and replace their diapers in the main activity room.

cynical. And then there were those people who seemed to stay the same: experiencing a consistent mix of good and bad days with less emotional investment in their work seemingly allowing for a more consistent attitude or approach to it.

Sufrin writes, "We seek to know people's lifeworlds by building relationships with them. We insert ourselves into aspects—often intimate ones—of their everyday lives in ways that cultivate concern for their well-being" (Sufrin 2015). Slowly, over time, I got to know people connected to Unit 1, and through those relationships I began to see the ward as shaped by the conflicting concerns, priorities, and capacities of the people whose lives it touched – myself included. When my main fieldwork ended, I promised to return. After years of having a "next visit" already scheduled whenever I left Unit 1, the timelines for return trips following my main fieldwork became far more uncertain.

Chapter overview

Unit 1 and Summit Care were full of people striving to provide care while balancing countless demands on their time and the knowledge that some needs simply could not be met. Staff, residents, families, administrators, visitors, the stray anthropologist they took in – everyone involved needed to care for themselves alongside caring for others and for the wellbeing of the institution, overall. In the end, my time there left me struggling with the questions: What can we hope for from institutional care settings? What makes care "good" or at least "good enough"? What are the costs and benefits of care happening the way it did in Unit 1?

I begin my discussion of these questions in Chapter 1 by exploring "good care" in relation to Unit 1 and Summit Care. Building on Annemarie Mol's praxiographic approach, I explore some of the many Chinese terms used for "care." I show how, in describing particular

kinds of care practices, these terms were used in Unit 1 to capture different aspects of good care, in part by presenting residents as different kinds of care recipients (e.g. patients, quasi-children, or consumers). I then turn to ethnographic examples of stories operating as a form of care within Unit 1. Using Susan Blum's work on lies and deception, I look specifically at stories told in semi-staged and edited photos that staff regularly took of residents and then shared with their loved ones in a family WeChat group, and how those images provided a kind of care even if all involved knew (or at least suspected) the images were staged. Drawing on my own experiences interacting with residents in Unit 1, I then reflect on how my efforts to care for and support residents through stories became complicated and entangled with those of family members, staff, and even people outside the site. We were each other's audiences, and the care we tried to offer through our conflicting stories ultimately reflected and compounded uncertainties about residents' capacities, their needs, and what might constitute "good care" for them.

In Chapter 2, I offer a more institution-centered analysis, exploring how institutional concerns and priorities at Summit Care influenced care approaches and practices within the Unit 1 ward. Specifically, I look at how the need to prioritize institutional stability and maximize available resources translated into Unit 1 and Summit Care operating as flexible institutions, where differentiated levels of care were provided to residents and families depending on their respective demands. I argue that Unit 1, in particular, operated as a flexible institution because limited regulation from the Chinese state and (to a lesser degree) Summit Care administrators translated into residents' families being the key arbiters of whether or not Unit 1 staff were meeting residents' needs. I then explore how normalizing such a wide range of care practices for different residents in the ward relied upon and reinforced a *mei banfa* (没办法, nothing to be done) ethics of engagement among staff and family caregivers. I show that *mei banfa* allowed

caregivers to draw boundaries around the degree of care they felt obligated to provide, and that it entered caregiving decisions when the needs and wellbeing of an individual were weighed against those of the institution, as a whole.

In Chapter 3, I look more closely at the needs and experiences of staff in Unit 1, paying particular attention to the young women who worked as low-level nurse's aides. I examine the shifting social status these young women had, their motivations for working in Unit 1, and how working there shaped their daily lives in ways that ultimately pushed some women to seek jobs elsewhere. I argue that Summit Care leadership attempted to capitalize on and strengthen staffs' relationships with one another, using this staff relationality to help strengthen and sustain Summit Care as a more stable institution. In the end, I show that, while staff relationships with one another were important for bringing new workers to Summit Care, they could also sometimes draw workers to competing care sites.

In Chapter 4, I shift to looking at difficult care decisions in Unit 1, specifically the use of physical restraints in the ward. I show how staff at Summit Care and Unit 1 had been working for years to find the right balance between residents' physical safety and their quality of life, and how the risk of being sued or facing financial retribution for any injuries residents sustained in the ward complicated those efforts. I consider how restraints were used to offer care through *guan* (管, to oversee/have a care for/manage), as restraints expanded the staff's capacity to keep an eye on residents who could, and sometimes did, otherwise seriously injure themselves. I then explore why, despite staff and family efforts to act in residents' best interests, residents' experiences of physical restraints were often treated as less important than the safety benefits they offered, paying particular attention to how resident experiences were approximated and understood by staff and family caregivers. Drawing on Hanna Brown's work on nurse-patient

relationships in a resource-poor Kenyan hospital (2010), I suggest that even seemingly unkind uses of restraints could be forms of care. Specifically, I show how Unit 1 leadership's need to keep the ward staffed sometimes translated into allowing seemingly unkind workers to stay in the ward because they could still offer care through *guan* and there was always the hope that they might improve the quality of their care over time. Ultimately, I argue that restraints were used as a kind of workaround for providing care with limited resources, and they were used in part because residents' experiences of care were seen as secondary to perceptions their family members or external evaluators had of that care.

CHAPTER 1: Stories of care and careful stories

Provide daily living care, meet old patients' basic daily living needs, [provide] good foundational nursing care, provide psychological support to old patients and their families, alleviate elders' pain, offer elders survival and quality of life, provide hospice care, maintain the dignity of elders' lives.[36]

Use technology to treat and cure old people, love and care for old people from the heart[37]

The old people here worked hard for the country and their families all their lives, [and they] made great contributions. We treat them as the country treats heroes, as children respect their parents, and love them forever.[38]

-Excerpts from a Summit Care brochure

My dissertation elevator pitch was ready long before I began fieldwork. When asked about my research, I replied without hesitation, "I'm studying 'good care' at a Chinese dementia ward. I want to understand how people in different roles – doctors, nurses, nurse's aides, families, residents, etc. – see 'good care' in theory and how their different perceptions ultimately come together to shape the way care happens in practice." Clear, (relatively) succinct, to the point. The only problem? Even now, I struggle to pin down exactly what I think "good care" meant in Unit 1. A cursory look at the wide range of descriptions in Summit Care's own brochures suggests I was not alone in that struggle. While items like "basic daily living" support seem fairly straightforward, it is harder to imagine just what providing "dignity" and "psychological support to old patients and their families" is meant to look like in practice. This is to say nothing of what brochure readers are supposed to associate with words as elusive as "treat," "cure," and "love."

[36]提供生活照料，满足老年患者的基本生活需求，做好基础护理，给老年患者和家属给予心里支持，减轻长者痛苦，提供长者的生存及生活质量，提供临终关怀护理，维持长者的生命尊严。

[37](Section heading in the brochure) 用技术救治老人，用心关爱老人

[38](Final lines in the brochure) 这里的老人为国家为家庭辛劳一生，居功至伟。
我们待他们必如国家对功臣，子女敬父母，爱至永年。

Explaining "good care" is also difficult because the staff and family members I asked to define the concept frequently replied by describing circumstances that were rare or even impossible within the ward. They mentioned people maintaining physical independence, being able to travel, being surrounded by friends and family, being able to decide what they did every day. Whenever I followed up with questions about what that "good care" might look like in Unit 1 specifically, they frequently seemed stumped. Many would pause before giving muddled replies that again tended to not reflect the majority of residents' experiences (e.g. people saying it meant residents being able to walk independently).

Defining good care was further complicated by the sheer volume of tasks that staff did in Unit 1 – with so much activity, how was one to parse their "good care" from everything else they simply did as part of their jobs? In other words, was good care a special subset of care, and if so, how? Certainly, significant staff time was devoted to "the basic needs of getting a body through a day" (Pinto 2014, 123) as they fed, bathed, turned, and monitored residents' bodies, while also cleaning dishes, doing laundry, and working to maintain an overall sense of hygiene in the ward. There was also affective care, as staff smiled and patted hands, shoulders, and faces to offer reassurance and made efforts to keep mental notes of pieces of residents' personal histories, phobias, and pet peeves. And there was the care that went above and beyond – not just offering meals but providing snacks or preparing special foods and activities for holidays. Staff also invested time in discussing, reflecting upon, and trying to respond to resident needs and family demands. They engaged in countless examples of habituated "care in the everyday" (Aulino 2019, 3): coaxing reluctant residents to eat "just one more bite" of food, and then "just one more" after that, sticking their hands down the back of residents' shirts to check for sweat, or telling residents to add or remove layers of clothing to regulate body temperatures. And they

tended to the bureaucracies of care as they filled out medical reimbursement paperwork, updated and shared chart notes, and monitored and adjusted prescriptions.

More than anything, it was the variations in staff practices that made distilling any sense of a singular approach to care or any shared understanding of good care in the ward feel untenable. Staff took some residents on errands outside the ward and used restraints to keep others from moving even within it. They responded immediately to smells of urine or feces sometimes and waited for pre-scheduled times to change residents' diapers even after registering those smells other times. They laughed and clapped their hands to spark small moments of engagement with some residents and rushed by others without making eye contact. They responded to residents' different physical needs, doling out pills to those who could swallow them and crushing, sprinkling, and mixing medical powders into bowls of blended food for those who could not. They checked their cell phones even though they were not supposed to look at them while on the clock and pulled out their cell phones to discuss and share pictures of favorite residents even when off the clock. They continued to offer activities residents had told them they did not enjoy, and they went out of their way to offer activities residents had told them they did enjoy. They did all that and more, and it seemed like it could all be good care depending on one's perspective.

Therefore, rather than attempt to define what "good care" was in Unit 1 directly, I want to trace some of the ways stories about care for those in the ward were told and what motivated their telling. Because stories are unwieldy to begin with and "Uncertainty and openness may be the nature of narration" (Pinto 2014, 32), telling this story also seems to demand telling the story of how my own perceptions of care in Unit 1 shifted over time. When I first decided to focus on Summit Care as my primary research site, I did so in large part because I intuitively felt like the

staff there were providing "good care" and genuinely interested in thinking through their work alongside an anthropologist. Unlike some care sites that had seemed bleak – unclean (e.g. strong odors of urine or feces) or simply depressing (e.g. too little light filtering in, too little mobility or sense of engagement among the residents, overcrowding, etc.) – in Unit 1 the staff were engaged in and committed to their work. As in any medical setting, they could not meet every need, but, it seemed to me, they were at least trying.

As I got to know the people in Unit 1 better, I fought the urge to be more critical of them – staff, families, and residents alike. Why were the staff so impatient? Why were the families not more engaged or understanding? Why did so many residents not do more to support and connect with one another? By the end of my fieldwork, it felt like the most pressing question was not "what does "good care" mean here?" or "how might "good care" be more fully achieved within Unit 1?" but rather "why would anyone imagine that things could be any different than they already are in Unit 1?" That is to say, for all the unmet needs among staff, residents, and families connected to this ward, it ultimately seemed to me that people there were already doing the best they could. So, did that make the care I observed "good," or at least "good enough," by default?

In this chapter, I explore some of the different ways in which care practices were presented, and thus to a degree enacted, through stories. While concerns around resident safety were complicated and central to the work done in Unit 1, I will primarily explore those in Chapter 4. Here, I focus instead on how care in Unit 1 was shaped by the stories different groups within the ward told one another: residents, families, staff, and me as their resident anthropologist. I argue that because we served as each other's audiences, our conflicting stories became entangled, reinforcing uncertainties about residents' needs, their capacities, and what might constitute "good care" or "good enough care" for them. The accuracy of these stories

mattered far less than the effects[39] their tellings had on listeners connected to the ward. Such stories were meaningful even when all involved knew they might be somewhat fictional.

How do you say "care" in Chinese?

I realized early in my fieldwork that the word "care" does not translate well into Chinese. Or, perhaps more accurately, it translates *too well* since I discovered many Chinese options could be used depending on the context. As a researcher setting out to understand "good care" ("care" yet further complicated by layering a notion of "good-ness" upon it), making sense of these possible translations felt critically important. While my doctoral elevator pitch made sense in English (at least to anthropologists), the phrase "I'm studying understandings and practices of good care" took on a kaleidoscopic range of possible meanings in Chinese. Each potential translation hinged on the character(s) I chose to stand-in for the word "care." While some Chinese translations of "care" seemed closer to the person-centered care model advocated by many Euro-American dementia care sites, I rarely, if ever, heard those particular words used by people at my fieldsite. In Unit 1, the terms I regularly heard used to describe care seemed distant from theoretical debates about personhood and dementia.

Defining "care" in medical anthropology

Rather than offering a definitive solution, medical anthropology research on "care" highlights how heavily debated the term's meaning can be in English as well (Aulino 2019, 40-41; McKearney 2020). Some focus on care as it relates to political economic systems (Brijnath 2014; Buch 2018; Kaufman 2005; Livingston 2012). Others focus on care, particularly for

[39] As Cheryl Mattingly puts it, "Stories are also agentive. They act in and on the world" (Mattingly 2010, 52).

people living with dementia, as grounded in relationality (Driessen 2018; Kontos 2006; J. Lee 2019; Pols 2005), or experiment with ways of expanding possible forms of communicating or engaging with people living with dementia through technology (Moser 2010) or play in the form of "clowning" (Hendriks 2012). Still others approach care as centered on questions of personhood: how caregivers "recognize" loved ones living with dementia (Taylor 2010) or how people "hold" (Lindemann 2014), "value"(Svendsen et al. 2018), or sustain those living what Svendsen et al. refer to as "precarious lives" (Svendsen et al. 2017). With so much debate around how one ought to approach studies of care, the notion of "good care" is sometimes condensed down to simply being "relationally and contextually contingent" (Brown 2010, 137).

For over a decade, many debates about care within medical anthropology have engaged with the work of the Dutch ethnographer and philosopher, Annemarie Mol. Mol writes that, "an ethnographer/praxiographer out to investigate diseases never isolates these from the practices in which they are, what one may call, *enacted*. She stubbornly takes notice of the techniques that make things visible, audible, tangible, knowable" (Mol 2002, 33, emphasis original). Drawing on this methodological approach, Mol's seminal book, *The Logic of Care* (2008), emphasizes the importance of analyzing particular practices of "care," rather than offering an abstracted theoretical definition for what care means across contexts. She argues that in medical interactions, "the crucial moral act is not making value judgements, but engaging in practical activities" and where "'good and bad' are never settled" specifically because "in the logic of care, defining 'good', 'worse' and 'better' does not precede practice, but forms a part of it. A difficult part" (Mol 2008, 86-87).[40] Seen from this perspective, the wide range of possible

[40] There is something very Confucian in this, as Confucius also supposedly never gave a single definition for what "filial" or "孝" behavior meant writ large and instead is said to have always given individualized answers tailored to the circumstances of whoever asked.

Chinese translations for the word "care" discussed below, though not exhaustive, can each be understood as flagging different ways of practicing or enacting "care" in Unit 1.

The many Chinese "cares"

Recent ethnographies of elder care in Asia highlight some of the tensions inherent to translating the word "care." Felicity Aulino argues for studies of "care in the everyday" in Thailand and accordingly defines care as, "the habituated actions of providing for others based on what counts in context" (Aulino 2019, 12). In contrast, Rose Keimig's study of dementia care in Shanghai centers the importance of affective intentionality in caregiving interactions, the very thing Aulino frames as a limited and Westernized conception of care. Nonetheless, Keimig highlights scholars who have defined "care" in Chinese in terms of Confucian concepts like "the virtue *ren*, (translated as 'compassion,' 'benevolence,' and 'kindness')" (Pang-White 2011, 376 *in* Keimig 2021, 93) and goes on to briefly discuss care as *guan ai* (关爱, to love and care for), *guanxin* (关心, to care about), *guanli* (管理, to manage), and *zhaogu* (照顾, take care of) (Keimig 2021, 98, 121, 123)[41]. And yet, many other possible translations[42] exist depending on the context.

[41] It is telling that of these possible terms for "care," the notion of *ren* (仁, compassion, benevolence, kindness) and words involving the character *ai* (爱, love) were perhaps the closest in meaning to the patient, person-centered, iterative approach to care described by Tom Kitwood and other Euro-American gold standards for contemporary dementia care (Kitwood 1997), and yet these terms were also the ones I heard least often within Unit 1. Although *guan ai* occasionally appeared in printed materials related to the ward (see epigraph to this chapter) and although the director of Summit Care and other administrators or leaders in the facility would sometimes describe their work in terms of the more philosophical term *ren*, I almost never heard these terms used in daily staff interactions.

[42] In addition to those discussed below in relation to Unit 1, "care" can also be translated as *zhaohu* (照护, to nurse or care for), *aihu* (爱护, to cherish or take good care of), and *guanhuai* (关怀, to be attentive to or show care for), to say nothing of related words like to "help" (*bangzhu* 帮助) or "support" (*zhichi* 支持).

Within Unit 1, frequently used terms for care each seemed to relate to different kinds of daily practices. Staff and families tended to use *zhaogu* (照顾, to take care of) to describe the lower level nurses' aides' labor (e.g. feeding and bathing residents, changing diapers, etc.)[43]. They would discuss *zhaoliao* (照料, to treat or care for through medical treatment) when describing the more medicalized forms of care provided by nurses and especially doctors (e.g. treating acute illnesses with medication, managing chronic illnesses like diabetes and heart disease with blood sugar and blood pressure monitoring, etc.). They would describe the need to *guan* (管, to oversee/have a care for/manage) various areas of the ward or the residents in general. Even residents themselves sometimes explained the value of life in the ward as "*you ren guan"* (有人管, effectively, there are people watching over) or criticized it as "*mei ren guan*" (没人管, effectively, there's no one watching over). The term *tigong fuwu* or *fuwu* (提供服务 or 服务, provide with care/services or to serve) was also used, often when staff or families were trying to be respectful of the residents in the ward (see Chapter 4). This phrase cast older adults as consumers, even though residents' family members were almost always the true decision makers when it came to assessing the care in Unit 1. As such, *tigong fuwu* or *fuwu* resonates with what Hong Zhang (2017) and others (notably Keimig 2021) have described as the commercialization and commodification of elder care more generally in mainland China. A final term that was used regularly by families and staff in Unit 1 was *hong* (哄, to coax or deceive to keep in good humor). This primarily described strategies for getting residents to do things they were resisting (e.g. to take a shower, eat, or go to bed at a particular time), as well as a general

[43] Keimig also observes this use of *zhaogu* at her research sites in Shanghai (Keimig 2021, 123).

attitude one sometimes needed to have when interacting with residents (e.g. "*yao hong tamen*" (要哄他们, you have to coax them)).

Of these "cares" that I actually heard used regularly within Unit 1, it is significant that three of the five connote childcare: *zhaogu, guan,* and *hong* (to take care of, to oversee/have a care for/manage, and to coax or deceive to keep in good humor). Nearly ten years ago I conducted interviews with elder care providers at a hospice facility in Beijing. At the time, I was struck by how many of the staff described their patients with the phrase, "older adults are like children"[44]. This made me attentive to descriptions of residents as being "like children" during my fieldwork at Summit Care, as well, and when I asked family members and staff what similarities they saw, they frequently replied using the word *hong* (哄, to coax or deceive to keep in good humor). As the daughter of one resident in Unit 1 put it, she had to "coax" her mom to get a haircut by telling her that she would not be able to continue getting showers if she did not get a haircut and the haircut was already paid for and was non-refundable (all of which was untrue). She said that in the past she would never be able to "coax" her mother like this, and she would never need to; her mother would have taken care of necessities like getting a haircut independently. In other words, older adults were like children because they did not know what was in their best interest and needed a caregiver to step in and tell, convince, deceive, or "coax" them to do what was right.

This understanding resonates with Julie Livingston's descriptions of care in an oncology center in Botswana when she writes:

> any medical system is built on the premise that patients cannot fully care for themselves. Therefore, paternalism in the sense of moral obligation inherent to the acknowledged, structural inequality between caregivers and care-receivers is necessary in order to

[44]老年人跟孩子一样

> provide care for those who are vulnerable. This extends to those who provide care in the home (relatives) as well as those who provide care in institutions (doctors and nurses). (Livingston 2012, 166)

And yet, at Summit Care, the hierarchy between care provider and care recipient was inflected with multiple, competing inequalities. Staff treating the older adults in the ward paternalistically made sense in terms of their physical and cognitive impairments, but it also seemed absurd given the clear socioeconomic power most of those older adults had relative to their caregivers. As in many caregiving settings in China and elsewhere, the residents in Unit 1 often were comparatively well educated, wealthy consumers (or at least family members of consumers) of the services staff offered. Relative to their caregivers, these older adults (either directly or via their adult children) theoretically had power in this setting. And yet, countless aspects of residents' daily lives in Unit 1 were decided on the whims of its staff.

The kind of care staff provided residents with in any given interaction related in part to how they perceived their relationship to the residents in that moment. If residents needed medical or hygiene related care, they were often treated as "patients" in need of *zhao liao* or *zhao gu*, respectively. If they resisted needed care, they could easily become treated "like children" in need of *hong.* If staff felt the need to be particularly respectful or cast residents as "clients" they were offered *fuwu*. When they were simply "residents" in the ward with no immediate needs, they required someone to look out for them and *guan*. While individual residents could receive different types of care from one moment to the next, I suggest they were effectively being "cast" by staff and family caregivers as different kinds of care recipients and that each casting related to different forms of care practices.

"A good life in old age"

Though I initially tried to translate "good care" directly as *suowei 'hao' de yanglao* (所谓'好'的养老, so called 'good' elder care), I ultimately chose to translate "good care" as *hao de laonian shenghuo* (好的老年生活, a good life in old age) when interacting with research participants. I chose this expression because I found that it seemed to anchor conversations about care in a clear end-point (achieving a "good life in old age"). In this way, it helped hold open many possible translations for "good care," allowing participants to explain which kinds of "good care" most resonated with them and their role(s) in Unit 1 as we discussed what they thought "good life in old age" might involve.

Looking more closely at the stories and experiences of a particular resident can help to illustrate some of what "good care" meant for daily practices beyond the limitations of what terms for describing it can capture individually.

Grandpa Fei

When I think about "good care" in Unit 1, so many of its discordant themes seem to echo through my friendship with Grandpa Fei – staff's attempts to balance residents' safety and wellbeing, families' shifting desires to shield their loved ones from threats and support them despite limited resources, my own conflicting desires to observe and enrich daily life in Unit 1. Thinking about Grandpa Fei also brings up my own insecurities about how to describe the friendship we developed and the impact it undoubtedly had on my perceptions, experiences, and writings related to Unit 1.

In his mid-eighties, Grandpa Fei had been a resident of the ward for over three years by the time I finished my fieldwork. He had moved into Unit 1 after a debilitating stroke highly impaired his speech and initially made it impossible for him to control the left side of his body and prevented him from walking. While living in the ward, Grandpa Fei attended physical therapy and speech therapy sessions several times a week. Slowly, he regained the ability to walk short distances with the help of a three-pronged cane and a nurse's aide. Though his speech remained difficult to understand, it too marginally improved. Grandpa Fei, in other words, could be seen as an excellent example of a resident who experienced significant physical benefits as a result of moving to Summit Care.

To my American eyes, Grandpa Fei's demeanor – always insisting on expressing his needs and demanding staff response – also made him seem like a kind of resilient success story for the ward. He religiously reminded staff to take him to his physical therapy sessions. He refused to wear an adult diaper and instead timed his water intake to align with a set schedule of bathroom breaks that he and his children had negotiated with Unit 1 staff. Not only that, but he then enforced this schedule (as best he could) by keeping a close eye on the large clock in Unit 1's main activity room and persistently calling out at the appointed times.

Grandpa Fei also had tools to support his agency in a way that other residents lacked. Unlike the majority of those living in Unit 1, Grandpa Fei had an old, "brick"-style cell phone that he used to call his adult children to ask when they were visiting next or to let them know he was running out of snacks or needed them to buy something for him. His physical therapy sessions offered not only a regular "activity" outside the ward, but also a series of exercises that he could busy himself with practicing as he sat in Unit 1 trying to pass the time.

And yet, despite his proactive approach to navigating the institution and the resources available to him, despite the fact that he actually had experienced physical improvements as a result of being in Unit 1, Grandpa Fei was miserable. For all his physical therapy and speech therapy sessions, Grandpa Fei primarily spent his waking hours staring out the unit's barred windows or attempting to nap in his chair for as long as he could until a staff member spotted him and nudged him awake. He was deeply depressed, sometimes saying that every day in the ward was the same, that he would rather be dead, and that there was no point living like this.

As the child of an affluent family in 1930's China, Grandpa Fei had been born into privilege and seen his opportunities and quality of life steadily decline over time[45]. His adult children explained that Grandpa Fei carried a bitter, lasting resentment over all that he and his family had lost and that it fueled his alcoholism and dysfunctional relationships with just about every person in his life -- his deceased wife, his children, and countless past colleagues at work. While in Unit 1, Grandpa Fei frequently was left to wait – sometimes for a few minutes, sometimes for up to half-an-hour – whether he called out for someone to refill his water cup or to take him to the bathroom. While some relatives would have insisted on staff being more responsive, Grandpa Fei's children were often more likely to empathize with staff complaints that Grandpa Fei was too demanding than they were to empathize with his complaints that staff were not meeting his needs.

[45] Like Jessica Robbins describes in her evocative ethnography of aging in Poland, Grandpa Fei also seemed to understand his life as story as "following a path that is tied to the life of the nation" (Robbins 2021, 15), though not always in a positive way. Many Unit 1 residents were deeply patriotic, however, and singing revolutionary songs that all of the residents had learned in their youth was a common (and generally well-received) group activity.

Stories of and as care

In the absence of being able to cure Grandpa Fei's medical issues and return him to a life of independence outside of Summit Care, people around him instead attempted to offer care through stories. His adult children knew that Grandpa Fei desperately wanted to return to his own home, and they initially nurtured that hope, promising that he would go home once he regained the ability to go to the bathroom without assistance. I saw this as a fictional story told to Grandpa Fei rather than a statement of fact because his adult children also explained to me one-on-one that they were confident their father would never be well enough to meet this agreed upon standard of independence. They also said that even if he somehow became well enough, they did not feel comfortable with him living alone, nor would they feel comfortable with him living with any of them. This meant Grandpa Fei was not going to leave Unit 1, regardless of how well his physical therapy did or did not progress. Though this story appeared to be well-intentioned, as the years passed, it seemed to become another weight for Grandpa Fei to carry. If the story was true, what was he still doing waking up every day in Unit 1?[46]

While Grandpa Fei's children and caregivers half-heartedly attempted to keep his spirits up, they also exchanged stories to support one another in their care of him. For example, in addition to telling Grandpa Fei the hopeful sounding story about his own capacity to recover, his adult children also offered stories to the Unit 1 staff to help them frame and process their interactions with him. It was Grandpa Fei's children who told staff that he had been raised in a

[46] This resonates with Seaman and Stone's argument that assessing the use of deception in care for people with dementia requires attention to the motives, modes, and outcomes of that deception (Seaman and Stone 2015, 67). In Grandpa Fei's case, while the motive (to calm and encourage him) and the mode (telling him he could go home once he was able to go to the bathroom independently) stayed the same, the deception produced both positive results (initially motivating Grandpa Fei in his physical therapy and leading to small, short-term improvements in his speech and mobility) and negative results (making Grandpa Fei feel increasingly depressed over time when the promised return home did not occur) (ibid, 68).

house with servants; a detail that was then used to cast Grandpa Fei as the unreasonable, unpleasable old man in the narration of his present circumstances. Sharing such information with staff seemed to be a way for Grandpa Fei's children to show care and support for the people working to meet his daily needs. It gave staff permission to ignore his requests if needed, and to scold him for calling out too frequently or too insistently for help with tasks they felt were not urgent or necessary. It also gave staff a way to make those actions (which were effectively part of their own self-care) compatible with the narrative that they were doing a good job. It reassured them that Grandpa Fei's children were satisfied with the care he received – so much so that they took the extra step of telling the staff that they knew their father would sometimes ask for too much and they felt staff could ignore his requests in those moments. Since Grandpa Fei's children ultimately had the power to decide whether or not he remained in the site, their satisfaction with the care being offered was a far more pressing concern for staff than Grandpa Fei's satisfaction[47].

And yet, I do not believe that Grandpa Fei's children were actually satisfied with Unit 1 staff to such a strong degree. Like several family members I spoke with, Grandpa Fei's children explained that they had even gone so far as to visit other care sites in the hope of finding a facility that could better meet his needs. Despite some frustrations with staff, they felt they could not move Grandpa Fei because so few of the local eldercare facilities were equipped to meet his medical needs related to his stroke. His children also accepted that no institution could offer perfect care. One of them even explained feeling that their father's difficulties in getting along with Unit 1 staff was in part because "my ability to restrain [him] is too weak"[48]. While physical restraints were a complicated part of many residents' care in Unit 1 (Chapter 4), Grandpa Fei's

[47] See Chapter 2 for more on the role family members played in assessing and shaping care practices in Unit 1.
[48] 我约束能力太差了

child was using the verb *yueshu* (约束, to restrain) metaphorically, describing difficulties with setting and maintaining boundaries while interacting with Grandpa Fei. When seen from this perspective, his children giving staff justifications for sometimes ignoring Grandpa Fei's demands can be understood as care for the staff and, by "restraining" him and pushing him to adjust his expectations for daily life in the ward, Grandpa Fei, as well.

Staff also told stories to Grandpa Fei's children as part of caring for him. One genre was stories about how difficult Grandpa Fei was. He rang his call bell 18 times in one night because he could not sleep. He demanded bathroom trips when staff were overwhelmed with diaper changes. He periodically refused to eat meals from the cafeteria because the sauce was too spicy. The moral of these stories often seemed to be underscoring just how committed and tolerant the staff were; how they were doing their best to meet the needs of an overly demanding man. Although these stories were about Grandpa Fei, their clear audience was his children. On one level, the stories conveyed that Grandpa Fei's basic needs were being met (care as *zhaogu*) and monitored (care as *guan*). Someone was paying attention to his night-time call bells and even tracking the number of times he rang, paying attention when he called out for a diaper change, and providing him with regular meals and monitoring his eating. In the context of these stories, any of Grandpa Fei's demands that staff were unable to meet often seemed to be presented as simply not in-line with the "services" (*fuwu*) that were possible in a busy ward. By centering his children as the primary audience of these stories, staff cast Grandpa Fei as no longer the sole, or even the most reliable, narrator of his own needs.

A particular kind of story: Pictures worth a thousand words

One set of practices related to story-telling and care in Unit 1 – for Grandpa Fei and for all residents – was taking, editing, and sharing photos of residents in a staff-managed WeChat group for Unit 1 family members. Just as Arthur Frank argues that through brochures, "Institutional medicine is asserting its preferred narrative" for patients' stories (Frank 2013 [1995], 79), in Unit 1 a preferred narrative was asserted not only through brochures like the ones quoted at the beginning of this chapter, but also through this family WeChat group.

WeChat has been described as, "the most popular social media platform in mainland China, with over 1 billion active users [worldwide]" (Luan et al. 2020, 1). Beyond combining aspects of Facebook, Instagram, texting, video chat, and blogging, WeChat also allows users to do everything from managing stock portfolios and medical information, to renting bicycles, doing online shopping or paying for produce from in-person vendors at local markets, ordering food to be delivered via app or paying for a meal in a restaurant, getting directions or sending real-time GPS coordinates of one's location, giving or sending money as a gift or to pay a bill, calling cabs or purchasing train, plane, and movie tickets. WeChat does it all. A WeChat group was therefore a natural option for staff to use when communicating with residents' families.

Beyond the family group, however, WeChat still offered many important communication channels for staff in Unit 1. There was a social WeChat group where staff could commiserate and discuss plans for future outings, group meals, and other social activities inside and outside the ward. There was a work group where staff could share updates about how patients were doing (including photos or video clips) or updates about family demands, issues in the ward, or reminders for the whole staff. There were countless sub-threads where groups of staff shared more candid conversations about work and life more generally with one another. There were

one-on-one threads between staff at all levels – nurse's aides, nurses, doctors, and leaders in the ward – with family members where individual residents' health updates or other more sensitive topics could be discussed in relative privacy[49]. Among these other options, the family WeChat group offered a place for the designated contact person for each resident to see daily updates about all the residents in the ward, as Unit 1 staff posted upbeat photos and information about how residents were doing.

Sitting in Unit 1 and watching these photos being taken was often a bit surreal. While staff sometimes caught residents in moments of genuine joy or connection – doing something cute like napping on a neighbor's shoulder – the photos shared in the family WeChat group were frequently highly staged. Staff would seek out a particular resident who needed to have a photo taken, adjust the resident's clothing and position in their seat (or ask another staff member to move them into a supported standing position), tidy the surroundings of wayward tissues and cups, perhaps add in a new prop like a newspaper or book for the resident to hold, and then begin offering cues like, "smile" or "look over here." Once a photo was taken, the staff member responsible would assess the image and sometimes edit it by adding a playful filter (e.g. images of sparkles or hearts around a resident's face or animal ears and whiskers over their face) or bring it to Unit 1 leadership for approval before posting it to the family group. In that process, a photo could be rejected and retaken if the resident did not seem sufficiently happy or if problems were identified with the way staff were behaving in the foreground or background of the image. For example, I once saw a photo rejected because, despite smiling faces as a staff person helped a resident walk down the hallway, the staff person's hand was not in the designated "safe"

[49] I say "relative privacy" because, in addition to the Chinese government having the ability to monitor information shared and stored on WeChat, it was not uncommon for screenshots of one-on-one interactions to be copied and shared in larger group threads by staff.

position on the resident's arm to keep them from falling if they accidentally stumbled. Such photos had to be retaken because, in the wrong hands, they could be used as evidence of bad care in a family member complaint.

While this may seem like a somewhat troubling falsification of images in a Euro-American setting, as Susan Blum writes:

> Moral evaluation of deception, rusing, lying, exaggeration, and all their cousins depends on their consequences and contexts. Unlike the first-order approximation in the United States, where such actions are automatically deplored, in the Chinese context we find no automatic criticism of these non-truthful actions. They can perhaps attain a higher good, relying on a higher notion of social truth or justice or welfare. Complex ruses may be admired for the planning, intelligence, cleverness, and knowledge that is required. (Blum 2007, 44)

Blum argues that while deception is part of human interaction everywhere, "there are also facets that are specific to China. Some of what is unique are (1) the domains in which deception is practiced and (2) the ways specific instances of deception are regarded in the context of other behavior" (Blum 2007, 135). Blum puts forward what she refers to as "guiding principles for China – at least for urban Han China" (ibid, 19), which are particularly useful for understanding WeChat images as stories of care in Unit 1. Blum writes that these "guiding principles" in China are:

> Consider consequences.
> Anticipate others' responses. (theory of mind)
> Give and save face.
> Consider power and role.
> Guard information.
> Select script.
> Keep track of inside and outside.
> Avoid transparency.
> Thicken interactions.
> Do the right thing in context.
> Consider bystanders.
> Take relationships as primary.

> Language is culture, not (only) nature.
> Performance counts.
> Proclaim loyalty and affiliation.
> Trust! And suspect. (Blum 2007, 19)

In the context of these principles, the staged and/or edited images of residents in Unit 1 become legible as stories where staff behaved morally in many ways. They considered consequences, anticipated others' responses, and considered power and role because, as staff, they needed to send images that were presented well so that families would not get upset and potentially exercise their power to file a complaint against the ward or move their loved ones to another site. They gave and saved face, did the right thing in context, considered bystanders (e.g. unknown third-parties to whom the images might be forwarded), and incorporated the idea that performance counts in and of itself because polished images reinforced that family members had made the right choice in bringing their loved ones to Unit 1 and that staff were doing well at their jobs because residents were shown to be thriving in the images (regardless of how representative those images were of residents' overall experiences). And they protected the ward by helping leadership to guard information (e.g. about times in residents' daily experiences when they were not thriving), to select a script (e.g. edit and select images that presented the ward how they wanted), to keep track of inside and outside (e.g. by creating a partially-monitored system for regulating which images were shared beyond those physically in the ward), to avoid transparency (e.g. by curating select images rather than offering constant access to images), and to thicken interactions (e.g. by creating a regular mechanism for staff to have positive interactions with family members about their loved ones' care).

The way these photos were shared suggests that staff prioritized the gaze and assessments of those outside the institution and particularly saw family members as important assessors of their work. Not only did they hope to make family members feel cared for by staging and sharing

positive images of residents with them, but they also saw family members as important potential threats to their institution, as poorly staged photos could be used as "evidence" of inadequate care in family complaints. This suggests that there was an intentionality behind the photos, but that it centered more on self-preservation among staff than a fully affective intentionality toward residents or their families.

Blum's framework for understanding moral evaluations of lies and deception in Chinese social interactions[50] is useful for understanding not only how these photos were taken, but also how residents' family members described receiving them. On the one hand, it was clear that residents' family members did not necessarily see the photos as accurate representations of daily life in the ward. As the relative of one resident told me, "I don't even look at these [photos] anymore"[51]. After struggling to find the right words, this person explained understanding that staff were posting photos to the WeChat group to "put families' minds at ease"[52] and thinking staff "do pretty well"[53] at achieving that goal through their posts. This family member then continued and said seeing the pictures being taken while visiting the ward led to the realization that, "when [staff] are taking the pictures, they…coax the old people, you know. Then suddenly when an old person smiles a little, [they] immediately snap a picture, just like that…actually [staff] want to put families' minds at ease, you know. I think it has this function. How the rest of the day really went, only they know that. We still don't know [that]"[54].

[50] Blum focuses specifically on lies and deceptions individuals tell one another in interpersonal exchanges, but I argue that her insights apply to the story-based communication that occurred verbally and through images in the family WeChat group in Unit 1, as well.
[51] "我现在都不看这些了"
[52] "让家人放心"
[53] "比较好"
[54] "他们照的时候，他们。。。哄老人嘛，然后突然老人一笑一下，马上就照一下，就这个。。。其实他们也是想让家人放心嘛，我觉得起了这个一个作用。其他的那一天是真的怎么样，那只有他们才知道，我们也不知道。"

In terms of daily care practices, the production and sharing of happy resident photos seemed to give this family member "peace of mind" by providing evidence that the resident pictured had been genuinely cared for in the photo staging process. Seeing a photo of a smiling loved one could tell families that their relative had experienced something that made him or her happy; it just could not tell them "how *the rest of the day* really went"[55]. While the residents' circumstances may have been improved briefly as a result of having their pictures taken, the primary recipient of the "care" such photos offered seemed to be residents' family members.

Knowing the photos were staged did not make the family member quoted above see them as immoral deceptions[56]. On the contrary, this person not only claimed to understand staff members' intentions behind sending the photos, but then even went on to praise staff as "do[ing] pretty well" in taking them. In other words, just as Blum's framework would suggest, this family member felt that *because* staff had staged the images (*performance counts*) staff had behaved morally and even shown respect (*give and save face*) and offered a kind of care to the family members by putting their "minds at ease" (*take relationships as primary*). That the family member felt staff "do pretty well" while also acknowledging that the photos are no indication of "how the day really went" simply conveys the family member's role as the optimistic yet skeptical recipient of the images (*Trust! And suspect*). Seen in this way, the one shortcoming of the photo-staging seems to be its inability to fully embody the care ideals the photos conveyed. When residents' family members physically visited the ward, they might see residents coaxed

[55] Emphasis added.

[56] Though Arthur Frank focuses on primarily on self-narratives, this point resonates with his argument that, "even edited stories remain true. The truth of stories is not only what *was* experienced, but equally what *becomes* experience in the telling and its reception" (Frank 2013 [1995], 22). This suggests that even for highly altered stories (in this case told through altered images), "The more reconstructed the story, the more powerful the truth of the *desire* for what is being told, as the corrected version of what was [or in the case of Unit 1, is currently being] lived" (ibid).

into particular kinds of images (a failure to *keep track of inside and outside*), and the gap between what the photos showed and what residents experienced immediately beforehand would become apparent.

Recent research on health information sharing on WeChat among older adults in China suggests similar dynamics at play. Specifically, it shows that the credibility of health information did not always impact whether or not older adults shared it (W. Wang, Zhuang, and Shao 2020). Sometimes the act of sharing is more meaningful than the content of that which is shared. This can be true whether one's goal is to *give and save face,* to *thicken interactions*, to *do the right thing in context*, to *take relationships as primary*, or simply because it allows one to perform concern for another person and *performance counts*. Seen through this lens, the "gift-like" (ibid, 10) act of communicating via photos in the Unit 1 family WeChat group becomes legible as a tool for strengthening staff relationships with residents' families, and for families in turn to strengthen relationships with people in their wider social circles. This was the case regardless of how representative such photos were.

By creating idealized depictions of life in Unit 1, the photos shared in the family WeChat group offered a way for staff to provide care to residents' families, and arguably to residents themselves. Blum writes:

> In everyday contemporary contexts, *cheng* ('sincerity') and *chengshi* (also 'sincere') signify not necessarily honesty and truthfulness, but rather a moral stance that suggests willingness to be taught by appropriate authorities, and a kind of humility, a stance toward one's expected role…It can mean *sounding* sincere and heartfelt – which is not to say the performance has to belie a match with real thoughts and feelings, nor does it require such a match. What is crucial is the performance; a match with internal states is incidental (*Performance counts.*) (Blum 2007, 193-194)

To the extent that residents, families, and staff felt the photos had been taken in ways that *appeared* "sincere and heartfelt," they could be perceived as sincere and moral acts. For families,

these images additionally offered a concrete tool for strengthening their relationships in their own social networks because they could then circulate these happy photos as evidence that their loved ones were doing well in Unit 1. Even one of Grandpa Fei's children told me that photos staff took of me and him sitting together were frequently shared in the family WeChat group[57] and that his children would regularly forward them on to their more extended family to show them how well their father was doing.

An ethnographer's story

Throughout this dissertation, I struggle with what Arthur Frank describes as, "the question of what can be said about a story of primary witness, and to what extent the story has to be left to speak for itself" (Frank 2013 [1995], 22-23). Unit 1's story would be told very differently if it was written by a person on staff, or by a family member of a resident, or by a resident. And yet, in addition to telling my experiences of Unit 1 through this dissertation, it also feels important to reflect on ways I too was entangled in attempts to provide care through stories while in Unit 1. This was especially true when it came to my interactions with Grandpa Fei. Though I followed staff in referring to him as "Grandpa Fei" when I was in the ward, when I mentioned him to people in my life back home, I used a more emotionally accurate shorthand and simply called him, "my friend guy."

For months, I sat beside (or at least nearby) Grandpa Fei as I observed the main activity room in Unit 1. In a space where so many residents tended to look around the room without seeming to follow what was happening, Grandpa Fei's focused and persistent eye contact stood

[57] Because I was never added to this group, I relied on staff and family descriptions of it and times when staff or family members would show me exchanges taking place in it on their phones.

out. After looking up from my notebook several times to see him staring at me early in my fieldwork, I went over to ask how he was doing. As the months went by, I slowly got to know Grandpa Fei and tried to help him when I could. When his cellphone charger broke, and he felt like the staff and his children were not replacing it fast enough, I prodded them to see if they had made progress toward acquiring a new one. When he left for physical therapy appointments in another ward, I joined the residents who sat near him in keeping an eye on the possessions he left to save his place at one of the ward's large tables. In the long stretches of unscheduled, institutional time, we chatted. I shared pictures from my life in the United States, created English language practice sheets for us to go through on pages of my notebook, played puzzle games I had learned on the bus to summer camp as a child, and spoke with Grandpa Fei about his life before and outside the place where we sat. Though I made an effort to get to know and support many of the residents in Unit 1, Grandpa Fei became one of my closest contacts.

One day, after asking my usual opening questions – "How are you today?" "Have you eaten?" "Did you sleep well last night?" – and receiving Grandpa Fei's usual replies – "Fine." "Yes." "No." – it occurred to me to ask if he had had difficulty sleeping before coming to Summit Care. He told me that, yes, for many years, he regularly failed to sleep through the night. But, it used to not be a problem, he said, because he would wake up, go to his computer, and play *weiqi* (围棋, literally "surrounding chess") online until he either fell back asleep or simply passed enough time until he could start his day.

Wei qi is commonly referred to in English as "Go," a name derived from its Japanese name igo (囲碁). The American Go Association answers the question "What is Go?" with the paragraph:

> Go is [an] ancient board game which takes simple elements: line and circle, black and white, stone and wood, combines them with simple rules and generates subtleties which have enthralled players for millennia…Draws are rare, and a typical game retains a fluidity and dynamism far longer than comparable games. An early mistake can be made up, used to advantage, or reversed as the game progresses. There is no simple procedure to turn a clear lead into a victory -- only continued good play. The game rewards patience and balance over aggression and greed; the balance of influence and territory may shift many times in the course of a game, and a strong player must be prepared to be flexible but resolute. Go thinking seems more lateral than linear, less dependent on logical deduction, and more reliant on a "feel" for the stones, a "sense" of shape, a gestalt perception of the game. ("What Is Go?" 2021)

While a game won through "gestalt perception" might seem like an intriguing addition to a dementia care ward, the need for "patience and balance," for "continued good play" as one keeps track of a complex and ever-changing board, offers a less natural match.

In any case, there was no Go set in the ward and no way for Grandpa Fei to access a computer to play electronically. Now when he could not sleep, Grandpa Fei just lay awake uncomfortably in bed unless the staff agreed to give him sleep medicine[58]. In my naïveté, when I learned about Grandpa Fei's previous hobby, I immediately found a small, inexpensive Go set online and asked staff if I could give it to the ward. Initially, they were concerned that the small game pieces could become choking hazards. However, they ultimately decided they could keep it in a locked drawer in the ward's activity room and simply take it out if residents like Grandpa Fei wanted to use it during supervised down time. When I first showed Grandpa Fei the set, he seemed reluctant to even look at it. And yet, when I asked if he wanted to play, he nodded "yes." With that, we began frequent, albeit limited, lessons in Go and *wuziqi* (五子棋, literally "five son chess," a far simpler connect-five game played with the same board and pieces as Go).

[58] Grandpa Fei told me he needed sleep medicine, and when he took it the medicine usually worked, but staff often refused to give it to him. Staff explained that while there was a sleep medication they gave him on occasion, they usually refused to give him anything or simply gave him a sugar pill placebo because they were worried about him developing too high a tolerance for the real medication.

Though I quickly got to a point where I could match Grandpa Fei in *wuziqi*, we always struggled with Go. Despite many attempts and the best intentions, I could not seem to grasp the nuances of the game. After frustrating efforts to make sense of Grandpa Fei's cryptic instructions – "you have to play defense *and* offense," "you'll lose players if you go there" – I began watching online videos, looking for Go tutorial phone apps, and browsing for Go books. Though Grandpa Fei's explanations were sometimes difficult to understand because of his difficulty enunciating after his stroke, I tried my best to learn, and he tried his best to teach me.

Even after it became clear that we were unlikely to ever be well-matched at Go, we continued to play, and our playing provoked what I came to see as meaningful reactions from those around us. Residents (particularly new male residents) would periodically stand over our table and watch our games, much as I imagined they might have done in public parks before coming to Summit Care. The older, more lucid women who sat near Grandpa Fei in the main room would periodically comment on how smart he was – they had never learned to play Go, and what they perceived as his ability to play (in addition to his ability to speak and read some English when talking with their resident anthropologist) seemed to raise him in their estimation. When Grandpa Fei's daughter saw me playing with him on one visit, she said, in what seemed to be an incredulous and hurt tone, that he had never been willing to teach her. I learned from her that in his child rearing years Grandpa Fei had felt Go was a game for boys (and for all I know my difficulties grasping it only reinforced that idea as he sat in Unit 1). After one of his sons repeatedly saw us playing together he told me that his father taught him to play when he was young but had always been a harsh critic. According to his son, Grandpa Fei had lost the ability to play Go well following his stroke. Like the many photographs shared in the family WeChat group, images of Grandpa Fei and me playing Go seemed to capture many possible stories –

about who our onlookers were and who each of us was, as well. But, like the residents in the photographs, I was only part of such stories, rather than the narrator of them (at least, until now).

When I told stories about our Go games it was because staff and visitors coming through Unit 1 saw us playing and asked me (as if Grandpa Fei were not there): "Can he really play?" Every time this question came up, I immediately answered, "Yes! He's really good. He beats me all the time." For some, this elicited replies (now directed at Grandpa Fei) like "Not bad!" or "Really impressive!" Other people would stay and watch us for a few moments, as if to see for themselves whether or not he could "really" play. More often than not, these passersby would give some sign of acknowledgment to me, a smile and nod or a faux impressed (perhaps pandering?) exclamation of "Wa!" before going about their business without interacting with Grandpa Fei at all. Considered in relation to Blum's analysis of deception in Chinese social interactions, I see the intensity of my responses to this question as what Blum describes as, "performing praise" where one exaggerates in a moral effort to "consider bystanders" and "cause witnesses to perceive the praised person's merit" (Blum 2007, 52). As Blum explains, in such situations, "It is not sufficient to say what one would have said if alone in a room" (ibid).

These interactions always stood out to me because they echoed the other kind of question staff and visitors to the ward frequently asked me about my interactions with Grandpa Fei: "Can you really understand him?" On the one hand, this was a reasonable query. As a 20-something, visibly non-Chinese woman, I could not fault anyone who happened upon me sitting in Unit 1 for wondering whether or not I really understood the mixture of Mandarin and Sichuanese swirling around me. While nearly a decade of language study and years of living in Sichuan on and off did in fact allow me to understand the vast majority of what was being said, there would have been no way for someone who saw me sitting with Unit 1 residents to know that.

However, the question was not asked "Can *you* really understand him?" so much as "Can you really understand *him*?" On the surface, this, too, was fair. Grandpa Fei's speech had been significantly impaired by his stroke. He spoke slowly and struggled to enunciate and to project his voice without yelling. As a result, multiple staff members initially told me that he "could not communicate." Over time, I began to see such statements more as a commentary on Grandpa Fei's environment than on his ability to speak and be understood. It seemed to me that staff could not understand Grandpa Fei because they often did not have the time to listen carefully to what he was saying. I, who had the luxury of boundless and unstructured time, could sit and patiently wait for Grandpa Fei to form words. If I was unsure of what I had heard, I could take a moment to repeat it back to him followed by "is that right?" so he could easily say or even just nod "yes" or "no" to confirm. And, because I spent time talking with him, over time, I became more used to his pronunciation, making it steadily easier to continue talking with him.

Having experienced this change in my own ability to understand and communicate with Grandpa Fei over time, I felt frustrated by staff claims that he simply could not be understood. In the same way that passersby would ask me if Grandpa Fei could "really play" Go, staff asking if I could "really understand" him seemed like attempts to recast him from being the narrator of his own story to a passive pawn within it, as if people were asking permission to disregard whatever preferences or experiences he might voice.

At the same time, looking back on these interactions now, I wonder if the real aim of these questions was for those who saw the two of us interacting to better hone their own approaches to his care. Was he "an old person like a child" who needed to be "coaxed" and protected from inadvertently acting against his own best interests? (In which case, were my adamant claims that he could still play Go simply interpreted as paternalistic white lies told to

encourage a child?) Was he an "elder" or consumer to be "served or provided with care/services"? Was he a patient who needed medical treatment? Many types of residents lived in Unit 1, and part of the work of caring for them thus inherently became identifying or "casting" each as a particular kind of "old person" from one moment to the next. While Grandpa Fei's care needs were constantly in flux, I began to see staff and visitor questions about his abilities as attempts at calibrating how they should interpret, engage with, or retell stories of his care.

Still, when people asked me "Can he really play?" I could not help but wonder: What answer did they expect? There I was, clearly sitting next to Grandpa Fei, clearly at least attempting to play a game of Go with him. Did they imagine I might say, "no"? Did they assume that he was so far gone, and I so knowledgeable that I might confidently reply, "No, not really. I try, but he's not getting it"? Their question seemed to imply that I could judge what Grandpa Fei could and could not do and would not reply, "How should I know?" or "I don't know. I'm still trying to figure out the rules" even though, especially early on, that would have been an honest answer. Like his care in Unit 1, Grandpa Fei's ability to play Go depended on who one asked. I could genuinely tell the story of his prowess, just as a brochure for the facility reasonably could have highlighted the initial improvement in his physical abilities as signs of good care in the ward. His sons genuinely could have told stories of his decline, his post-stroke inability to play Go, and the need for him to adjust his expectations and "restrain" himself to the point that he could accept and adapt to the more limited offerings of institutional life (even as they gave him empty promises of someday returning home). Staff could engage with those around him in honest attempts to gauge whether and to what extent their daily work of meeting his needs should involve directly interacting with him. The reality of Grandpa Fei's circumstances – whether or not he really had physically improved while living in the ward, whether or not he

really could play Go, whether or not his speech really was difficult to understand –depended on who one asked and which interactions one happened to observe.

Conclusion

When I first brought the Go set to Summit Care, I imagined Grandpa Fei playing with staff, visitors, (when possible) other residents, or perhaps even against himself when I was not there. Just as I had entered Summit Care eager to help staff identify and respond to opportunities for offering even more "good care," I had hoped that learning about Grandpa Fei's previous hobby and providing staff with a tool for engaging it would naturally lead to its resurrection. The reality, as far as I am aware, was that the Go set primarily stayed locked in the drawer where it was first placed. The staff were too busy to play with him, and even if they had time, many did not know how to play Go and had no interest in struggling to learn from Grandpa Fei.

The only times the Go set got used were when I borrowed the key ring from the nurse's station and retrieved it to play with Grandpa Fei during my visits and, as staff told me, one time when a young group of volunteers came to the ward. During that visit, one of the young men in the volunteer group agreed to play Go with Grandpa Fei after the staff asked him. Apparently, the volunteer brashly and easily won. Afterwards Grandpa Fei was reticent to play. As frustrated as I was when I learned what happened, I realized that my story was partially to blame. Perhaps if I had not tried to care for Grandpa Fei by insisting on his continued ability to play Go, the staff would not have asked a volunteer to play with him, or at least the volunteer might have approached the game with more compassion for his competitor. For Grandpa Fei and me, playing Go offered what Felicity Aulino might identify as a ritualized part of the "care in the everyday" because it allowed us "a way of acting *as if* the world were a certain way, even when faced with

uncertainty or contradictory evidence" (Aulino 2019, 35). Our failed but continuously attempted matches gave us a way to connect not just in the moment but to something that had been meaningful to Grandpa Fei in the past. As Blum argues, the "performance counted," and, as we attempted a game, we also could "give and save face" simply by maintaining the perception that our attempt was valid. Unfortunately, when we could not "keep track of inside and outside," when a volunteer with his own relationships and priorities entered into the equation, it felt like a challenge to the morality of my decisions to praise and support Grandpa Fei's Go playing. The tangible impact of my care-full story on actual practices within the ward suddenly seemed unruly.

As a researcher, my struggles to cater to different audiences were entangled with those of the people around me – staff, residents, and families, alike – just like theirs were. As Arthur Frank writes, "The self is being *formed* in what is told" through self-narratives (Frank 2013 [1995], 55), so too I would argue that care is "formed" or enacted through the stories told by those who engage in it. Though we all – staff, residents, families, and me – had our own priorities when it came to which forms of care mattered most, we also shaped one another's understandings and practices of care through our own stories about it. Care, in other words, had a multitude of audiences, recipients, and providers, all defining it differently and calibrating their definitions in tandem based, at least in part, on one another's actions. We were each other's audiences, recipients, and providers of care in different ways and at different points in time. Care in Unit 1, whatever else it was, was a constantly shifting balance of needs and priorities that were actively negotiated through the stories we told.

Like Sarah Pinto, I am reminded that "to call [these] stories or to emphasize their coherence is to miss what may be among their most important messages to us – that stories can

fail to hold together, and that there are things to be learned in the specific ways they fall apart" (Pinto 2014, 31). The truth is: even after months of periodically playing with Grandpa Fei, I could not say whether our struggles to successfully complete a game of Go were due more to his inability to explain the rules or my inability to match the depth to which he understood them. The truth is: it felt good to "play" even with only a shadowy grasp on the game. The truth is: we played because it gave us something to do. The truth is: I am not sure why we kept playing after it became clear that, whatever the reason, we were not a match for one another in the game. The truth is: I miss "my friend guy," and I wish I could show him how much better I have gotten at playing Go since returning to the US and finding more English language tutorials. The truth is: the more I play, the more his initially inscrutable directions make sense. "You have to play offense *and* defense." I'm finally getting it, and it makes me sad that I cannot tell him that.

The moral of this chapter's story is: How one understood care in Unit 1 depended on how one understood those participating in it.

CHAPTER 2: *Mei banfa* and Stretching the Flexible Institution

Overview

Building on the previous discussion of how "good care" was understood and narrated in Unit 1, in this chapter I look more closely at why and how such a wide range of daily care practices became normalized for different residents in the ward. I focus on the experiences of two residents – Granny Li and Luo Jinsheng – who each received dramatically different levels of care despite living in the same environment and being cared for by the same staff. Their stories illustrate the way residents and families stretched the boundaries of Unit 1's care and in so doing produced a flexible institution where multiple, dynamically negotiated care standards could operate simultaneously within one site. By exploring why some resident needs were met with concrete interventions while others were dismissed as *mei banfa* (没办法, nothing to be done), I argue that Unit 1's ability to meet a wide range of care needs as a flexible institution ultimately also required and reinforced a *mei banfa* ethics of engagement (Kulick and Rydström 2015, 17) among caregivers – both family and staff. The state's limited involvement in providing eldercare created an opening for caregivers to use *mei banfa* as a justification, prioritizing institutional needs when the needs of patients or families threatened institutional stability or access to resources.

Granny Li

Li Shulan, or Granny Li as staff often referred to her, was a kind, heavyset, short woman with a warm smile and a short temper. Already in her eighties when I met her in 2015, Granny Li seemed to have mild to moderate dementia, and often enjoyed sitting and chatting with a handful

of three to five of the other more talkative women living in Unit 1. Having spent most of her career as a policewoman married to a policeman and having raised three children, Granny Li had a clear sense of how she thought things "should" be done. As her daughter put it when I asked how she would describe Granny Li, "My mom…is a very stubborn old lady…no matter what it is, if she thinks something is correct, then [it's correct]…from another perspective, before, ah, throughout her life, she [was conscientious in her work], and also, just for everything, one meant one, and two meant two. She didn't twist things around. She's this kind of old lady"[59]. Within Unit 1, Granny Li spent most of her days sitting in the same spot at one of the large tables in the main activity room. She preferred activities that were, as she put it, *you yong* (有用, useful) or focused on *xuexi* (学习, studying) and particularly enjoyed practicing calligraphy and doing addition/subtraction math flashcards. Though she could walk very short distances with assistance, any time she moved between locations within the ward, it was via a wheelchair her family had provided and made sure to always store behind a potted plant in the main activity room so that she could keep an eye on it from her spot at the table.

Granny Li's children had a tremendous impact on her care, and she almost always had at least one of them by her side while living in Unit 1. In fact, when Granny Li had a cold, her children began a 24/7 rotation, with Granny Li's youngest son sleeping in a hospital bed next to her or in a bed in one of Unit 1's small activity rooms[60]. Her oldest son and her daughter would

[59] 我妈。。。就是一个很执拗的老太太。。。什么事儿反正只要她认为是对的，就是对的。。。从另外一个角度来说，她过去哈、她的一生当中，她的工作很认真，而且呢，就是对什么事儿都是一是一，二是二，不会转弯，就是这种老太太。

[60] When Granny Li's son first requested to sleep in the ward overnight, one of the beds in her room was unoccupied, and he was allowed to sleep there. Over time, some of Granny Li's roommates objected to having a man sleeping in their all-female room, and staff found his presence increasingly annoying as they tried to carry out their nightly room checks (every half hour) without disturbing him. When a new female resident was assigned to the previously open bed in Granny Li's room, her son moved to the open bed in one of the small activity rooms down the hall. However, staff had originally used this bed to nap in themselves, and eventually were able to

then alternate their visits to ensure that one of her children was always present during the day as well. While visiting, Granny Li's children would talk with other residents, staff, and family members. They also encouraged Granny Li to work on physical therapy (and did exercises with her), regularly took her downstairs to sit in the Summit Care courtyard, and periodically helped with meals, cleaning, and showering for Granny Li[61]. Despite multiple staff (from doctors, to nurses, to nurse's aides) telling me that tea was not provided to residents in the ward because it was bad for old people's health[62], Granny Li's children frequently brought her a thermos of uncaffeinated herbal tea that they kept on the table in front of her, sitting between her tissue package and her thermos of hot water. In the winter, she had extra layers of warm clothes that were added and removed throughout the day whenever she said she was feeling cold or when one of her children felt the back of her neck and determined she was sweating. Her children regularly brought her special snacks, and periodically paid for her to have massages and other Traditional Chinese Medicine treatments in the ward. Unsurprisingly, given the almost constant presence of her adult children in the ward, Unit 1 staff also regularly checked on Granny Li throughout the day – chatting with her, teasing her, or simply coming by to affectionately pat her arms or face. Of all the residents in Unit 1, Granny Li received the most intensely personalized care.

In the course of her care, a somewhat strained relationship developed between the Unit 1 staff and Granny Li's children. When I asked staff about difficulties they had experienced with residents' family members on the ward, many staff mentioned Granny Li's children, singling out her sons, in particular. Several staff members described feeling like they were not trusted to do

---

convince Granny Li's son that it would be better *for her* if she was not constantly expecting him to be in the ward at night and looking for him, so he resumed visiting her only during the day.

[61] While Granny Li's sons tended to do physical exercises with her, her daughter tended to help more with tasks related to cleaning or bodily care. Her daughter also tended to form deeper relationships with the other residents who sat near Granny Li and with their family members.

[62] 对老人的身体不好

their jobs when Granny Li's youngest son began sleeping on the ward (which his sister later confirmed was indeed the case when I interviewed her). And yet, staff also mentioned Granny Li's daughter as an example of a family member who added to the ward and helped them. Collectively, her children walked a line between making demands on the institution – stretching the institutional boundaries of what services it provided – and accepting that institutional resources were limited and a service like *yi dui yi* (一对一, one-on-one) care would only be possible for their mother if they provided it themselves. The extent to which the relationship between Granny Li's children and the staff was strained became fully apparent once Summit Care opened its VIP ward, and Granny Li's children almost immediately had her transferred there. Once this happened, both staff in Unit 1 and Granny Li's children began describing their experiences of her time in Unit 1 in more negative terms. Her daughter said that though she understood that the staff were tired and not paid enough, the nursing care in Unit 1 was unacceptably poor, and many of the staff did not pay attention to residents' hygiene enough or take their work seriously enough. Staff in Unit 1 said they felt like Granny Li's children had always been dissatisfied with their care even though the staff had tried to accommodate their demands as best as they could.

Luo Jinsheng

If Granny Li's care was at one extreme in terms of how personalized and attentive it was, Luo Jinsheng received care at the other end of the spectrum. Luo Jinsheng was in his eighties, nearly blind, nearly deaf, just under five feet tall, very thin, and legally considered to be an "orphan elder" because he had never married or had children. Despite this legal designation, Luo Jinsheng's younger sister coordinated and oversaw his care. As she explained it, Luo Jinsheng

needed to live in Unit 1 for his own safety. Not only did Unit 1 have a higher staff-to-resident-ratio than other wards in Summit Care, but, as a dementia care ward, it also had the crucial added features of automatically locking metal doors and barred windows. Given Luo Jinsheng's propensity to wander, these were essential safety features for his care. However, because Luo Jinsheng's siblings could not afford Unit 1's fees[63], hospital leadership had initially refused him entry. After nearly two years of negotiation, he was allowed to live in Unit 1 at two-thirds the monthly rate, and his sister was ecstatic.

Despite his sister's satisfaction, Luo Jinsheng often appeared to be having or causing issues on the ward. The combination of being virtually blind and virtually deaf while constantly wandering meant that Luo Jinsheng was frequently injured. Sometimes he would be bruised or limping after tripping and falling over an unseen piece of furniture or another resident. Sometimes he would have scabs or cuts on his forehead. More often, it seemed like his eyes were simply watering as he slowly walked up and down the ward's long hallway, alone, sometimes muttering to himself, with his hand stretched out in front of him. This sad description is not to say that Luo Jinsheng was without agency. The degree to which he and his wandering annoyed staff and residents alike, was a testament to his agency. No other residents were as effective at escaping physical restraints, and even the most intensive staff attempts to stop his wandering often failed. Even with this agentive resilience, however, Luo Jinsheng often appeared to have significant unmet needs, and family members of other residents sometimes described him as *hen kelian* (很可怜, very pitiable).

[63] The money to pay his medical bills came from a property that should have been their collective inheritance.

Despite appearing to me and family members of *other* residents as experiencing clear unmet needs – or "suffering"[64] – Luo Jinsheng rarely seemed to receive empathy from the facility's staff. Though one older nurse's aide would occasionally sit with Luo Jinsheng, I almost never saw staff attempt to talk with him beyond shouting simple phrases like "time to eat!" into his ear before steering him toward the main activity room. My attempts to interact with Luo Jinsheng were often met by staff with amused confusion. On one of his particularly agitated days, for example, I joined his wandering in an attempt to help calm him down. He took my hand, and we walked together hand-in-hand for nearly an hour, up and down the ward's long hallway. Staff looked at us with quizzical expressions and joked that it was Luo Jinsheng's lucky day having a beautiful girl on his arm like that. To these staff members, Luo Jinsheng's behavior earlier that day had been unremarkable. To me, it had seemed like a cry for comfort and reassurance, and it had also seemed like his body language became calmer as we walked.

When I interviewed Luo Jinsheng's sister, she described him, saying, "I feel like now he's even more fortunate than a normal person"[65]. Comparing him to other residents in the ward with adult children, she continued, "[these] parents are longing for their children to come, [and their children] don't come for a long time. I think [they] aren't as fortunate as my brother"[66]. When I asked why she thought they were not as fortunate as her brother, she explained that it was because, "there are lots of people caring about him. Also his cognitive impairment…He

[64] There is a long and rich history of studies of suffering within Medical Anthropology (Das 2007; Good et al. 1994; Kleinman 1988; Livingston 2012), and for anyone taking seriously the body language and behaviors of residents like Luo Jinsheng, Unit 1 could easily be described as a site of suffering. I am more interested, however, in how the unmet need conveyed by these residents' body language and behaviors seemingly became what Carolyn Rouse might call "uncertain" for some people in their care environment but not others (Rouse 2009). With the simultaneous coexistence of seemingly needed, seemingly desired, and seemingly lacking care, I want to constantly stay mindful about the question: what does it "do" for us to identify and label people's experiences as "cared for" or "suffering" – or not?

[65] 我感觉他比常人都幸福现在

[66] 父母盼望儿女来，半天不来，我觉得他(们)没有我的哥哥幸福

lives in his own world"[67]. Given how frequently Luo Jinsheng appeared to be upset, socially isolated, physically unclean, and/or injured, it is striking that his sister would describe him as "fortunate" at all, let alone "even more fortunate than a normal person." The crux of her argument for why this is the case seems to come at the end of her statement: her brother was more fortunate than the other residents or a "normal person" because of his cognitive impairment. Though the vast majority of older adults in Unit 1 were also cognitively impaired, she distinguishes *his* experience as, "He lives in his own world."

As his sister told it, Luo Jinsheng's cognitive impairments made him incapable of engaging with the world beyond himself in the first place. In this way, she described him as non-suffering or "fortunate" almost by default. A key component of the context here is that she believed she had already done all she could for him, whereas the residents she identified as being *less fortunate* were experiencing something that could, at least in theory, be ameliorated. If their children visited, then that would demonstrate that they were fortunate as parents. Luo Jinsheng, however, was "in his own world" regardless of what anyone else did or did not do.

In Unit 1, as a flexible institution, "variability in treatment"[68] operated hand-in-hand with caregivers (staff and families, alike) responding to certain expressed needs as beyond the scope of care they could reasonably provide. Though a single fall would have been an extremely serious event for a resident like Granny Li, Luo Jinsheng tripped or fell somewhat regularly. The difference was that while families like Granny Li's demanded care for a wider range of issues, Luo Jinsheng's sister was so relieved to have gotten her brother admitted into Unit 1 in the first place, that she seemed hesitant to make additional demands about his daily care within the ward.

[67]有很多人在关心他。还有他的这个智力障碍。。。他是活在他世界里面

[68] Carolyn Rouse's study of Sickle Cell patients in the United States illustrates a similar dynamic. As she puts it, "Uncertainties in medicine allow for variability in treatment access" (Rouse 2009, x-xi).

With no family demands for additional care, Luo Jinsheng's remaining, unmet needs went unacknowledged, or even illegible as needs altogether.

In her ethnographic study of a Botswana cancer ward, Julie Livingston writes, "pain begs a response" (Livingston 2012, 121). But in Luo Jinsheng's case, that did not always seem true. Staff, for example, were often unfazed or simply annoyed by his wandering and his tearful and pained facial expressions. For me, the American ethnographer, and for some of the family members of other residents, there was perhaps more room to respond emotionally to Luo Jinsheng's situation. The difference, I would argue, was caused in large part by whether, and to what extent, one believed his situation could be improved.

Preconditions for differentiated care in Unit 1

In part, the drastic differences in Granny Li's and Luo Jinsheng's daily care in Unit 1 stem from China's broader elder care landscape at the time of this research (2015-2019). There was (and today, in 2021, still is) tremendous public and private interest and investment in developing and expanding elder care infrastructure within China. One consequence of so much ongoing change – simultaneously building care infrastructure, developing educational and professionalization programs, experimenting with new laws and health care policies, etc. – is opacity around defining and enforcing regulatory standards.

I saw this difficulty play out in real time when government regulatory agencies came to evaluate Unit 1 and Summit Care during my fieldwork. I stayed in Unit 1's main activity room during one of these visits and was not in the ward during the second, so my direct observations of them were limited. However, based on my observations and Unit 1's staff descriptions, these

visits were highly performative[69]. Staff knew weeks in advance when regulators were going to visit the wards, and were on-edge when the day of a visit finally arrived. The day I observed a visit, leaders in Unit 1 messaged back and forth with leaders on other wards in the hospital, checking to see what kinds of questions the examiners were asking, and how those in other wards felt they had done in their examinations. In the lead up to the second visit during my fieldwork, nursing staff in Unit 1 spent days preparing documentation and making sure their patient records were complete and neat because they thought examiners might ask to see their forms. When the day of the visit finally arrived, examiners' limited time on the ward was spent testing nurses' skills and knowledge of things like how to appropriately wash one's hands (there was a seven-step system). When it came to interacting with residents, they spent most of their time focused on a single, bedridden resident at one end of the ward, seemingly without trying to get a sense of the experiences of the approximately 45 people living there at the time. The regulators' focus, as staff described it to me, was on observing residents' physical states and looking for things like bed sores or dirty skin or clothing. There was only a cursory observation of how staff related to the residents in the main activity room, despite the fact that this was where the majority of residents spent the majority of their days and where much of staff members' interactions with residents occurred.

Even within Summit Care itself, administrative oversight often could feel disconnected from care practices within the Unit 1 ward. One primary mechanism for oversight was a weekly meeting between hospital administrators and the head nurses of each ward in Summit Care. The goal of these meetings was to share information about the hospital as a whole, discuss especially difficult cases, and give the administrators an opportunity to praise or critique different wards

[69] See the discussion of Susan Blum's work in Chapter 1.

and set priorities for what the leaders in each ward should focus on over the next week. The day after these meetings, the morning shift change in Unit 1 was always especially long (approximately 40 minutes to an hour instead of the usual 20 to 30 minutes) as the head nurse read out her notes to share information from the previous hospital-wide meeting with Unit 1's staff. Often, one of the hospital administrators would also attend this extended shift change meeting in Unit 1 and emphasize particular points the head nurse mentioned. Despite the staff's sober and sincere demeanors as they listened to the list of things they should be doing better[70] during these meetings, more often than not, the ward's true priorities were set immediately after the shift change meetings. This was when Unit 1 leadership identified which agenda items needed to be addressed and which could (at least for the time being) be ignored in a short (usually three minutes or less) conversation with staff crowded together at the nurse's station.

The lack of externally enforced care standards in Unit 1 played a direct role in leaving daily care practices more flexible and open to negotiation. Residents' family members were often the ones engaged in these negotiations with staff, since day-to-day care within the ward was primarily assessed, overseen, and regulated by residents' families. For Granny Li, Luo Jinsheng, and the other residents, family members became the arbiters of what did or did not constitute acceptable care for their loved ones in Unit 1. Staff provided all residents with a baseline level of care. Based on what I observed, that included, among others, the following services for Unit 1 residents:

- One bed in a communal, gender segregated (male or female) room with 4-7 beds total
- Living in a locked, somewhat temperature-regulated, medical ward that was physically separated from the rest of Summit Care and from the outside world

[70] This could include, among other things, filling out paperwork incorrectly, not washing hands in the prescribed way, not paying enough attention to addressing particular family members' complaints about hygiene or daily care practices related to their loved ones, spending time on cell phones in front of family members, and being chastised for decreases in particular residents' health status (e.g. a resident's bed sores worsening, a skin infection passing through a ward, etc.).

- 3 hot meals a day (plus soup before lunch), mass prepared by the Summit Care cafeteria staff and delivered to the ward at prearranged meal times in metal trays or bowls
- Boiled, hot water for drinking provided at least 5 times each day
- Laundry services for clothing and bedding
- Staff checks and assistance (as needed) for going to the bathroom at least 5 times per day (once when waking up, once after breakfast, once in the early afternoon, once after dinner, and once before bed)
- Staff checks and assistance (again, as needed) with basic hygiene including showering on a set schedule (this varied depending on the season), clipping finger nails and toe nails on a pre-set schedule, basic haircuts, shaving for men, and changing clothes once staff identified that a resident had soiled his or her clothing
- The opportunity to attend daily morning and afternoon group activities in the ward, attend special event activities for birthdays and holidays, and be present for group TV time in the ward's main activity room
- Staff coordination of daily medications, managing chronic illnesses like diabetes with daily blood sugar monitoring and insulin, and treating minor acute illnesses (e.g. cold symptoms)
- 24/7 presence of medical staff (at least one nurse and one nurse's aide in the ward at all times and a doctor on-call in the hospital at all times) and the possibility of being physically restrained if staff felt it was necessary for safety reasons
- Regular health check-ups (including physical and cognitive assessments, checking body weight and blood pressure, etc.)
- Periodic shared snacks
- The opportunity to be referred to other wards or outside hospitals as needed for managing acute and chronic illnesses

For the vast majority of residents living in Unit 1, however, this list of services was just the beginning, and the difference between care like Luo Jinsheng's which barely met these standards and care like Granny Li's which far exceeded them often hinged on family member involvement. Though all residents lived in the same medicalized care setting, some residents' families provided more specialized equipment. This could include everything from daily supplies like adult diapers, to quality of life enhancements like hot compresses, to luxury items like massage chairs. While all residents had access to three meals per day, staff or (far more often) families provided some residents with access to special foods, including special condiments in their rooms, snack foods, milk boxes and fruits to supplement their diet each day, specially prepared nutritional supplements or meals ordered directly from the Nutrition Unit as opposed to

the cafeteria at Summit Care, and homemade or purchased meals delivered to the ward from outside the facility altogether. While all residents received basic medical treatment, some had access to more skilled or individualized care through other wards in the hospital paid for separately by their families, including regular physical therapy, rehab, Traditional Chinese Medicine treatments, access to particular medications, or even access to outside specialists and medical consultations beyond the facility. While all residents lived in the locked Unit 1 ward, special attention from staff or families could produce tremendous variability in residents' levels of access to the outside world, with some taking daily trips to sit or walk around Summit Care's outdoor courtyard, some having regular opportunities to visit other wards or areas of Summit Care on errands with staff (e.g. accompanying staff to pick up laundry for the ward), some getting periodic meals in restaurants outside the facility while eating out with family, and even some having periodic daytime or overnight visits home to see family.

Often influenced by their relationships with residents' families, staff played a key role in differentiating residents' levels of care as well. Though every resident was observed and monitored by staff on a basic level, some developed friendships and relationships with staff, which could lead to receiving gifts or special privileges from staff (e.g. occasionally being given a special snack or having staff sneak in a cigarette[71]), and some had staff regularly stop by to sit with them or chat at various points during the day. Staff addressed some residents' requests for things like a phone call to a loved one, a doctor to come check on them, a cup of water, or a change in room temperature without question, while the same requests from other residents could

[71] This is similar to Sufrin's description of jail deputies exercising favoritism when she writes, "it was not uncommon for deputies to transgress their own rules and give pregnant inmates an extra meal tray or bags of chips from their work-issued meals. And some deputies even stealthily brought in outside food like shrimp and steak burritos for pregnant women, delivering the food with a wink of the eye. 'It's for the baby'" (Sufrin 2017, 129).

be met with indifference[72]. The degree to which residents experienced different levels and forms of care within Unit 1 and different degrees of access to and interaction with the world beyond it was a strikingly accepted part of what *institutional care* in Unit 1 seemed to entail. Rather than exceptions made to a shared care standard, the wide diversity of resident experiences within the ward seemed to *be* the institutional norm.

Families, triage, and the flexible institution

Unit 1 and Summit Care, as institutions, relied on residents' family members to set, enforce, and improve its care standards. Many studies have documented care workers being asked to over-invest in caregiving work despite low (and sometimes no) financial compensation (Buch 2018; Glenn 2010; Levitsky 2014; Rodriquez 2014; Tronto 2013). Though family members of residents in Unit 1 were not expected to make the same sacrifices as nurse's aides and caregiving staff, there was a similar uncertainty around how much investment in their loved ones' care was appropriate, as staff seemed to encourage, and to a degree expect, family involvement far beyond simply paying the facility's monthly fees.

In part, family involvement in care was necessary because there were not enough staff members available to meet all residents' needs; staff and families effectively negotiated the level of care each resident received through a kind of triage[73] that balanced residents' needs and Unit

[72] As described in the previous chapter, Grandpa Fei, for example, was labeled by staff as being especially *zisi* (自私, selfish) because he would repeatedly ring his call button at night when he could not sleep or felt pains in his body that staff told me they could not address. As a result, it was common for the nurse and nurse's aide on night shift to repeatedly ignore the call button when it came from his bed even when they would immediately go check when a call button was hit by another resident.

[73] There have been many studies of "triage" from an anthropological perspective, ranging from HIV treatment (Nguyen 2010) to what Solomon describes as "triage as a mode of biological citizenship," (citing Petryna 2002 and Biehl 2013 *in Solomon 2017*, 356). It is common for "triage" to emerge as "a biopolitical strategy, reinforcing and creating anew configurations of power through choices about which lives are worthy recipients of life-sustaining interventions" (Fassin 2020, Redfield 2005, Redfield 2013 *in* Sufrin 2017, 261). Sufrin writes that, "these processes

1's resources. Despite having higher staff-to-resident ratios than other wards in the hospital, Unit 1 still experienced staffing shortages. Not only was there worker turnover[74] (as in many caregiving facilities), but the staff-to-resident ratio in Unit 1 had been shifting ever since the inception of the ward several years before my fieldwork began. As the director of Summit Care and leadership in Unit 1 described it, the ward had opened fully staffed. That is to say, although there had been significant turnover for individual members of the staff, the number of doctors, nurses, and nurse's aides in the Unit 1 ward as a whole had not significantly changed since the day the ward opened. Because the ward opened with only a fraction of its beds full, however, this meant that the staff-to-resident *ratio* had never stopped changing.

As a result, any staff member who had been in the ward for more than a year or so at the beginning of my long-term fieldwork was acutely aware that Unit 1 could no longer provide the level of care it had initially offered. These more experienced staff no longer had as many resources available per capita (particularly regarding how much time and individualized attention they could offer each resident). As a result, some described a sense of increased pressure related to working in the ward, as they tried to complete administrative tasks for an ever increasing number of residents (e.g. charts, insurance reimbursements, coordinating care with residents' families, etc.). This could easily lead to staff feeling simultaneously disappointed with the level of care they were providing and resigned to the idea that this was the only level of care possible without additional institutional investments in staff hires or other institutional supports for their work. These changes in staff capacity also occurred alongside residents' dramatically different

---

contain not just a practical, but a moral dimension, one that involves reckoning someone's health-related deservingness in the face of finite resources" (Sufrin 2017, 63). Although choices about deservingness ranged from "life-sustaining" to utterly mundane in Unit 1, a triage mentality in this setting was "an active, contingent process of care" just as Sufrin describes at her site (ibid). Here, I am using the term to refer to prioritizing the allocation of limited institutional resources, including staff time and attention.

[74] See Chapter 3 for more discussion on staff turnover in Unit 1.

(and constantly fluctuating) care needs, as well as residents' family members' varying expectations of the care site and what it was meant to offer.

Families responded to the limited staff availability and resources in the ward in many ways. Some regularly visited the ward, conveying that *they* still valued their relatives and staff therefore should, as well. Others went out of their way to help staff and display their own personal investment in their loved ones' care. This could include helping with everything from giving their loved ones showers, to doing their laundry, to feeding them meals, to cleaning their living spaces. Some family members also made a point of actively interacting with staff and with their loved ones during visits as opposed to simply checking their phone while sitting next to their loved ones in the main activity room. Perhaps most importantly, some family members conveyed their personal investment in a loved one's care by providing material resources to support that care, including making payments on time and ensuring deliveries of needed supplies like adult diapers and medications for their loved ones. Some families also tried to encourage staff investment in their loved ones' care through gestures like giving staff gifts to demonstrate that they valued the staff work, or (as a last resort) even filing complaints or relocating their loved ones to another care setting if they felt staff were not being sufficiently responsive. These negotiations happened through different (and sometimes even opposing) strategies over time and often were a driving force behind Unit 1 operating as a flexible institution. Through these implicit and explicit negotiations with staff, families directly played a role in shaping what services each resident received while in the ward.

Mei banfa as a response to unmet needs

For all involved, confronting discrepancies in how residents like Granny Li and Luo Jinsheng were cared for could take a psychological and institutional toll. While residents policed one another – gravitating toward those like Granny Li who seemed to receive more care and pushing away those like Luo Jinsheng who seemed to receive less – family members and staff seemed to grapple with conflicting feelings about whether the care they provided was enough. Families sometimes wrestled with whether and at what point to move their loved ones to a different ward within Summit Care or to a competing facility. Staff sometimes questioned whether and how long they wanted to continue working in the ward. One nurse explained in frustration that she understood that lots of hospitals tried to use the smallest possible investments to get the biggest possible returns, but that she felt like basic care standards were not always being met in Unit 1. She said part of the problem was that even if leadership knew there were issues with the level of care provided in the ward, "they care more about some fairly abstract things, like the things we hang on the wall in the ward"[75]. The "things on the wall" were banners Summit Care and Unit 1 had received celebrating official designations and awards they had gotten from various government offices. They were "abstract" in that they often seemed to be status markers that indicated successful political connections more than objective attainment of higher care standards. She explained that, "of course, lots of problems, we can't talk about them, and [it's not like] one person can just fix all of its [the ward's] problems"[76]. The care problems in the ward were beyond what any one person could address. And yet, accepting such limitations in the care Unit 1 offered seemed to fuel a general deterioration of that care. As she explained:

[75]他们更在意的是一些比较冠冕堂皇的东西比如说科室，我们挂在墙上的那些东西。
[76]当然很多问题，我们是不能把它说出来，也不能一个人就能把它所有的问题解决

> In a big work environment, if, it's just that this, this, Chinese people have an old saying that 'one piece [of rat feces spoils the whole pot of soup]'[77]…if some good behaviors are in the minority, it will be very easy for people to do bad [work] in a big environment. [It's] just everyone pulling each other down together.[78]

This nurse's hesitant reply was part of her answer to why she was considering leaving Summit Care altogether. As such, it shows both a personal cost to staff – working in an environment where she felt unable to improve care standards, while simultaneously feeling at risk of having her own work standards "pulled down" – and the costs created for the institution. If this woman were to leave Unit 1, she would create a staffing shortage. And yet, she was considering leaving because, among other reasons, she did not want to continue working in such an environment and felt she could not personally improve it.

For residents, families, and staff confronting the limits of what Unit 1 and Summit Care could offer as institutional settings – the limits in how far their institutional flexibility could be stretched – often provoked an emotionally distanced ethics of engagement: *mei banfa* (没办法, nothing to be done). Rose Keimig describes the use of this phrase in a dementia care ward in Shanghai as a sign of "resignation" and includes a poignant example where "One resident summed up the whole institutional experience as simply a *mei banfa de banfa* (没办法的办法), or 'what you do when there is nothing you can do'" (Keimig 2021, 147). This description resonates with the many examples I saw of families coming to Unit 1 only after they had tried everything in their power to care for loved ones at home. When there was nothing left to try at home, families began touring care facilities. Though Keimig then references two brief quotes

[77] Although she did not finish saying this expression in its entirety, it seemed clear from the context, that this is the expression she was referencing.

[78]在一个大的工作环境里，如果，就是有这个这个，中国人有一句老话叫一颗【老鼠屎坏了一锅汤】。。。好的一些行为，如果占了少一部分的话，在大的环境大家做不好会很容易，就是大家都一起拉下来。

from Anna Lora-Wainwright's book, *Resigned Activism*[79], the full excerpt is helpful. Lora-Wainwright interviews people living in heavily polluted rural communities in China, and she writes that in these settings *mei banfa:*

> is a way to convey their own feelings of powerlessness: to emancipate themselves from the expectation (from themselves, their family, the community, the anthropologist) that they may be personally responsible for effectively curbing pollution. It is a means through which they comfort themselves about the limits of their own agency. (Lora-Wainwright 2017, xxvii)

Mei banfa offers comfort by releasing someone from being "personally responsible" for addressing a large-scale problem.

Whether invoked to explain individual, institutional, or societal inaction, this phrase was frequently used by those connected to Unit 1 in response to moments when unmet needs were simultaneously acknowledged and allowed to persist. Lora-Wainwright argues that when *mei banfa* is used to justify inaction the "relative lack of action is not a simple consequence of lack of knowledge" (ibid, xxiii). Just as the villagers she studies have an "often complex and multi-layered" understanding of local pollution and its effects, I would argue that residents, families, and staff in Unit 1 also did not leave residents' needs unmet due to inabilities to identify those needs. Instead, a sense of uncertainty around which needs had to, or could be, met and a sense of *mei banfa* entered Unit 1 through the kind of ebb and flow Lora-Wainwright describes where "the longer pollution continues, the more villagers come to regard it as inevitable, and learn to adjust their expectations and demands accordingly. It is…the fluid interplay of activism and

[79] In response to controversy around Lora-Wainwright's insufficient crediting of collaborators for their contributions to the 2017 publication of *Resigned Activism*, there is currently a revised edition of this book scheduled to be released May 25, 2021. My understanding is that all involved feel the revised edition presents their respective contributions accurately and appropriately. Because I do not currently have access to the new edition, my page numbers and quotes are from the 2017 version.

resignation" (ibid, xxiii). In Unit 1, residents' families played a key role in designating when and how particular needs required a response (or not) within its walls.

Lora-Wainwright writes that we must, "better grasp the origins of resignation and scenarios in which the line between victims and beneficiaries is blurred," and I would argue the same is true when it comes to questions of care (ibid, xxiv). Residents, families, and staff can both benefit from and become victimized by institutional care systems, just as the people Lora-Wainwright interviewed in polluted rural towns were both financially benefiting from local factories and physically being injured by the pollution those factories produced. In both settings, responses to seemingly unmeetable needs can result in people "learn[ing] to adjust their expectations and their demands" (ibid, xxv) or reaching some kind of tipping point and either organizing (in Lora-Wainwright's case) or moving their loved one to another care site (for Unit 1 families). It seemed like this adjustment of expectations was something staff watched and waited for when new residents entered the ward. When a new resident pushed back against institutional routines or demanded to speak with family or return home, staff described them as not having *shiying* (适应, adapted or conformed) to daily life in the ward. Unit 1 could offer a certain amount of care, beyond which it fell to residents and others to adjust their own expectations or actions to meet that standard.

And yet, a *mei banfa* ethics of engagement emerged in Unit 1 in part because administrators recognized that the institution's ability to operate relied more heavily on satisfying its staff and its residents' family members than its residents. Resident satisfaction was important, but it tended to have more indirect impacts on the institution's ability to function. Residents needed to be protected and kept physically and medically "safe." Beyond that, there seemed to be an underlying assumption that since residents generally would have preferred to

live at home, it was unlikely that they would ever be fully satisfied with their care in Unit 1. Unless residents' dissatisfaction became so intense that they took steps to threaten their own or others' safety, their feelings about their care therefore became, at least to a degree, institutionally ignorable.

This echoes Lora-Wainwright's argument that pollution in so-called "cancer villages" in China is taken seriously when, "Despite bureaucratic and scientific dismissal of what villagers may regard as painfully obvious, their persistent complaints become evidence of harm, or at least threatening enough to social stability that the government opts to intervene" (2017, 55). Likewise, in Unit 1, regardless of whether or not different groups in the ward agreed on the presence of unmet needs, those needs were not generally addressed unless they seemed to become "at least threatening enough to [institutional] stability" and to Summit Care's financial interests. Family satisfaction with the ward, however, could have immediate effects on the institution. Looking closer at Granny Li's case further illustrates this point. While the institutional norms and procedures could be stretched to accommodate a wide range of Granny Li's family's demands, remaining unmet needs Granny Li might have (for example, not enjoying what she saw as more frivolous activities in the ward like dancing or watching TV) became categorized as *mei banfa.* This was the case even if the needs Granny Li identified would have been easy for staff to accommodate and even if they might have been accommodated for a resident whose family prioritized them.

In Luo Jinsheng's case, the already overextended and exhausted staff members in Unit 1 tended to feel there was nothing more they could do for him. Many staff knew Luo Jinsheng's story and that the institution was already allowing him to live in Unit 1 at a heavily discounted rate. While Granny Li's children's frequent demands made staff oscillate between seeing them as

helpful filial children who supported the ward and seeing them as further complicating that work with inappropriate demands, Luo Jinsheng's sister expressed only gratitude to staff. Her satisfaction with his being allowed to live in Unit 1 at all seemed to allow staff to respond to his remaining needs as fundamentally un-addressable. With such limited resources and an already satisfied family member, what more was there for them to do? For Luo Jinsheng, any remaining, unmet needs were effectively rendered *mei banfa,* unrecognizable to staff and to his sister as opportunities for additional care in the first place.

For staff in particular, *mei banfa* allowed caregivers to draw a line between the care they did and did not feel obligated to provide by weighing the daily operations and institutional future of the facility as a whole against a single resident's or a single family member's individual needs. It was not that caregivers could not *imagine* how Luo Jinsheng's quality of life might be improved or that they could not go get calligraphy paper for Granny Li if she was uninterested in the day's activities in the ward. Rather, for each resident and each family, there was always *something* more that could theoretically be done, and the staff and the facility simply did not have the resources or capacities to address all of those needs at once. As a result, a need that staff did not feel directly obligated to provide (either because families already seemed satisfied or because they did not believe addressing the need was possible and/or meaningfully beneficial to the resident long-term) could easily be dismissed when weighed against the wellbeing of the institution. If staff provided one-on-one care to an individual like Luo Jinsheng, then there would not be enough staff to care for everyone else. If the nurse running daily activities left the main room to get calligraphy supplies when a different activity was scheduled, then the main room would be left temporarily unstaffed and another resident might get hurt, which could leave the ward open to lawsuits. The result? *Mei banfa*. Nothing to be done. In order to care for the

institution as a whole, *mei banfa* became an accepted part of caring for individuals (even if the lengths to which staff and families would go before reaching that threshold varied between residents).

Conclusion: Making peace with the limits of a flexible institution

Caring for people with dementia and other physical or cognitive impairments is taxing work, and assessing the care provided in Unit 1 requires weighing met and unmet needs for all involved – families, residents, and staff. In their attempts to address a wide range of resident and family needs, staff sometimes invested hours in coordinating specialized care for residents like Granny Li, while remaining unfazed by a resident like Luo Jinsheng limping by as they filled out paperwork. The care many residents received in Unit 1 could easily fall short of the ideals the ward strived for, but Unit 1 still occupied a clear niche within the elder care market. By stretching the range of services it offered, Unit 1 was able to simultaneously cater to family members like Luo Jinsheng's sister, who fought for nearly two years to get him into the ward at a price her family could afford, and to families like Granny Li's who ultimately grew so dissatisfied that they decided to move her to a VIP ward that cost nearly twice as much money each month[80]. *Mei banfa* was essential to Unit 1's flexibility because it offered a way for caregivers – family and staff – to set limits on how much they invested in providing care. In this way, it allowed finite resources to be stretched, with especially demanding or needy residents and families receiving more support than they would have if all resources and staff time were divided equally across all residents and families in the ward. Even if some residents' families,

[80] The majority of Granny Li's care was still paid for by her government pension. Her daughter acknowledged that if her family had been required to pay the full cost of her living in the VIP ward, then it is unlikely she would have ever been moved from Unit 1.

like Granny Li's, eventually still decided to move their loved ones to other care settings, Unit 1's flexibility extended the length of their connection to the ward.

Just as the level of care residents received in Unit 1 was influenced largely by their families' involvement in monitoring and contributing to that care, so too was the ward's ability to provide care determined in large part by the level of State involvement and investment in its institutional resources. Residents, families, and staff often seemed to have conflicting perceptions of the state's role in eldercare, with faith in the government's ability on the one hand, and acceptance that it had not fully taken responsibility for care provision on the other. When residents (especially patriotic residents) were frustrated with the way they were being treated, they would sometimes invoke their status as Chinese citizens. When they were dissatisfied with something, these residents would insist that the state would not want its people treated this way. "How can this level of care be permitted?" seemed to be their implied, unspoken next sentence. For family members and staff, the state was also sometimes invoked in discussions of care, but it was often as a way of explaining their own *mei banfa* approach to a particular caregiving situation. They would talk about the power of the state and its ability to mobilize resources to set and achieve ambitious goals. After all, the institutional eldercare landscape itself largely had been brought into existence in the preceding decades as a result of state directives, investments, and incentives. As one adult child of a resident in Unit 1 put it when asked what issues were *mei banfa* when it came to eldercare:

> *Mei banfa* means you need to rely on the government to pay attention to this problem. What can ordinary people do? [Literally: what *banfa* do ordinary people have?] So, this, I feel like this problem depends on the government striving to address the issue, certainly this problem would then be taken care of, [with] everyone working together. Because the government…it will certainly go from all sides, including medical equipment, ah, whatever nursing care, ah…in this respect…if [it] can spread around a lot of capital, then

> surely, certainly [it] can improve [things]. If the government doesn't pay attention to this thing, [there's] no way to improve [it].[81]

As this family member describes, the state could be seen as both immensely capable of addressing unmet eldercare needs and as not directly responsible for the quality of care provided in a setting like Unit 1 if one assumed that the state simply had not yet taken a sufficient level of interest. The state alone had the resources and capital needed to "go from all sides" in addressing an issue as complicated as eldercare. Without that, "what can ordinary people do?" became a natural response that also justified any imperfections in care that was actually provided. The state may not have been held uniquely responsible for elder care provision in these situations, but it did appear to be seen as uniquely capable. Without the state "paying attention" to the issue, people could negotiate for the institution to stretch itself and its care offerings to a point, but they had to accept that the institution could still only be expected to provide so much.

Lora-Wainwright describes one of her research sites by saying, even when incremental improvements were made in the local environment, "overall, pollution had become accepted as a fact of life; it [any particular improvement] was only a matter of degree" (Lora-Wainwright 2017, 152). Though it is upsetting to think of the unmet needs of a resident like Luo Jinsheng becoming "accepted as a fact of life," just as there is no fully pristine environment, there is also no care site capable of fully meeting every individual's needs. In Unit 1, people wanted to improve the care they offered, but they also accepted that there was only so much they could do without undermining the overall survival of the institution. Care could be improved, but it would only ever be "a matter of degree" without dramatically different external investment from the

[81]没办法是因为你要靠那个政府来重视这个问题，老百姓你有什么办法？所以这个我觉得这个问题要靠政府来争取重视这个问题，肯定这个问题就办得好，大家一起动手。因为政府。。。肯定它在方方面面地会去，包括什么医疗器啊，什么护理啊。。。在这方面。。。能播很多资金去的话，那一定肯定能改善。如果政府不重视这个东西，没法改善。

state or the private market. As a result, families were relied upon to help set caregiving priorities, to fill in and compensate for any limitations related to institutional resources, and to assess whether or not care standards were adequate. Unit 1 staff did their best to ensure basic needs were met and to work with families and residents as much as possible to accommodate special demands or requests. Beyond that: *mei banfa.*

CHAPTER 3: Labor in flux

On April 16th, 2018 three of the young, more educated Unit 1 nurse's aides quit without giving notice. One of them was not only the nurse's aide group leader[82] in Unit 1 but also scheduled to work the night shift that night. Summit Care administrators were shocked. Daytime staff in Unit 1 rushed to get residents ready for bed the moment they finished their dinner, and the majority of residents were cleaned and settled in their rooms before the sun even began setting. As I described it in my field notes, "staff [then start] circling together strategizing who should be responsible for what; who will do double shifts; feels like a team huddle in 大厅 [the main activity room]/hallway and again at [the nurse's] station" (4/16/18 fieldnotes). While staff turnover was expected, a whole group of employees leaving all at once and so suddenly, when they knew Unit 1 was experiencing an acute staffing shortage, and on the heels of two high level Summit Care administrators leaving the facility in the preceding weeks[83] made this loss particularly serious.

In the following days and weeks, I learned more about the circumstances of these women's departure. In part, their quitting blindsided the Summit Care administration because Xiao Yue, the group leader, had been highly supported by Summit Care leadership. Though Xiao Yue was only in her early twenties when she quit, she had worked at Summit Care for four years and steadily moved up its administrative ranks and pay scales during that time. The Director of Summit Care supported her taking multiple certification exams to improve her professional knowledge, supported her leaving the facility to attend training at nearby elder care sites, and, as I was told after she left, Xiao Yue was earning approximately 5000RMB per month by the time

[82] 组长

[83] These three nurse's aides quit around the same time as an Assistant Director and the Summit Care administrator in charge of managing nurse's aides throughout the facility.

she quit – nearly as much as the head nurse, more than many of the regular nurses, and nearly double the standard nurse's aide salary of 3000RMB per month.

These three nurse's aides' quitting called attention to two defining questions related to labor dynamics at this facility: What were women as young as Xiao Yue doing working as nurse's aides at a facility like Summit Care in the first place? And, having seemingly been successful at rising up through its ranks, why would they leave so suddenly? The answers to these questions relate to how staff and administrators navigated a volatile elder care landscape. I argue that while leadership at Summit Care attempted to draw upon and strengthen these women's social networks in order to bring stability and new staff to the institution, they did not appreciate the degree to which these women's social connections could also pull them away from working at Summit Care.

The Director's perspective: Mutual investments and mutual growth

About a week-and-a-half after the hectic evening on April 16th, I spoke with Summit Care's Director one-on-one. A slight, soft-spoken, middle-aged man, the Director was almost always wearing a button-up shirt, long pants, and thin wire glasses. Though he once commented to me that he felt he was too introverted and not suited to the big dinners and social obligations expected of someone in his position, I almost never heard staff criticisms about his leadership style. He gave the impression of being sincere and thoughtful, albeit sometimes exhausted by the many demands on his time and attention. He read widely and had traveled to various areas of China and Japan to study alternative elder care approaches, and he seemed genuinely interested in doing what he could to improve the lives of those at Summit Care and their families.

We met in his office and, as usual, drank tea for over two hours while sitting at the formal tea table next to his desk[84]. After discussing a range of other topics – the new facility's VIP ward, the current medical reimbursement system, what made families choose Summit Care in the first place, safety considerations in the facility – the Director then abruptly brought up the three women who quit. He held Xiao Yue responsible for all three women's leaving. He knew that the two regular nurse's aides were good friends with Xiao Yue, and he did not hold them as responsible because he felt they had simply followed her. Xiao Yue, he said, was the one who had truly decided to leave. Furthermore, in her case he felt "very dissatisfied about her leaving"[85] partly because he could not understand why she did not just talk to him if she had issues with how things were going in the hospital. He wondered: maybe it was just because she was so young and this was her first job? And yet, *especially* because it was her first job, he told me he felt she should not have left in such a sudden and irresponsible way. She had been at the hospital for four years, and she knew they were especially short-handed when she left. To make matters worse, he explained that she had asked for time off from April 5th through April 16th, knowing that staff were paid on the 15th of each month. To the Director, this quitting suddenly after being paid made it seem like Xiao Yue thought she would not get paid for her work if she gave formal notice[86]. She did not even give the Director a chance to talk with her and try to address her concerns, he said. Maybe, he wondered, she thought she would not have *mianzi* (面子, face) if she tried to talk with him about quitting after everything he and the facility had done for her?

[84] Although we usually only met once at the beginning and once at the end of each of my fieldwork trips, each meeting tended to involve hours-long tea discussions followed by a meal in the Summit Care cafeteria.
[85] 对她的离开很不满意
[86] Although the Director seemed offended at this lack of trust on Xiao Yue's part, another woman who quit the facility several months later told me that her supervisor *had* threatened to withhold her last month's salary. That woman was eventually paid what she was owed, but the incident raises questions around how rightful such concerns on Xiao Yue's part might have been.

Ultimately, he concluded: she must already have another job arranged somewhere else. As I learned later, this was indeed the case, and Xiao Yue and her friends had already arranged jobs at the facility where the recently departed Summit Care administrators had relocated.

As Elana Buch describes, care workers frequently must navigate complicated relationships between care and money. In an American context, Buch argues that good care is assumed to be "motivated by deep moral and emotional commitments…rather than by material and economic concerns" and that this results in "professionalized and market forms of care…suffer[ing] suspicion" as a result of being potentially motivated by financial concerns rather than "the warmth of familial love" (Buch 2018, 17)[87]. In China, by contrast, familial eldercare and financial and property exchanges have historically gone hand-in-hand (Santos and Harrell 2017, 12), and they continue to go together, albeit in new ways, in contemporary Chinese settings (Zhang 2017, 241). The Director's criticism of Xiao Yue therefore had less to do with Xiao Yue having been paid for her labor than with her selfish decision to wait until payday and then quit without notice when she knew the facility needed her labor and the ward would be short-staffed the night she was supposed to be on duty. She was not respectful of the impact her quitting would have on the staff team and the stability of the institution itself. From the Director's perspective, Summit Care had invested in Xiao Yue, and then, rather than recommit herself to investing in and strengthening the facility as a whole (thereby morally justifying its financial investment in her development), she effectively robbed the institution of those resources and left it in a temporarily weakened position.

[87] See Buch's discussion of Zelizer (2005), Folbre (2012), and Folbre and Nelson (2000) for more on how such moral distinctions between professional, paid care and uncompensated family care have taken shape in the US context (Buch 2018, 225).

"Marketing": Leveraging institutional resources to retain staff investment

The Director described his interactions related to keeping employees as a matter of marketing[88] in conversations with me. He had especially devoted time and effort into thinking through how to recruit and retain young, more highly trained nurse's aides like Xiao Yue. He told me that he had first attempted to raise the social status of nurse's aides' jobs by changing their titles in Unit 1 from *hugong* (护工, nurse workers, with a lower status connotation of day laborers) to *huliyuan* (护理员, nursing staff). Particularly early in my fieldwork, I also saw the Director encouraging and supporting these young women to continuously pursue higher certification levels. Some of the young nurse's aides regularly studied together for these tests (see Figure 1), and by scoring well, they could move up slowly through the bureaucratic ranks within the Chinese healthcare system. This practice was widespread, and when I visited other care sites in the area as part of my pilot research in 2015, I commonly saw directors at elder care sites proudly show off the passport-like booklets where their nurse's aides were accumulating stamps for each certification program or training they attended. Not only did each improvement in certification bring additional skill and prestige to a care facility, but at Summit Care, having the young nurse's aide's staff focused on studying for and passing the same series of tests could also contribute to a sense of group cohesion and shared experience. In "marketing" the facility and the careers it offered, the Director was trying to get these young women to invest in Summit Care's institutional growth and to see that growth as inextricably linked to their own expanding opportunities.

[88]销售

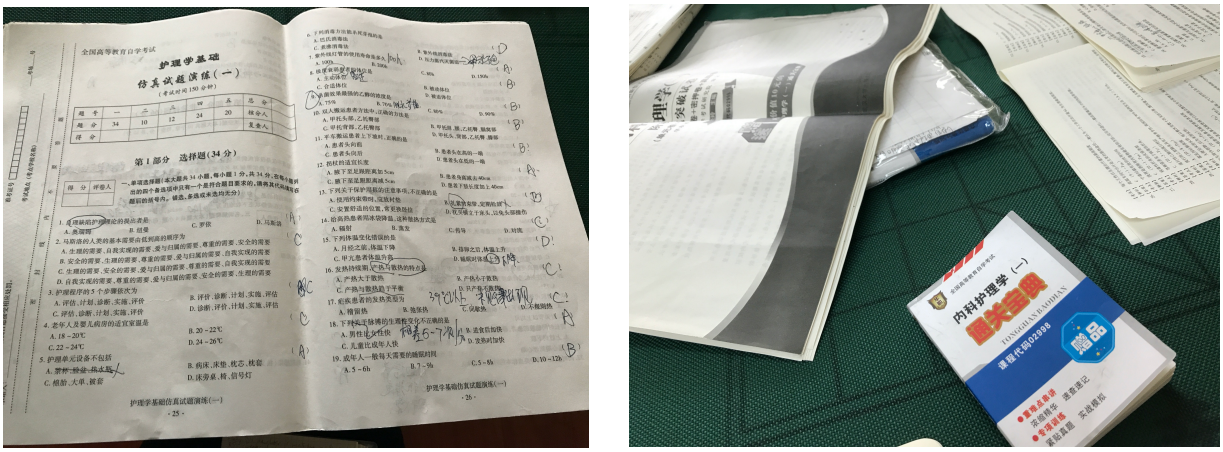

Figure 1: Example of nurse's aide practice test for a certification exam (left) and photo of a table full of study materials when a group of nurse's aides were studying together on their work break (right). Photos taken October 2017.

However, as the Director told me when I began my long-term fieldwork in the fall of 2017, these certification systems were still developing. He explained that just months earlier in July 2017, the policies incentivizing nurse's aides to go through formal training and certification programs had changed. Although the Ministry of Civil Affairs would keep some of its certification programs, many of these official credentials[89] for nurse's aides were now gone[90]. He said he understood that the government wanted to encourage more people to become nurse's aides because it was difficult to find people willing to take the job and that the goal of this policy change was to remove possible barriers to more people entering the field[91]. At the same time, he said he wished these policies could follow the Japanese model of allowing people to work as nurse's aides without certification while offering better work opportunities and compensation to people who did have certification (from 9/21/17 fieldnotes). Without this kind of credentialing, the Director felt there was no way of demonstrating the value of education and internship

[89]资格证

[90] As indicated by the study materials photographed in October 2017, not all certification exams were discontinued. Nurse's aides continued to study for and take various certification exams even though fewer kinds of exams were offered and the impact each exam would have on their career trajectories was less certain following the July 2017 policy change.

[91]降低门槛

programs like the ones Unit 1's nurse's aides had experienced. If facilities wanted to be able to hire young, energetic, educated caregivers instead of the *meiyou wenhua* (没有文化, uneducated, literally "uncultured") older women from the countryside, then those young women needed a sense of their future.

Unable to control external incentives for young nurse's aides, the Director focused instead on trying to keep these young employees invested in their careers at Summit Care for as long as possible by doing what he could to meet each individual's most important need(s). During my time at Summit Care, I observed this play out repeatedly. A worker (usually a female nurse or nurse's aide) would contemplate leaving Summit Care in search of a different job or to get married or have a child, she would meet with the Director, and he would find a way to keep her working at the institution. Zhang Jing, a nurse beloved by residents and families alike had worked in Unit 1 for several years when she started feeling burned out, frustrated with the demands on her time as a nurse, and ready to consider quitting altogether before getting married. After she spoke with the Director, however, he created a new administrative position for her, with higher pay, more regular hours, and higher status, and she decided to keep working at Summit Care. Women like Qiu Meng began working in Unit 1 as nurse's aides, and then worked their way up to being full nurses in the ward through a series of exams and negotiations with the Director. Liu Na worked as a nurse in Unit 1 for over a year and was loved by residents, families and other staff for her cheerful and playful energy. When she decided she wanted to leave to be closer to her family in the countryside, she had such a difficult time convincing Unit 1 leadership that she could not stay that her father ultimately had to call them on the phone to persuade them that Liu Na was needed at home. When she eventually found a different nursing job back in the city, Liu Na told me she felt so bad about leaving Summit Care that she worried about running

into the Director or other site leaders by accident somewhere in the city and did not want them to know she had returned from the countryside. In all of these cases, the women involved felt a need to be honest about their desires to leave, as well as an obligation to at least seriously consider any employment counter-offers they might get.

These staff negotiations played a key role in sustaining and growing Summit Care as an institution, as providing for staff's and residents' needs had long been cyclically intertwined with the facility's ability to attract and retain financial support[92]. The hospital had been developing incrementally over time – opening new wards, hiring new staff, getting new equipment – as it attracted more patients. Each improvement in the facility's infrastructure and services then drew more families and residents, who brought fresh financial resources to support further development. And, the longer staff stayed, the deeper their relationships with one another, with residents, and with families could become. However, continuing this cycle required being able to build upon previous gains. When it came to staff, this meant retaining workers in whom the facility had invested training resources. It also required that administrators ensure that Summit Care was continually advancing. Otherwise, it could not hope to compete in the broader (and constantly changing) eldercare market. As leadership in Unit 1 put it, "the hospital needs to develop, we want to survive, so there's this competition. Everyone [else] is writing [articles], everyone [else] is taking outside classes, going and cultivating [staff] talent, so we have to keep up. Otherwise [we'll] get eliminated through competition."[93]

Unfortunately, Summit Care was limited in terms of how it could engage in this competition. In the years before and during my research, there had been an explosion of newly

[92] See Chapter 4 for expanded discussion of the history of Summit Care and the services it provided.
[93] 医院要发展，我们要生存，就有这个竞争，人家都在写，人家都在去外面上课，去培养人才，我们就要跟上，要不被淘汰

constructed, high-end elder care facilities in Sichuan and nationwide. Summit Care staff and administrators knew that they could not compete with these newly built facilities in terms of how luxurious or attractive their site's physical infrastructure was. Instead, they had to compete in terms of the services and types and quality of care they offered. A key part of that was hiring and cultivating increasingly professional staff. Under these circumstances, losing employees like Xiao Yue, whom the facility had financially invested in through her comparatively high salary, supported by sending her to attend professional training and activities, and promoted to a leadership role within the nurse's aides' staff was a double loss. Not only was she no longer at Summit Care serving to attract or retain families, staff, and residents at the site, but she also had left for one of the facility's competitors, thereby making a competitor that much more formidable.

Hugong, *huliyuan*, and *xiao meimei*: Salvage accumulation and the shifting status of nurse's aides

Despite the Director's efforts to keep young women like Xiao Yue interested in working at Summit Care, the majority of the nurse's aides at the hospital were women between their 40's and 60's from the countryside with middle school education or less and essentially no medical training – these were the workers called to mind by the term *hugong* as opposed to the higher status term *huliyuan.* Summit Care was not alone in its reliance on these older nurse's aides. A synthesis of long-term care facility studies in mainland China found that nurse's aides, or "direct caregivers," were generally "40 to 60 years of age and older; they are primarily women and have little formal education" (Song et al. 2014, 426). At a care facility I visited in Beijing in 2011, I once asked the director there how he would recruit enough nurse's aides to staff his expanding

hospital. That director had told me that he was planning to double the size of his facility, and I had recently learned that the average length of employment for nurse's aides at that institution was only two weeks. I asked him how he could double his staff when it was already such a struggle to keep nurse's aides in his wards. He replied nonchalantly that it would not be a problem; he would give current nurse's aides a day or two off, and they would go back to their hometowns in the countryside and return with a friend or relative from home. With each person bringing one person back with them, his nurse's aide staff would double.

Although no one at Summit Care described recruiting the older nurse's aides in such simple terms, it did seem like similar tactics were at least periodically used by Summit Care administrators. Sometimes I met older women working in Summit Care wards who I was told were relatives of Unit 1 staff. Sometimes I heard nurses or nurse's aides describe their older female family members asking them about nurse's aide job opportunities at Summit Care or telling them about job opportunities at other facilities where they worked. Put another way, these women's social networks appeared to offer a recruitment tool for Summit Care and competitors' sites. This echoes Bear et al.'s claim that, "forms and senses of self, family, ethnicity, race, and community are always "inside" and mutually constitutive of capitalist social relations and vice versa" (Bear et al. 2015). Tsing describes such dynamics as a form of "salvage accumulation" (Tsing 2015) when she asks:

> Where do capitalist resources come from? Capitalists are unable to *make* most of their resources. Consider oil and coal, those formerly living products whose formation has required so much more time than capitalists can imagine. Capitalists use them, but they cannot manufacture them. This is not just true for ancient things. Capitalism makes use of animal digestion and plant photosynthesis without having any clue how to shape these processes, despite the sophisticated engineering of plants and animals…These are the processes I call "salvage accumulation." Accumulation is the amassment of wealth under capitalism; salvage here refers to the conversion of stuff with other histories of social relations (human and not human) into capitalist wealth. (ibid)

Just as Tsing describes salvage accumulation in other fields, I would argue that at Summit Care one form it took was in administrators harnessing staff's pre-existing social networks in order to bring new employees into the facility.

Even more than drawing on intergenerational family relationships, this kind of recruitment seemed happen through friend groups when young, more highly trained nurse's aides were recruited to come to Summit Care. This is how several nurse's aides described why they had originally chosen to come to Summit Care during interviews with me:

> Because [I] hadn't graduated yet, [I] didn't have a diploma." Laughs before adding "And maybe [I was brought together] with this hospital by fate." Laughs again and later continues "My reasons were extremely, how do [I] put it, uh, I came here to work because [clicks tongue]…Being at home was very boring, so [I started] looking for work. Then [I saw them advertising for] nurse's aides! Then I said [to myself], "Uh, nurse's aides? Well, first do it [for a while], why not give it a try!" And then I've been doing it ever since.[94] – Unit 1 Nurse's Aide
>
> At the very beginning, it was my friends who wanted me to come here. So then I just came. [Laughs].[95] – Unit 1 Nurse's Aide
>
> At the time [I] thought having a medical background you know, [this facility] would definitely be way better than those purely [non-medical] elder care facilities. And also, but, we had a book that [the Director] and them [Summit Care administrators] had written. [L: Oh!]…And then, so later I just came here, and then [the Summit Care Nursing Administrator] told us a lot about different aspects of elder care. Afterwards we decided. [It] was me and a few people…[we] just came here, and [I] really feel like I've gained a lot.[96] – Unit 1 Nurse's Aide

[94] "因为还没毕业，没有毕业证。" Laughs before adding, "然后可能跟这个医院有缘吧。"Laughs again and later continues, "我的理由非常的，怎么说呢，诶，我来这儿上班是因为【clicks tongue】。。。在家里很无聊，然后再找个工作。然后就说护理员！然后我说"诶，护理员吗？那，先干着了，试一下吧！"然后就干到现在。"

[95] "最初的时候是我朋友让我到这边来的。然后我就来了。"【laughs】

[96] "当时就觉得有医疗背景嘛，肯定比一般的那种纯养老的机构肯定会好很多。而且，但是我们有一本书就是【the Director】他们写的。【L：哦！】。。。然后，所以后来就来这儿，然后【the Summit Care Nursing Administrator】就跟我们说了很多关于养老方面的事儿。后来我们就决定了。是我们几个人。。。然后后来就是来了，然后真的觉得收获了很多。"

While the last woman mentioned being interested in working at Summit Care because of its reputation for providing medical care in addition to daily living care, all three spoke to what I would argue was the most significant factor in their decisions: social networks they had outside the facility or with other staff. The first woman came to the facility because she was bored sitting at home, and the hospital would allow her to begin working before she had finished her degree. The second and third women explicitly came with a group of friends.

The Director tried to establish more formal channels for recruiting younger nurse's aides to Summit Care and particularly to Unit 1. He explained that he had built partnerships with the local secondary or vocational training programs[97] from which young nurse's aides like Xiao Yue graduated. He helped arrange for the students from these programs to work in Unit 1 or other wards as "interns" for several months at a time as part of their training. The internships allowed groups of these young women to come to Summit Care together and get a feel for working at the facility, to get to know the staff, and to inform their decisions about whether or not to work at Summit Care after graduating. The Director said that he hoped to eventually have these younger more educated workers throughout Summit Care (from 6/1/2017 fieldnotes). When considering Summit Care's long-term survival as an institution, this approach made sense given that China's aging demographics meant facilities would not be able to find as many middle-aged nurse's aides in the coming decades (from 1/20/2017 fieldnotes). As the head doctor in Unit 1, a man in his 40's, put it to me once "there won't be anyone [left to provide care] when we're older"[98] (from 6/15/17 fieldnotes). Recruiting older, less educated nurse's aides into the facility could be valuable in the short-term, but finding ways to recruit and retain young women like Xiao Yue seemed to be the future.

[97]中转和专科毕业的
[98]我们老了，就没有人

For the Director, hiring these younger women also involved taking on a sense of responsibility for them. The majority these younger nurse's aides were in their late teens or early twenties, and a gendered undertone to their standing within Summit Care became apparent when the Director, like many others in the facility, diminutively referred to them as *xiao meimei*[99] (小妹妹, "girls," "young women," or literally "little sisters"). The Director's attitude toward these women seemed to mirror Yan Hairong's descriptions of "The more 'enlightened' employers" of *dagong mei* (打工妹, Chinese domestic workers), who tended to "take an interest in the subjective transformation of their domestic workers, and…[tended] to believe that by doing so they are helping those workers" (Yan 2008, 94). Importantly, Yan also describes a young female migrant worker feeling like *dagong meis*' "struggle for recognition, self-expression, and self-realization as modern subjects…turns out to be a process in which they have given all they have and from which what they still [quoting the woman directly] 'get in return is zero'" (Yan 2008, 231). Yan comments that this, "echoes and reinforces" the idea that "self-development proves to be a bankrupt dream…The prospect of self-valuation is haunted by a constant danger of liquidation" (ibid). Likewise, for the young women working as nurse's aides in Unit 1, the value of their efforts to incrementally upgrade their credentials over time was always subject to uncertainty. Policies and external valuations of their efforts could change overnight.

The Director told me he went out of his way to invite these young nurse's aides to participate in training activities and events so that they could see themselves as part of a bigger picture, or assess the overall system[100], as he put it. He said that he wanted to teach these women

[99] This parallels Ong's observation that "[e]thnographers of Asian workers in export industries" have described "tropes emphasizing the junior status of the women," diminutively referring to them as "daughters" of various kinds (Ong 1991, 286-287).
[100] 考核体系

methods for analyzing problems[101] so that they could develop and have better job opportunities later. And yet, the opportunities he could offer within Summit Care were not necessarily the ones these young women wanted to pursue. As one of the young Unit 1 nurse's aides I interviewed put it, these women were "waiting for opportunity." What that opportunity might look like, whether or not it was at Summit Care, or what directions they wanted their lives to take were less important than a hopeful sense that being away from home might offer a gateway to a brighter future. Yan describes something similar as she reflects on the pressure many *dagong mei* face to marry as they get older, writing, "As they reach their early to mid-twenties, young migrant women are racing against time in hope of a change in their life opportunities" (Yan 2008, 231). Although the Director could draw upon these women's social networks to help attract and retain additional staff at Summit Care, they were not always convinced that their best "opportunities" were those he could offer through the site.

In fact, the booming elder care industry in the region meant that there were many high-end private care sites eager to hire young, attractive women. Not only were such young, female caregivers seen as more professionally skilled than the middle-aged nurse's aides, but their youthful energy was also described to me by administrators, staff, and family members at Summit Care as creating a better environment for older adults within the wards. Furthermore, once hired by a facility, these young women then could be photographed and used in promotional materials for the site, which Summit Care and other sites did regularly. For the women working at Summit Care, comparable jobs at luxury independent living facilities promised better paid and far less demanding work than caring for the physically and cognitively impaired residents in Unit 1. As one administrator who left Summit Care following my long-

[101] 思考问题的方法

term fieldwork told me when I returned in 2019: everyone on staff at Summit Care could make much more money elsewhere (summarized from 9/14/19 fieldnotes). When she told me that, this woman's salary at her new job was already more than triple her Summit Care salary, and she was contemplating negotiating with her new employer to further double it in the coming months. And yet, employee decisions around whether or not to stay at Summit Care were about more than just money. Even Xiao Yue had stayed at Summit Care for four years before suddenly quitting.

On some level, the Director seemed to understand salary and long-term career advancement opportunities were not the only things nurse's aides valued in their work, and he tried to cultivate and strengthen a sense of staff cohesion by regularly providing funds for Unit 1 staff to go out for meals or have other social events. Particularly in the days after Xiao Yue and her friends quit, Summit Care administrators sent special lunches to the remaining staff in Unit 1 and arranged events like a night of barbeque, games, and karaoke at a countryside inn (see Figure 2). While the head nurse had paid for some of the food and alcohol out of pocket, the Director stopped by in person while everyone was eating and sent electronic red envelopes[102] with various amounts of money to the Unit 1 staff WeChat group until everyone had gotten at least one. Though each envelope only contained 10RMB-30RMB, the game of seeing who could grab each envelope fastest had everyone laughing around the table, facilitating the deepening of social relationships among staff throughout the night. This, in connection with encouraging words from the Director saying that he knew everyone would band together to meet the staffing challenges over the coming days seemed like an attempt at getting everyone to feel morally invested in strengthening and sustaining a cohesive staff unit. The Director seemed to be setting an expectation that those present should feel obligated to invest in and support one another as part

[102]红包

of their work in the ward. This kind of intra-staff relationality was effectively harvested through "salvage accumulation" when women were recruited via existing social networks, and it was cultivated in an effort to sustain Summit Care as a stable institution as facility leadership attempted to deepen staffs' feelings of commitment to the facility and their fellow workers.

Figure 2: The picturesque courtyard at the countryside inn where Unit 1 staff were treated to a night of BBQ and games. Photo taken April 2018.

While these events could be helpful for morale and for genuinely deepening interpersonal relationships among staff, leadership at Summit Care also had to be careful not to make too many demands on their employees' downtime or too many moral demands on how much they were expected to invest back into the institution. The work staff did in Unit 1 was extremely taxing, and although they seemed to enjoy group dinners and social activities with one another, the facility's impact on their daily lives was already so large that even attempts at morale boosting could easily feel burdensome[103].

[103] Despite many differences in the kinds of activities and social status involved, this sense of being expected, if not required, to socialize as part of one's work obligations is similar to what John Osburg describes among Chinese businessmen in Chengdu (2013) and the social obligations among government officials and business men in China described by Elana Uretsky (2016).

Staff perspectives: Working lives and social lives for Unit 1 staff

Nurse's aides' jobs were low status, low paid, and physically and emotionally draining. Their work required responding to residents' variable and complex physical and emotional needs, as well navigating conflicting demands from hospital administrators, residents' families, and residents themselves. All of this also often had to happen on top of and in spite of their own exhaustion. Like nurse's aides in many places, these women were responsible for the low status dirty work of care: feeding, helping with cleaning, dressing, going to the bathroom, and physically transferring residents from bed to wheelchair and from room to room. On average, they did this work for 3000RMB (~$710)[104] per month of salary in addition to subsidized food and housing via the facility. Though some of these young women aspired to move up the ranks within the facility (or its competitors' sites) slowly over time, many seemed to see their work at Summit Care as temporary – a job for the time being until marriage, family life, or other unforeseen career opportunities emerged[105]. While they were at Summit Care, these women's motivations were described to me by Unit 1 leadership as largely non-financial. As one female

[104] It is important to note that in China wages are generally stated per month as opposed to per year. Also, because the Purchasing Power Parities (PPP) between RMB and USD fluctuated substantially between 2015 and July 2018 when my long-term fieldwork concluded, all conversion estimates included in this dissertation use the 2018 value of 4.227 RMB per 1 USD and then round to the nearest whole dollar amount(OECD 2021). This approximate yearly salary of 36,000 RMB put nurse's aides at about 50% of the average salary across sectors in the area in 2017, which was 65,098 RMB. While their salaries were significantly lower than the average salary for other blue collar jobs like construction work (54,119 RMB) and more middle-class jobs like working in the "transportation, warehousing, and postal industry" (81,587 RMB) , the nurse's aides at Summit Care were actually earning just above the average for "residential services, repairs, and other services" (居民服务、修理和其它服务业) workers who made approximately 35,409 RMB per year (华律网整理 2020).

[105] While this indirect expectation of future, unforeseen career opportunities may seem strange in the United States, the pace and intensity of economic change and development in China, particularly in Sichuan, made it very reasonable for these women to assume that there could be small business or new career opportunities in their future (Huang 2018). For example, many of the middle-aged family members of residents I spoke with explained that they had moved through multiple sectors and careers over the course of their working lives depending on what kinds of job opportunities they heard about through their social networks or happened to come upon themselves. Though these family members were often more educated than the young nurse's aides in Unit 1, even nurse's aides' family members tended to move through a range of jobs and careers as migrant workers, farmers, and small-scale entrepreneurs.

leader put it, "These *xiao meimei*, I think they're all [like this]. As long as everyone is at work together, happy, [then] even a few hundred less [RMB in their] salary doesn't matter"[106] (6/13/18 Interview). And yet, this raises the question: what did it take for them to be "at work together" and be "happy" enough that they would stay at Summit Care for non-financial reasons?

Nurse's aides' lives were shaped by working at Summit Care in many ways. Their housing, for example, was primarily provided by the hospital. At the beginning of my fieldwork, this meant 4-person, temporary dorms built on the roof of the facility. Each dorm was composed of a front room with a set of bunkbeds pushed against two of the walls and a cement and tile back room containing a small sink, a shower head and a squat toilet. There was a shared outdoor area of the roof for doing laundry by hand and hang-drying clothes, and a market area next to the hospital with a handful of restaurants, shops, and stands that provided a convenient way for these women to buy whatever they needed.

Right around the same time Xiao Yue and her friends quit, Summit Care began preparing for and undergoing a series of construction projects, and everyone living in the rooftop dorms had to move. There were several older, concrete apartment complexes surrounding Summit Care, and the administration arranged for staff to move into them. Although the apartments were sparsely furnished aside from bunkbeds and belongings the women transferred from their dorms, everyone I spoke with said they preferred living in the apartments. They enjoyed having a living room area, even if it only had small wooden stools, an old TV, a coffee table and an old wooden sofa bench. In most units, there was a small balcony with space for air-drying laundry without leaving the apartment, and, best of all, there was a kitchen. Like many older kitchens in the area, the ones in these apartments did not have refrigerators, but they did have areas to plug in a

[106] "她们这些妹妹，我觉得都是。只要是大家在一起上班、开心，工资少了几百块都没有关系。"

hotplate, as well as an exhaust fan, a large sink, a free-standing filtered water jug, and tiled countertops and storage areas (from 5/17/18 fieldnotes). This was enough for women to be able to cook their own food more easily, which was a tremendous selling point.

For women whose meals primarily came from the Summit Care cafeteria, cooking their own food was a luxury. The cafeteria received mixed reviews from staff members I spoke with – some saying it was surprisingly good, others saying it was far too bland or too spicy[107], and nearly everyone agreed the meals became repetitive and steadily less appealing over time. And yet, staff living on or near the hospital grounds tended to eat most of their meals in the cafeteria because they received preloaded meal cards from the facility that made eating there virtually free. Even those who did not like the cafeteria's usual dishes often gladly still came to the cafeteria for its weekly noodles and sauce dinner, dumplings dinner, and its morning steamed buns, all of which staff agreed were quite good. In general, however, it was a treat when women sharing the same dorm room periodically pooled their money to buy fresh ingredients from the market next to the facility and then used illicit hot plates and rice cookers in their dorm rooms to cook shared meals (See Figure 3).

[107] Although the vast majority of nurse's aides were from the surrounding countryside and preferred spicy Sichuanese food, those who came to Summit Care from other areas of China sometimes found the cafeteria food incredibly spicy even as the local nurse's aides complained it was too bland.

Figure 3: A meal several nurse's aides invited me to when I returned to begin long-term fieldwork. In less than an hour, they prepared fish, spicy cucumbers, rice, and boiled corn, melon, and frozen fishball soup all made using a rice cooker and hotplate hidden in their rooftop dorm. We ate on their makeshift cardboard box table, sitting on the padded floor mat they were always careful not to step on while wearing shoes. Photo taken September 2017.

Having (or not having) control of their own time was also a significant way in which Summit Care shaped these women's lives. As others have documented, working away from home is often one avenue for young women in China to experience more independence than they might otherwise (Lee 1998; Yan 2008). Likewise, working at Summit Care could offer young women the opportunity to consider their lives from a new perspective, away from the direct influence of their parents and hometown communities. Some women used this relative freedom to date and explore their sexuality away from parental supervision as they found boyfriends or girlfriends working at the site or in the surrounding areas. For others, it meant a chance to consider alternative career paths. Qiu Meng, for example, dreamed of someday opening a coffee shop with a friend of hers who would make baked goods for them to sell despite her parents pushing her to pursue a career in healthcare and focus simply on becoming a nurse instead of a nurse's aide.

For many, living and working at the site was a chance to simply experience a more urban and consumer driven lifestyle. Many of the nurse's aides I spoke with had never left Sichuan province; never been to an airport, let alone taken an airplane. Although they had certainly seen urbanized areas (even a "small city" in China can be home to hundreds of thousands of people), working at Summit Care gave them the discretionary income and opportunity to pursue their interests in new ways. On their weekly day off, nurse's aides would sometimes go together into the city center to walk around high-end shopping malls, visit arcades, or see a movie. They would also sometimes buy a bus or train ticket to visit a tourist attraction outside the city and return to the facility with bags of snacks to share with the rest of the staff. Fairly early on in my fieldwork, I became acutely aware of the almost 10-year age gap between me and some of the younger nurse's aides when a group of us went into the city together one evening. As we were going up an escalator, we passed what appeared to be a group of foreign high school students on a trip. The nurse's aides I was with started talking excitedly about how handsome a teenage boy at the front of the group was. When they asked for my opinion, I responded without thinking and said "he looks like a child to me." Although I immediately tried to walk my comment back, our age difference – which often felt minimal in the ward when they were caregivers and I was their resident anthropologist – suddenly seemed gapingly large.

Outings like that allowed nurses, and especially nurse's aides, at Summit Care to deepen their relationships with one another while also relaxing and blowing off steam despite their heavy workloads and severely restricted opportunities for social activities or interactions outside the facility. In Unit 1, as in the rest of Summit Care, nurses and nurse's aides worked on rotating shifts that made it difficult for them to maintain regular sleep schedules, let alone social calendars. While the older nurse's aides in other wards could work 12-to-24-hour shifts which

allowed them to take 24 to 48 hours off to return to their farms on the city outskirts, the younger and more educated nurse's aides in Unit 1 generally worked in approximately 8-hour shifts with an average of one day off per week. When I shadowed nurse's aides through two rounds of night shifts, I was shocked at how exhausted I felt[108]. Even without engaging in the added physical strain of moving and cleaning residents' bodies throughout the night, I was so tired by the end of each round of shadowing that I could barely hold my pen to record notes in my notebook.

Since staff sometimes had as few as 6 hours off between shifts, living at or near the facility was extremely important, as any time spent on transportation to or from the facility detracted from time available for sleeping, showering, eating, or generally unwinding before they had to be back in the ward. The head nurse and group leader for the nurse's aides spent hours determining each employee's work rotation each week. They did their best to accommodate requests for particular shifts on particular days and, most importantly, requests for specific days off. However, the more involved a request was, the more likely one would be asked to take a series of undesirable shifts in order to compensate for it. For example, as the first row in the schedule below indicates (see Figure 4), a nurse's aide who requested 4 days off in a row one month ended up with the following schedule where red indicates beginning a shift (or a part of a shift) after 8 hours or less of time off since last at work:

[108] Research has shown a range of negative impacts related to sleep deprivation in various healthcare settings, including decreased attention performance in medical students (Pérez-Olmos and Ibáñez-Pinilla 2014), increased medical errors among healthcare professionals (Lazzari 2018), and increased physician burnout (Stewart and Arora 2019).

Middle Shift (中) 3:00pm-12:00am
Transition Shift (调) 6:00am-10:00am & 6:00pm-10:00pm
Day Shift (白) 7:30am-12:00pm & 1:30pm-6:00pm
Transition Shift (调) 6:00am-10:00am & 6:00pm-10:00pm
Day Shift (白) 7:30am-12:00pm & 1:30pm-6:00pm
Morning Shift (早) 6:00am-3:00pm
Night Shift (夜) 12:00am-8:30am
Middle Shift (中) 3:00pm (the same day)-12:00am
Transition Shift (调) 6:00am-10:00am & 6:00pm-10:00pm
Day Shift (白) 7:30am-12:00pm & 1:30pm-6:00pm
Day Shift (白) 7:30am-12:00pm & 1:30pm-6:00pm
Transition Shift (调) 6:00am-10:00am & 6:00pm-10:00pm
Day Shift (白) 7:30am-12:00pm & 1:30pm-6:00pm
Day Shift (白) 7:30am-12:00pm & 1:30pm-6:00pm
Night Shift (夜) 12:00am-8:30am
Middle Shift (中) 3:00pm (the same day)-12:00am
Transition Shift (调) 6:00am-10:00am & 6:00pm-10:00pm
Rest Day (休)
Rest Day (休)
Rest Day (休)
Rest Day (休)
Morning Shift (早) 6:00am-3:00pm
Night Shift (夜) 12:00am-8:30am
Middle Shift (中) 3:00pm (the same day)-12:00am
Transition Shift (调) 6:00am-10:00am & 6:00pm-10:00pm
Day Shift (白) 7:30am-12:00pm & 1:30pm-6:00pm
Transition Shift (调) 6:00am-10:00am & 6:00pm-10:00pm
Day Shift (白) 7:30am-12:00pm & 1:30pm-6:00pm
Day Shift (白) 7:30am-12:00pm & 1:30pm-6:00pm
Transition Shift (调) 6:00am-10:00am & 6:00pm-10:00pm

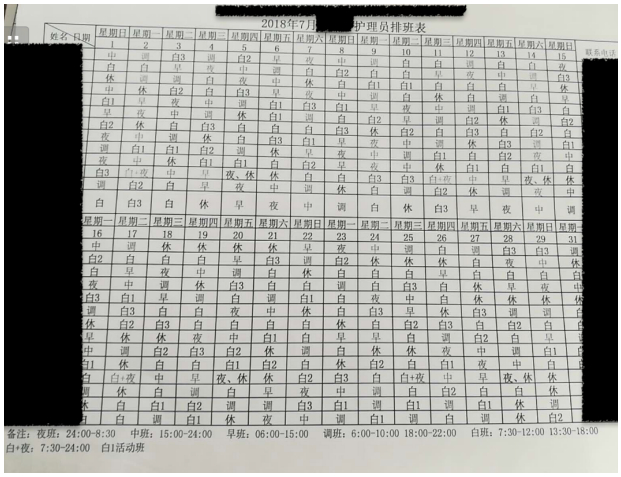

Figure 4: Unit 1 Nurse's Aide Work Schedule from July 2018. Photo Taken June 2018

Such scheduling provoked mixed feelings among the nurse's aides. Everyone agreed that it would be better to have two days off per week instead of just one. Beyond that, however, many felt conflicted. On the one hand, they agreed with Unit 1 leadership's justification for such a variable schedule: high levels of staff turnover required maintaining a staff where each worker regularly experienced each shift because there were different tasks and types of paperwork

associated with different shifts and there was no telling when someone might need to step in as a substitute for a newly vacant position. On the other hand, when I asked nurse's aides how they would feel about working the same shift every day (e.g. always night shift or always day shift), they were interested but raised concerns. One question was: Who would ever agree to night shifts only? When I suggested staff could hypothetically be paid more for working the night shifts, they thought that was interesting, but they said they doubted anyone would want to take night shifts all the time. They also thought it might be unfair for people to be paid more for night shifts because even though they were more physically demanding and staffed with only two people (one nurse and one nurse's aide for all of Unit 1 and one doctor on call in all of Summit Care), the night shifts actually required far less paperwork and administrative activity, so it was unlikely that day shift staff would accept being paid less than night shift. Perhaps one month or a couple of weeks on night shifts and then rotating to a different shift, they suggested.

Though nurse's aides generally described the rotating shift schedules as heavily taxing for the first month or so and then easier to cope with as one's body adjusted, there was no denying that fluctuating work hours tremendously impacted both nurse's aides' and nurses' available time. When work expectations expanded even into the hours staff expected to have off, it could seriously impact their morale. As one Unit 1 nurse who was contemplating leaving the site explained:

> The thing I'm most dissatisfied with [about working at Summit Care] is no matter when, [the hospital] doesn't care even if employees are on a day off or had night shift or when it is, any [time] [the hospital] has anything going on, [if] it demands [you] come to a meeting or a training, employees must go. Yeah, I'm especially, especially unhappy about this. Sometimes [clicks tongue], so sometimes I come late [to those events] on purpose [both laugh]. I'm very dissatisfied with this part [of the job]. Sometimes, actually, I think [hospital] leadership should know about this issue, but because they're [acting] in order to have the whole ward perform a little better, [so] they require everyone attend…If [one] lives far away, then it's especially, especially tiring. I think [hospital

> leadership] is [looking at things] from a management or training [perspective], from a big picture perspective it's OK [to do things] this way, but I feel like [they] should make [their] approach more, more, a bit more considerate. For example, if it's the day of [when they announce an event], really there [will be] a group of people [who] cannot attend. And also, you can't ensure that everyone will be able to attend every training because no matter what [there will] always be some people on duty.[109]

This nurse's description of feeling like leadership at the facility "should know about" this issue (implying they should also respond and address it) while at the same time justifying their behavior as prioritizing the performance of the ward as a whole helps to illustrate the conflict staff felt around balancing their own needs with those of the institution.

While the Director and facility administrators seemed committed to trying to reduce staff turnover[110] whenever possible, it was not always clear what approaches would be most effective. Limiting staff turnover benefited Summit Care both by decreasing residents' likelihood of living in understaffed wards, and allowing staff to form longer term relationships with residents and families, thereby increasing the likelihood that current residents and families would stay with Summit Care as a provider and recommend it to others. However, while more paid days off, higher hourly pay, lighter caseloads, more support for attending trainings and certification exams, and better food and housing could each make the prospect of continuing to work as a Summit Care employee more appealing, they each also came at a financial cost to the institution.

Although detailed financial information about Summit Care was never released to staff or shared with me, the feeling I got from the Director and from leadership in Unit 1 was that the

[109]我最不满意的地方就是无论在什么时候，它就是不管这个那个人员是在休息、还是上夜班、还是什么时候，它凡是有什么事情，它要求开会或者培训的话，人员就要必须去。对，这个我非常非常难受。有的时候【clicks tongue】所以有的时候我会故意迟到[both laugh]。我很不满意这一点。有的时候其实我觉得领导应该知道这一点，但是他为了就是整个科室表现好一点，他会要求人都到齐。。。如果【住的地方】有些远的话，就特别特别累。我觉得他是从管理或从培训，从整体来说是可以这样，但我觉得应该把这个方式再、再想周到一点。比如说，如果当天的话，确实这些人不能参加。而且你每次培训是不能保证所有人能到齐，因为不管怎么样都有人在值班。

[110] Staff turnover is a documented issue in many professional eldercare settings, even in (comparatively) highly resourced European care sites (Westerberg et al. 2018; Clausen, Tufte, and Borg 2014).

budget was tight between balancing affordable fees for families, staff salaries, operating costs, and investments in facility development. Though family members of residents mentioned to me several times that they felt staff should be paid more, they were also hesitant about the idea of Summit Care raising its rates to pay for such salary increases. It thus fell to the Director to make special arrangements with individual employees to extend their time at Summit Care whenever he could. While these efforts were rarely enough to keep staff there long-term, they did seem to keep even employees like Xiao Yue working at the site longer than they might otherwise have and (often) for less money than they could make elsewhere.

Conclusion: Making sense of Xiao Yue's response

On April 20th, four days after the sudden exodus from Unit 1, I found myself sitting across from Xiao Yue and one of her two friends at dinner. The table was full of current and former Summit Care employees. I knew everyone there and had been invited to join the group by several former Unit 1 nurses with whom I was particularly close. After several of us shared Didis[111] from the hospital, we met at an outdoor, semi-covered restaurant connected to a countryside inn. We sat on small plastic stools encircling a 3-foot-squared brick charcoal oven with a huge wok in the middle cooking a chicken and vegetable dish as the sun went down. The mood was friendly, albeit initially a bit forced. One nurse had brought her young son, who ran back and forth to the table and played in the outdoor areas near the restaurant. The women began teasing one another as the group relaxed – one saying that she was not eating much because she was going on a diet, and another jokingly saying back, "you're *always* going on a diet" and making everyone in the group laugh.

[111] Didi was the most popular rideshare app at the time in this area.

As they began catching up with one another, those still working at Summit Care asked Xiao Yue and the other woman who had left how they were doing. Xiao Yue immediately jumped in, gleefully explaining that she and the other two had found a 3-bedroom apartment with a living room that they were renting together for just 1000RMB per month, including wifi. She said that they had been traveling a lot to local tourist attractions since quitting and that her quality of life[112] had improved dramatically since living with the other two because they were extremely neat, and they cooked a lot. At that point, the other woman who had quit chimed in saying that they recently had made curry among other dishes. When one of the nurses still working at Summit Care asked Xiao Yue if she felt bad about leaving when the hospital had valued her so much[113], Xiao Yue snapped back that she had given a lot to the hospital, implying that she had not received much in return. Whether or not one agreed with the way she and her friends quit or the ways she had been compensated, she was undeniably correct that they had all given a tremendous amount to Summit Care and to Unit 1 through their work.

From housing, to having time to travel, to having the ability to cook what she wanted and be with friends, Xiao Yue's description of her life after Summit Care touched on the many ways in which nurse's aides' lives were shaped and constrained by the facility – her description sounded idyllic by contrast. A key component of what made Xiao Yue's new situation seem desirable, however, was that she was still with her friends – the two who had left Summit Care with her and the group assembled for dinner that night. At one point that evening, someone even remarked that nearly everyone at the table either already had left Unit 1 or was planning to leave it in the near future. As much as meeting one another and becoming friends may have initially been a selling point for these women to work in Unit 1 and at Summit Care, the reality was that

[112]生活质量
[113]很重视

their social network with one another could exist independent of their employment situations. In other words, the very social ties that perhaps initially kept them working in Unit 1 despite the comparatively low pay and difficult work could also then draw them away and make it more likely for them to follow one another to other work opportunities.

In Xiao Yue's case, a close relationship with one of the administrators who had left Summit Care in the preceding weeks was what ultimately drew her away from the site along with her two friends. While the Director may have been right that it was important for young women like Xiao Yue to be respectful of social hierarchies that led to job opportunities, he had not fully appreciated that the opportunities he could offer at Summit Care might not actually be the best options available to these women given the rapidly evolving eldercare landscape, overall. Even when he tried to tailor the specifics of each role within the facility to meet individual workers' needs when they told him they were considering leaving the site, he still might not be able to compete with the jobs and, as Xiao Yue put it, "quality of life" available to staff at other institutions. Though I never heard the intricacies of Xiao Yue and her friends' new daily work experiences, they made it clear that they were earning more money for less strenuous jobs and enjoying their apartment and downtime more than they had while working at Summit Care.

In describing homecare workers in Chicago, Buch approaches staff turnover by, "direct[ing] attention to the ways that home care practices meant to sustain lives and persons simultaneously create unequal and unsustainable social relations" (Buch 2018, 179). I would argue that her point applies to institutional care settings, as well. That is to say, sometimes "practices meant to sustain" institutions can "simultaneously create unequal and unsustainable social relations." Nurse's aides were recruited and retained at Summit Care, and particularly at Unit 1, through social networks. Sometimes those were existing social networks within families

or among classmates at local training programs, and sometimes they were social networks that developed or strengthened as a result of young women living, eating, socializing, and working together in highly taxing jobs. While "salvaging" and strengthening social connections between these women was one way for administrators at Summit Care to make their facility a more stable institution with cohesive and stable staff, this approach relied upon unequal, negotiated relationships between individual workers and Summit Care administrators. It was unsustainable in that these women's social networks could also lead them to hear about and pursue work opportunities at other care sites, as well.

In an institution and a care landscape that were both constantly undergoing so much change, it was difficult to determine where power truly lay. The young women working in Unit 1 as nurse's aides, for example, were inexperienced and working in very low status jobs with limited social capital. At the same time, their youthfulness and training made them an asset to the facility in terms of advertising their (relative) expertise and youthful enthusiasm. The Director's ability to facilitate social connections between these women by providing them housing and periodically paying for social outings for them made them feel more connected to Summit Care on the one hand, and provided them with expanded social networks that could ultimately lead them to other employment opportunities on the other. Likewise, job opportunities that attracted some of these young women to work at an integrated medical and elder care[114] site like Summit Care in the first place could also ultimately fuel their departure if they heard about less demanding or better compensated job prospects elsewhere.

As a result of this uncertainty, the Director attempted to institutionalize as much flexibility as possible in Summit Care and Unit 1, despite potential risks to the facility's

[114]医养结合

wellbeing, overall. The Director agreed to negotiate salaries, even though there was a chance that some staff would feel undercompensated. Hospital leadership provided training and advancement opportunities for workers, even though their increased professionalization could potentially make them more likely to be lured away to lower stress and/or higher paid jobs elsewhere. Social events and participation requirements outside of regular work shifts could enrich employees' social lives or professional development, but organizing too many of them could push some staff away and make them feel like the facility was impinging too heavily on their private lives. Wards like Unit 1 developed staff rotation systems that could help compensate for high staff turnover, even if they were also on some level a driving force behind it. Flexibility was a powerful institutional tool, but its impact on employees' lives could easily go too far, and it almost always required extra investments of energy and attention from those in leadership roles.

By the time I returned to Summit Care to conduct follow up research in 2019, the Director had decided to begin moving away from hiring young women like Xiao Yue to work in Unit 1. The investment needed to retain these workers and the risk that they might leave for opportunities elsewhere was simply too high. They were not as *kekao* (可靠, reliable) as older, less educated workers from the countryside, who were assumed to be far less demanding of their employers. Though the Director still seemed hopeful that Summit Care could retain younger, more experienced nurse's aides in the future, a series of setbacks in the facility's access to outside investments led the Director to prioritize "reliability" in the short-term. While many of the young nurse's aides and nurses I had met during my long-term fieldwork were still at the facility, the new hires in Unit 1 were almost all older and less professionally educated nurse's aides. And the question of how long young women in the ward would continue working there

loomed larger than ever as they excitedly told me about pregnancies, marriage proposals, and possible jobs at other sites.

CHAPTER 4: When hands are tied: Physical restraints in Unit 1

Physical restraints came in different sizes and shapes in Unit 1, but the most common were slightly padded, dark green rectangles of cotton approximately half-a-meter-long, ten centimeters wide, and less than one-centimeter-thick with about two-thirds-of-a-meter-long cotton cords on each short end. If a resident was sitting quietly in a chair or wheelchair wearing a dark colored shirt, then one could easily miss one of these restraints tied horizontally across her chest to keep her from falling forward or attempting to stand up unassisted. Often, residents in restraints seemed peaceful. There could be over a dozen residents sitting in the main activity room in restraints, and yet their demeanor would be seemingly indistinguishable from when they were not restrained. Other times, however, the pieces of green fabric became inescapably conspicuous. When multiple restraints were used – not just one across a resident's chest, but also mitten-shaped restraints surrounding each hand and securing it to the arm of someone's chair or wheelchair, and smaller versions of the chest restraints tying down each leg – they tended to attract more attention. The more residents tried to get out of restraints – attempting to stand and repeatedly being pulled back into a seated position, reaching around to try and untie the knotted fabric behind their backs holding them in place, attempting to slowly wiggle out underneath chest restraints or scoot to the edge of a deep sofa in an effort to stand – the harder they were to miss. What made restraints most conspicuous, however, was when a resident began calling out for help in an attempt to get out of a restraint. Although residents frequently seemed unfazed by having a single tie across their torso, cries to "*bang wo jiekai*" (帮我解开, help me untie [this]) were not uncommon.

I observed one especially negative resident response to restraints during my field work with Zhao Wang Yi, one of the male residents in Unit 1. Zhao Wang Yi was generally a good-

tempered man, who was happy to spend his days sitting, looking around, napping, and flipping through the books and magazines kept in the bookshelves next to his spot on one of the couches in the corner of the main activity room. More often than not, Zhao Wang Yi got around Unit 1 by taking small steps with his heels while sitting in his wheelchair, quietly moving himself forward and backward around the ward. Despite his mouth frequently hanging slightly open, he had an air of dignity about him – often napping with one leg crossed over the other and a book resting in his lap. When he wanted to get someone's attention, Zhao Wang Yi's deep, booming voice could be heard from across the ward.

One evening in 2017, Zhao Wang Yi spent over 20 minutes calling out for help. It had been a busy day in the ward – a group had come in to screen a recent film in Unit 1 as part of their local charity work – and after eating dinner Zhao Wang Yi began saying that he wanted to stand up. He strained to reach the knot securing his chest restraint to the metal bar behind the couch where he sat. He was not flexible enough to reach it, so all he could do was call out and repeatedly try and fail to stand on his own. According to my fieldnotes, that evening there were eight people in the room who could have theoretically helped him (not counting the other residents) – a nurse, four nurse's aides, the daughter of another resident, a male member of the hospital cleaning staff, and me. Technically, only the nurse or nurse's aides would have been allowed to untie him according to the facility's rules, but none of them even acknowledged that he was calling out and begging to stand.

As I got increasingly uncomfortable watching his distress, I asked the nurse in the room why no one was responding. She explained that this was due to staffing levels and that his family had signed an agreement saying that they understood more extreme care was needed sometimes, and they knew he was bound and restrained from time to time to keep him from falling. I asked if

his family required[115] that he be restrained like this, and she said no, but that if you give Zhao Wang Yi something to do, then he gets distracted, forgets about the restraint and calms down.

As she and I spoke, Zhao Wang Yi began focusing on the woman visiting a resident several feet away from him. She was the closest person to him who was not a resident in the ward, and he began earnestly pleading with her, saying, "I was wrong. Whatever you all want from me, I'll do it,"[116] and then, "I'm begging you,"[117] and "I'm willing to do better."[118] The nurse's aides continued to ignore him. The head nurse entered the room and did not respond to him. Seeing that I was still watching him, the nurse I had been speaking with told me that he was just calling out because he wanted to go to the bathroom, but that he did not need to call out because he was already wearing a diaper. The staff would leave him there until it was time to change him, she said. In my fieldnotes, I wrote "he smells like his diaper is dirty" after my note on her reply (12/6/17 notes). I asked the nurse if his family required that he not be taken to the bathroom when he was already wearing a diaper, and she replied, "no."

She then left the room, and I went over to talk with Zhao Wang Yi. He immediately asked me to untie his restraints, and when I said that I was not allowed to and could not help him with that, he (understandably) got frustrated and asked why I was talking to him at all if I could not help. Feeling like I had only made a bad situation worse, I went back to my chair across the room. At that point, the nurse I had been talking with returned wanting to talk more with me. She said that she agreed that there were lots of problems with this situation but then she continued to sit with me on the opposite side of the room without interacting with Zhao Wang Yi at all as he continued to cry out and beg to be untied.

---

[115] 要求
[116] "我错了。 你们有啥条件我都愿意 "
[117] "我求求你"
[118] "我愿意改正" (Literally translated: "I'm willing to reform")

Eventually, one of the four nurse's aides who had been sitting in the room throughout this almost 20-minute episode went over to Zhao Wang Yi and perched herself on one of the armrests on his couch. She began introducing him to the residents sitting around him, telling him who his roommates were, who she was, and what she did: "provide services for old people."[119] She then went a step further and explained to him that he counted as an "old person"[120] because he was 76, so she was there to *fuwu*, or serve, him. They went back and forth for a few minutes; she talking in a calm tone, honestly answering his questions, and staying respectful, albeit somewhat disengaged and periodically glancing at the TV that was on next to him as she spoke. Eventually, a male nurse who had recently started in the ward entered the room and asked her if she was working the night shift that night. She replied that she was not, and then added, "help me watch him,"[121] referring to Zhao Wang Yi, who had begun quieting down. At 5:57pm, she got up without another word. Her shift ended at 6:00pm and it was time for her to get ready to leave. Zhao Wang Yi looked around the room touching his face quietly. About 10 minutes after the nurse's aide had left, he was peacefully watching TV and reading some of the subtitles out loud without trying to get up at all or calling out for help. He had not been untied. His diaper had not been changed. And yet, he seemed calm.

Zhao Wang Yi's situation was difficult to watch, but the most surprising thing about it was not his distress or the fact that it continued for nearly 20 minutes without any staff response, but rather that when the nurse's aide *did* respond, she was able to calm him down so easily. For me as an observer, it felt as if she had known all along what to say and what to do, and yet she had chosen to remain silent, ignoring (or simply not registering) his anguish. Though I now see

[119] "为老人服务"
[120] "老人"
[121] "帮我看他"

that as an oversimplification, the incident does raise key questions related to Unit 1: Why were restraints used so frequently and in ways that regularly led to residents like Zhao Wang Yi crying out to be released? How can one make sense of staff responses (and lack thereof) to residents like Zhao Wang Yi begging to be untied? In other words, were there other factors at play limiting – restraining – the degree to which staff were able to respond to residents' needs?

Institutional concerns in context: Restraints as necessary tools for ensuring safety

While the story about Zhao Wang Yi's care may seem like one of neglect, in actuality, I would argue that it captures some of the ways in which Summit Care, and Unit 1 by association, were constantly changing and improving the care they offered and meeting very real threats to patients' physical safety. This is clearer if one considers what care looked like at Summit Care and Unit 1 in the years before my study began.

In addition to speaking with long-term staff and family members of long-term residents, I learned some of Summit Care's institutional history by speaking with an experienced gerontologist I will call Doctor Li Ying. Li Ying was a local celebrity when it came to eldercare. Years before meeting her in person, I became familiar with her name and her work. She published and spoke widely at professional and academic events related to elder care, and directors at some of the sites I visited during my pilot research would even mention working with her as a credential for their site. Something along the lines of, "We provide excellent care here. We follow Li Ying's recommendations."

Summit Care's connection to Li Ying was even more direct, as she visited the site for several hours one morning each week. During that time, she would move between the different wards offering advice and consulting on particularly difficult cases. She almost always stopped

by Unit 1 during her visits, and, by the time I interviewed her in 2018, she had been visiting Summit Care for approximately 4 years, since before Unit 1 first opened. The day of our interview, we sat at a small table next to a nursing station outside her office at the main hospital where she worked. Despite the activity swirling around us, she stayed intently focused on each question I asked her and responded in a straightforward and matter-of-fact tone. When I asked Li Ying what changes she had seen happen at Summit Care since she first visited it, she replied:

> It's changed a lot…originally the death rate was just too high [laughs a little]…There were many old people who could still walk when they came [to Summit Care], but because [staff] didn't pay close attention, [it was] possible [for them] to fall, because [the staff] were using too many medications. High blood pressure medication, hypertension medication, an-an-anti-psychotic medication, and also lots of sleep medications, so the old people were continuously falling down…I thought it looked like an impoverished…I originally didn't want to even go, and also walking [around there] everywhere stank. You'd walk into those rooms [and they] all stank of feces and stank of urine. You felt like every person you saw was lying on a bed, and more than that, [every person was] completely out of it. They couldn't communicate at all…I just felt it was like…reaching Hell…[they were] afraid of falls because [they would have to] continuously pay [families] for damages, and [they] really couldn't afford it…Originally, before, they would take…those who did not walk steady, [they] put all of them in, tied them in bed, bound them in bed. Didn't let [him/her] move around. Then [that patient] would just slowly lose [his/her] abilities.[122]

This bleak description of a hospital filled with unresponsive, bedridden patients in rooms that stank of feces and urine is a direct response to managing the financial risks Summit Care faced as an institution. As Li Ying explained, staff were afraid of falls, not only out of an abstract desire to protect their residents, but because they feared being held financially responsible by patients' families when they "really couldn't afford it." During my fieldwork, concerns about

[122] "有很大的改变。。。原来就是死亡率太高【laughs a little】。。。有很多老人来的时候可能还能走，但是，就是因为没有关注，可能就跌倒，因为他们用药太多了。高血压的药物，降压药，抗，抗，抗精神病药物，还有很多睡眠药物，所以老人又也是不断的跌倒。。。我都看得像一个贫苦。。。我本来都不想去，而且到处走，臭的。你走到那个房间里都是屎臭尿臭。你觉得看的人都是在病床上，而且就完全是傻乎乎的，完全没有交流。。。我就觉得好像。。。走上地狱。。。【他们】怕跌倒由不断地赔钱嘛，还有确实配不起。。。原来以前他们是把。。。走得不稳的，全部弄在，拴在床上，绑在床上。不让他/她活动的。然后就慢慢更失能的"

residents' families suing the institution were still present.

In part, these concerns stemmed from the unpredictability of the regulatory landscape for handling medical disputes. With few oversight mechanisms in place to ensure fair assessments of blame and damages, the range of avenues for pursuing medical disputes could threaten a hospital's financial stability. As Wang et al. explain there are multiple channels for addressing medical disputes, which "can be resolved through litigation or, where alternative dispute resolution (ADR) methods exist, through mediation or arbitration. Facing the scarcity of both medical and legal resources, China has advocated mediation as an ADR approach to deal with medical disputes" (Wang et al. 2020, 2). Medical disputes in China can also theoretically be resolved through the "Regulations on Handling Medical Accidents by the State Council" where compensation is possible if a medical review board determines that a "medical accident"[123] took place (Liebman 2013, 194), or through plaintiffs "bringing ordinary tort claims under the provisions of the General Principles of the Civil Law" and relying on "judicial inspection bodies" to make "determinations regarding negligence" (Liebman 2013, 197). As Wang et al. explain, there is also:

> the People's Mediation Law, [which states that] the People's Mediation Committee is under the supervision of the Judicial Administration department, and mediates disputes for free. The agreement after mediation has legal effect but no power of law enforcement. In order to be legally binding, patients or hospitals must seek judicial confirmation. Without this confirmation, if either side defaults on the agreement, mediators will advise them to choose other ways to deal with the dispute. (Wang et al. 2020, 2)

With a documented increase in medical disputes nationwide in China (Li et al. 2014, 5) and some people lacking confidence in the official channels for registering and resolving medical disputes, some patients and families resort to violence through *yi nao* (医闹, medical disturbances) against

[123] This is defined as "an error causing personal injury to a patient that results from personnel negligently violating relevant laws, administrative regulations, rules, standards governing medical care, or ordinary practice" (Liebman 2013, 194)

medical staff in response to perceived malpractice or wrongful death (T. Hu 2017). Even assuming a hospital like Summit Care avoids direct acts of physical retribution against its staff, the financial burdens resulting from litigation can be significant. As Li et al. explain, the limited availability of liability insurance means that, "hospitals are also in an unfortunate situation, in which they have to cover expenses for patients' compensation from medical litigation. This is in contrast with the situation in other countries in which the cost is covered by medical liability insurance companies[124]" (Li et al. 2014, 5).

Not only were staff and administrators at Summit Care well aware of the increases in medical disputes within China overall, but they also periodically weathered serious family complaints at Summit Care. Several staff members, including the Director, told me about a resident who had died the year before my long-term fieldwork began. The story was that the man had some cognitive impairment, and one summer day the guard at Summit Care's main gate left to go get lunch, and the man slipped out of the facility. The staff searched for him extensively, but when they found him over 24 hours later, he was already dead. As it happened, he had died right near the facility grounds, but staff initially had not seen him. The hospital assumed responsibility for his death and ended up paying[125] his family 400,000 RMB (~$60,000 US), a

[124] As Liebman explains, insurers "are most notable for their absence from medical disputes. Although national and provincial authorities have encouraged (and in some cases mandated) medical liability insurance for doctors and hospitals, the insurance system remains largely ineffective. Insurance generally covers only disputes in which a medical review board has found error. Hospital officials complain that insurers refuse to pay claims resolved outside the courts. Premiums are high relative to the amount of coverage obtained; in some cases insurance costs exceed the amount of indemnification provided by the policy…Smaller or less successful hospitals may lack the ability insurance premiums…Insurance companies have generally not been enthusiastic about marketing medical liability insurance, viewing the area as one with low yields and high risks due to the lack of transparency in China's medical system" (Liebman 2013, 206-207).

[125] I was not told explicitly how the parties involved came to this agreement. My impression from listening to the Director was that the situation was resolved out of court and that the hospital had paid most, if not all, of the damages directly and not via any kind of malpractice insurance.

sum equivalent to more than 10 years of an average nurse's aide salary at the time of my fieldwork.

The story of the man who died likely stood out to the people I interviewed because of the way it ended, but in reality there were many close calls with resident safety. During my fieldwork, one man escaped Unit 1, convinced a bystander on a public bus to cover his bus fare and made it all the way back to his house in a neighboring city before he was located by his son and returned to Summit Care. Another resident snuck onto the roof of Summit Care, and it was not until the Director looked out his office window and saw the man walking around alone on the open rooftop that staff realized he had gone missing. Yet another man stole one of the small knives staff used to cut fruit to give residents for snacks and slit his wrists in the night, only to be discovered and saved by staff on the night shift.

Each of these occurrences represented substantial potential legal and financial risks for the facility and, after each one, additional safety precautions were taken. Staff added a brightly colored vest over the bus rider's regular clothing so that it would be easier to keep an eye on him and so any passersby would know more clearly that he was a resident at the facility and not simply a visitor trying to make his way home. A padlock was added to the stairwell leading to the roof, with the key kept on a large keyring in the nurses' station. No more knives were allowed on the ward following the suicide attempt and apples and pears were carved up using spoons.

At the same time, each story also pointed to significant improvements in quality of life relative to Li Ying's description of her first visit to Summit Care. The residents involved in these stories were not bedridden. They were not so heavily drugged or physically restrained that they could not express agency within and through their environment. As the Director said to me after

describing the man who had died outside the facility, "in this case can you say it would've been better if the man had never stood up and stayed with tubes in him?" (4/15/18 fieldnotes). That is how that man had arrived at Summit Care. Having suffered a debilitating stroke, he was full of tubes: a feeding tube, a catheter, etc. After doing rehabilitation at Summit Care, he was able to get up and walk again, and his family was thrilled. But that newfound ability came with newfound risk as well.

In describing a level of care that echoed Li Ying's portrayal of Summit Care as it had been years before, the Director explained that the facility used to have a problem with how staff, and especially nurse's aides, thought about their work. He summed up their approach as "[If] you're standing, [they] want you to sit. [If] you're sitting, [they] want you to lie in bed,"[126] and this way it was "less [likely] something would happen."[127] At the time he explained this to me, the Director also said that this approach was backwards. Although he had been working at Summit Care since the early 2010's and pushing for the facility to offer increased medical and nursing services, those changes took time. According to Li Ying, things at Summit Care had significantly changed since her first visit to the site. As she continued:

> Now it's different…I said [to them], when the first patient comes, [you] absolutely need to preserve [that person's] ability to function…when I came I pushed them to establish two offices: [one for] nutrition and [one for] rehabilitation. Then I had them [make it so] their old people could not lie in bed; during the day, they had to get up and move around. In this way, [they] slowly changed a lot. So now on the whole, maybe the majority of patients are sitting up [during the day]…when I went, [the facility] didn't have anything. [There was] nothing. Afterwards, slowly slowly pushing them, slowly slowly pushing them, [it] slowly [started] building. Now it's much better, but there are still many big changes needed inside [Summit Care], and there's still a lot that is not done well.[128]

[126]"你站着要你坐起来，你坐着要你躺在床上"
[127]"少出事儿"
[128] "现在不一样了。。。我说第一个病人来的时候，一定要保持住她的功能。。。我来的时候是促进他们把营养和康复这两个建立起来。然后让他们的老人不能躺在床上，白天要起来动。这样慢慢改变了很多。所以现在基本上，可能大部分病人是坐起来的。。。我去的时候什么都没有。都没有。后来，慢慢慢慢促进，慢慢慢慢促进，慢慢建起来。现在就好得多，但是里面还需要很大的改变，还有很多做得不好。"

The new offices Li Ying pushed for *did* change Summit Care. They made it possible for a stroke patient to arrive full of tubes and recover to the point that he could walk independently again. Her final point that "there's still a lot that is not done well" or that could be improved underscores not just how "slowly" and imperfectly that process unfolded, but also that it was continuing to unfold during my research. Physical restraints were an integral tool for staff to use to mitigate some of the risks associated with institutional growth and change.

Staff concerns: Restraints as and for care through *guan*

For Summit Care as an institution, restraints were needed not only to keep residents safe but also to allow staff to provide a form of care without becoming too overworked. During the day, there was always supposed to be at least one nurse or nurse's aide in the main activity room in Unit 1, where there were sometimes dozens of residents. I frequently heard staff tell one another (or on rare occasion, their resident anthropologist), "Help me watch the main room" if they needed to momentarily leave their post as watchperson. After a quick bathroom break, errand, or check on a resident or family member they would then return and resume their watch.

Initially, I was confused by the way I saw staff behaving when they were in charge of "watching the main room." Many would sit in an open chair or on the arm of one of the residents' sofas, shoulders slumped, eyes expressionless, and stare into space. Others began flipping through their phones, or became absorbed in watching whatever TV show was playing on the large screen in the middle of the room. Some would chat with favorite residents or sit by them and interact by patting their arms, making faces at them, or exchanging back massages with them. If the person watching the main room happened to be especially close with someone visiting the ward – a resident's family member, a staff member from another part of the hospital,

or their American ethnographer – then she might spend some time chatting with that person, as well. If a nurse was watching the main room (which frequently happened during the unit's 1.5-hour lunch breaks), she sometimes multi-tasked by filling out paperwork and medical charts as she sat at one of the room's large tables. Conversations between the person watching the main room and any other staff member from Unit 1 who happened to be resting there were also common. On rare occasion, though more frequently with newer, less experienced staff members, the person on watch would energetically attempt to engage residents she did not know well, or who simply seemed bored or distressed in some way.

I wondered why the person watching the main activity room did not consistently attempt to spend time connecting with the residents who were sitting there. One clear answer is that, as discussed in the previous chapter, the nurse's aides and nurses in Unit 1 were often exhausted. A second answer, I believe, had to do with the Chinese concept *guan* (管). This word, and other Chinese words that included this character, came up frequently in Unit 1. When a nurse's aide described the room she had recently been made responsible for (e.g. she got those residents ready in the morning and evening), she would use the word *jie guan* (接管, to take over control). Literally, this word meant to "receive *guan*" for that room. When I spoke with family members about what it had been like for them to find appropriate care for their loved ones, some used the word *guanli* (管理, to manage or tend to), replying that it had been a difficult process because their relatives were *buhao guanli* (不好管理, or difficult to manage). Literally, *guanli* can be broken down into "*guan* with reason or order."

By itself, *guan* can be a difficult word to translate from Chinese into English. Since it is frequently used in discussions related to education and raising children, *guan* shows up often in academic articles related to Chinese parenting philosophies. Describing Chinese parenting styles,

Ruth Chao, for example, frames her discussion of *guan* by writing:

> Tobin et al. (1989) explain that this word literally means 'to govern.' They clarify that *guan* has a very positive connotation in China, because it can mean 'to care for' or even 'to love' as well as 'to govern.' Therefore, parental care, concern, and involvement are synonymous with firm control and governance of the child...[in another study] *guan* was most often used to describe the Chinese teacher's control and regimentation of the [preschool] classroom. (Chao 1994, 1112)

This intermingling of care, love, and "firm control and governance" reveals a trust that the person providing *guan* knows what is in the best long-term interest of the person receiving it. If they govern "with firm control" it is because they not only care about the person in their charge, but also feel committed to being involved in that person's care. The way in which one provides *guan* is determined not just by the individual but also by societal norms. As Chao explains, when it comes to parents raising young children, *guan* is related to:

> a set standard of conduct enforced by both the larger society and the parents. However, the motivations or intentions for imposing these standards are not to dominate the child, but rather to assure the familial and societal goals of harmonious relations with others and the integrity of the family unit (Lau & Cheung, 1987)…*guan* also impl[ies] for the Chinese a very involved care and concern for the child. (Chao 1994, 1113)

In other words, through highly involved care, *guan* serves not just the needs of the care recipient (child) or family, but societal needs as well. It helps the individual enter into a societal group successfully and involves keeping an eye on that person to make sure they stay in-line with the expectations of the larger group(s) to which they belong. When it comes to Summit Care and Unit 1, I would argue that the societal impacts, that larger group, was primarily at the level of the institution and its "harmonious relations" internally and with other actors. The individual needs of the child/resident are a concern to the person who will *guan* them, but they are secondary to broader concerns about how that child/resident fits into the larger societal/institutional whole. Thinking back to Zhao Wang Yi, what ultimately calmed him was the nurse's aide explaining who she was (someone who cares for old people), who he was (an old

person), what larger groups he was part of (an eldercare site), and how he fit into that larger group (reintroducing him to his roommates and explaining who was sitting near him in the main room).

Chinese mothers whom Chen-Bouck et al. interviewed identify what the authors refer to as "main underlying meanings of *guan*" (Chen-Bouck, Duan, and Patterson 2017, 497): mothers feeling "it was necessary to *guan* children"; viewing *guan* as a kind of "behavior regulation" through which they could ensure that their children were doing things when they were supposed to; seeing *guan* as a necessary form of guidance for young children who "were still immature and lack self-discipline" and who participants said "didn't know the consequence of some behaviors" and "couldn't tell right from wrong" without parental guidance through *guan*; and approaching *guan* as a kind of supervision to ensure that an "activity is done correctly or children are behaving correctly" (Chen-Bouck, Duan, and Patterson 2017, 498).

When applied to eldercare, physical restraints addressed all of the facets of *guan* identified by Chen-Bouck et al.'s participants. Given the limited number of staff and the comparatively large number of residents (a ratio that could be as high as 1:23 during night shifts or staff lunchbreaks), physical restraints were sometimes "necessary to *guan*" or monitor and care for the residents. Limited staff also meant that physical restraints were needed for "behavior regulation" to keep residents from doing things they should not do, including preventing them from injuring themselves, other residents, or staff. In particular, the restraints were also necessary to protect residents from not knowing "the consequence of some behaviors" and potentially injuring themselves by standing or walking around unassisted. Finally, when residents like Zhao Wang Yi did not want to follow the institutional schedule, physical restraints

could help ensure they were "behaving correctly" and waiting to have their needs addressed until an institutionally predetermined time.

I once asked a nurse's aide if she would want others to focus as heavily on safety when caring for her when she was older as staff did in Unit 1. She replied:

> I feel like when I'm old, [I would] still need, still [want to] have people *guan* me, right…If I'm by myself [that would] make a bad situation worse [idiom – literally: it's like smashing a pot because it's cracked]. What would [I do] if I fell down? Lying in bed [/being bedridden after a fall would be] even more uncomfortable, yes or no? I would wish instead [that] other people tie me up…That way I could at least walk, come out often. I don't want to lie in bed [all day]. [It's] very uncomfortable. It's better to die and be done with it [than live like that], isn't that right?[129]

There are several interesting aspects to this woman's reply. First, in her opening sentences, she presents the alternative to having someone *guan* her as being entirely by herself. This suggests that a caregiver simply being in the same room as residents can be seen as a form of care through *guan*, and staff were fulfilling at least some caregiving obligation simply by staying in the main activity room and identifying a stand-in caregiver whenever they had to leave it. Second, she seems to accept that any scenario involving her "being old" is an inherently bad scenario, albeit one that can still be made even worse. This understanding of aging perhaps related to a decreased sense that resident discomfort (whether caused by restraints or anything else) could ever be addressed, and seems to inherently make it easier to ignore signs of that discomfort. Third, her train of thought suggests that monitoring through *guan* plays a significant role in preventing falls in particular, something which physical restraints were uniquely effective at accomplishing, albeit arguably at a serious cost to some residents' overall wellbeing. Fourth, she describes the use of physical restraints as linking caregivers who *guan* her with maintaining

[129] "我觉得我老的时候还是必须，还是有人管我吧。。。如果我一个人破罐子破摔，如果摔倒了怎么办？躺在床上更难受，是不是？我还是希望别人把我捆着。。。这样我至少能走路，经常地出来。我不想躺在床上。好难受。这样还不如死了算了，对不对？"

and protecting her comfort and quality of life. Overall, her response paints restraints as a tool for impeding older adults' mobility *as needed* in order to preserve it long-term; this, even though the decreased quality of life she describes hoping to avoid ("lie in bed [all day]") could be precisely the experience a resident had while being restrained.

By aiding in their efforts to *guan* the residents, physical restraints also became an intervention tool that staff could turn to when they were struggling to meet all the residents' needs at once. Restraints expanded the staff's capacity to keep an eye on residents who could, and sometimes did, otherwise seriously injure themselves, and introducing them into a resident's care could provide both staff and family members with peace of mind after an accident. The same nurse's aide who said she hoped someone would *guan* and restrain her when she got older told a story that clearly illustrated the value of restraints to residents, families, staff, and the institution when she described a female resident who fell one night. She said:

> She tripped while I was on shift...[I] just barely happened upon her in the bathroom. If I had started checking rooms from that end [of the hallway] and had not *guan* her, she would've stayed in the bathroom bleeding…When I saw her, [I] immediately called the doctor. [She] had three cuts [on her head]…My god, [she] scared me to death…Before [that] she wasn't restrained. After that instance, [we] started restraining [her]…it seemed like the doctors communicated with [her] family about [us] needing to restrain that old person. [It] was for that old person's safety. If [they] didn't [want us to use] restraints, if they didn't sign [the authorization form], [then] they would be responsible for any consequences. That's how it was…Those [who] should be tied up, tie up. Those [who] should be bound, bind. But those [who] should get medicine [sedatives], still need medicine [sedatives]. Those [who] should…be followed around with someone at their side, still need someone following them around at their side.[130]

In this example, physical restraints protect everyone. They protect the resident from getting injured. They protect the staff member from being in a position where she risks

[130] "在我班上绊倒的。。。刚碰到她在厕所。如果我是从这边查过去，没管她的话，她会一直在厕所流血的。。。看她的时候，就叫医生。有三个洞。。。我天啊，吓死我了。。。之前没约束她。至从那次以后，就把【她】约束了。。。医生好像跟家属沟通了要约束那个老人，是对老人的安全，如果不约束，不签字的话，后果自负。就这样了。。。该捆的，捆。该绑的，绑。但是该用药的，还是要用药。该。。。跟着他们身边的，还是要跟着他们身边的。"

potentially missing a serious injury while on shift. They protect the family from needing to "be responsible for any consequences," meaning injuries, that might occur while she lives in Unit 1. They protect the institution from lawsuits by decreasing the likelihood that a resident will die or be injured due to an accident on the ward and by creating a paper trail that shows that the institution did everything within its power to keep residents safe should such an accident occur. They are not a one size fits all solution, but instead a caregiving approach that can take different forms depending on a resident's needs. "Those who should be tied up, tie up. Those who should be bound, bind." And so on.

Although physical restraints were a key part of what made it possible for Unit 1 to serve so many residents with its limited staff, they also necessarily impacted the quality of care that could be provided. One person alone could not reliably "watch the main room" and be responsible for everyone in it unless those residents who were strong enough to stand yet too weak to walk safely unassisted were restrained. Restraining those residents meant accepting that they might get uncomfortable and upset and, as a staff member, one would not feel the need to respond to every resident complaint because one could rest assured that the baseline safety and physical needs of that resident were being "looked out for" or "monitored" by being in the room and providing *guan*.

"You don't want to tie them too tightly": Resident experiences and approximations

Though keeping residents physically safe was the primary aim of Unit 1, restraints were part of what made that seemingly simple goal so complicated. As the handful of suicide and escape attempts suggest, residents' mental and physical health and safety were highly interconnected. Partly in response, staff were concerned about *yiyu zheng* (抑郁症, depression)

among residents and often paid attention to changes in residents' moods. While a resident who was regularly quiet and disengaged could easily be seen as unremarkable, a resident who was normally talkative suddenly withdrawing would lead staff to check in on that person more regularly, remark on the behavior change to one another in passing, highlight it in shift change meetings, and even sometimes do medical tests to see if something had changed in that person's physical health. In these scenarios, physical restraints could offer staff a kind of safety net (e.g. assuring them that a potentially depressed resident would not walk away and injure him or herself) but unless the resident was actively calling out or straining to escape restraints, they might not be seen as contributing to that person's psychological distress[131].

At the same time, some staff acknowledged that physical restraint use did have a direct negative impact on resident-staff relationships, if not on residents' (and perhaps even staff's) mental health overall. They described residents being wary of staff wearing blue uniforms – the color that nurse's aides often wore – since the nurse's aides were most likely to be the ones restraining residents. One nurse's aide described intentionally wearing a face mask when she had to restrain a resident so that person would have a harder time identifying her later.

As Li Ying mentioned, residents' physical health and safety were also threatened by restraint use if they became less mobile as a result of being restrained for too long. Not only did becoming dependent on a wheelchair or becoming bedridden drastically limit such residents' quality of life, but it also increased their risk of falling if they ever did happen to stand and increased their risk of infections from bedsores if they did not. Staff, and especially families,

[131] Some staff members were more cautious about restraint use than others. One nurse's aide I spoke with acknowledged, "Actually, with restraints, the most important [thing] is that you ensure that old person's safety, right. If he/she isn't agitated, isn't standing up, or isn't [doing] whatever else [that's concerning], we won't restrain him/her. [It's] not good for them." (其实约束的话，最重要的就是你要保证那个老人的安全嘛。如果他不烦躁、不站起来、或者不怎样的话，我们不会去约束他。对他们也不好。)

recognized this and often felt a pull to keep residents as mobile as possible for as long as possible. During fieldwork, I saw staff celebrate and take pride in residents who had been bedridden slowly being able to sit up in wheelchairs and those in wheelchairs slowly being able to walk with assistance as a result of their care. And yet, the risk that a resident who had been allowed to walk independently or sleep without restraints would injure herself was constant.

One reason physical restraints were used so widely in protecting residents' physical wellbeing is that they were seen by staff as safer than medical or chemical restraints. When issues arose with residents behaving erratically or trying to escape the ward, physical restraints were a natural first line of defense for the staff, as they did not require significant increases in staff labor and they were not seen as threatening residents' long-term health. Anti-psychotics or other sedatives and chemical restraints were seen as potentially causing damage to the brain and worsening residents' already compromised memory skills. They were still used with aggressive residents, but controlling resident behavior with physical restraints was generally assumed to be the safer alternative.

Despite the decidedly gray area within which staff and family members were trying to determine the appropriate level of risk in each resident's care, resident experiences of restraints were often treated as secondary, sometimes even inconsequential, by both family and staff. In over 500 hours of observations in Unit 1, I never heard staff discuss risks or benefits of chemical versus physical restraints with the residents themselves. In part, this lack of focus on resident experiences of restraints likely stemmed from the fact that residents whose communication skills were more heavily impaired also tended to be more frequently and more heavily restrained. Not all residents who were restrained *could* call out verbally for help as Zhao Wang Yi had done. For

these residents in particular, but for all residents to an extent, families and staff had only indirect access to what their experiences of restraints actually were.

The nurse's aide who said she hoped someone would *guan* and restrain her when she got older was one of the few nurse's aides I spoke with who had actually experienced being physically restrained. As she explained it to me, there had been a training session[132] done at the facility the summer before my long-term fieldwork began. As part of this training, she had been selected to put on an adult diaper and be put in a hospital bed with physical restraints for a full morning. She described the experience, saying:

> [I]t was these two days [of the year] that [I] was tied up, [it was] so hot! I was tied for 4 hours…so hot, god, [they] turned me once every two hours and I just felt hot! [They] even gave me water to drink, ai [clicks tongue] [it] wasn't good…[There was] simply nothing to be done. The only thing [I could] do was sleep…Getting old is really [clicks tongue] really miserable.[133]

Firsthand experience with being physically restrained gave this nurse's aide a unique perspective on restraints. Of all of the staff I spoke with, her descriptions were the most direct and the most detailed. While staff would frequently describe residents who were heavily restrained as having bad *shenghuo zhiliang* (生活质量, quality of life), this woman's experience allowed her to speak to the heat, the discomfort of being unable to turn her own body in bed, the boredom and the overall sense of being "miserable" in her experience. When I asked her later if she felt that experience had changed the way she personally used restraints with residents, she said yes, that she often thought back to what it was like to be tied up herself. And yet, she still restrained people and *hoped to be restrained herself* if she ever needed it when she got older.

---

[132] I do not know if this training exercise happened regularly or if this woman had happened to be at Summit Care the one time it was offered. I did not personally observe it taking place during my fieldwork, but I was also not present at a large staff training event that occurred while I was in the United States.

[133] "【我】就是在这两天被捆着的，好热啊，我捆了四个小时。。。好热，天啊，两个小时给我翻一次身我就觉得热！还喝水呢，哎【clicks tongue】不好。。。就是没办法呀。唯一的办法就是睡。。。老了就好【clicks tongue】好惨啊。"

The family members I spoke with also drew on their own experiences when imagining what it was like for their relatives to be restrained and when making decisions about whether or not to support the site's use of restraints in their loved ones' care. Some family members, like the middle-aged daughter of the woman who had fallen and cut her head in the night seemed to rationalize restraint use in Unit 1 by thinking of it as a rarely used tool for controlling behavioral outbursts. As she described it:

> Some old people, when [they're] acting out, [staff] will…use some measures, right. I know that. Actually even with my mom they, at the very beginning, she was really wild, you know…They also told me about it. Actually, we can understand…of course, I trust they wouldn't use this kind [of thing] all the time…I feel like under the circumstances when that, when [it's] most, most difficult to control [them] using [restraints], I feel like I can also understand that. But I feel like this kind of circumstance also can't have [staff] using [restraints] every day, you know. [slightly nervous laugh]…Anyway, I feel like they also wouldn't [do that], right…[Someone who] can live normally, they also, it seems don't use [restraints]…It's just when illness flares up, when [patients are] very wild that they use this. I feel like [this] is OK.[134]

This woman's nervousness and hesitancy in talking about restraint use in Unit 1, her unwillingness to even refer to restraints as anything but "measures," seems to sidestep any need to grapple with the emotional experience someone being physically restrained might have. Instead, she justifies restraint use by putting her trust in staff members to handle it responsibly. The staff told her when they were going to use restraints in her mother's care, and she trusts that they only used them when "illness flares up," making restraints a necessary but fundamentally acute intervention. She trusts that they will not be used "every day," implying that they would not be a response to chronic disabilities. In situations like this, perhaps one of the greatest

[134] "有些老人，他太狂的时候，他们会。。。用一些措施，是嘛。这个我知道。其实他们对我妈都，刚开始的时候，她不是很狂躁嘛。。。他们也给我们讲了这个事情。其实我们也能理解。。。当然我相信他们不会是随时都在用这种。。。我觉得那个在，在最，最难控制的情况下用了，我觉得这个也是能理解的。但是我觉得这种情况也不能经常用撒【slightly nervous laugh】。。。反正我觉得他们也不会吧。。。他能正常地生活，他们也，好像也没用。。。就是，在犯病的时候、很狂躁的时候，他们用这个，我觉得是可以的。"

benefits families received from placing their relatives in a medical care site like Unit 1 was the ability to distance themselves emotionally from patient experiences in the ward by putting their faith in the professional expertise of the staff. If physical restraints were necessary to manage a loved one's *illness*, then of course that was understandable. And yet, this woman visited the ward regularly and would have had many opportunities to observe staff regularly using restraints when staffing levels were low on the ward; she would have seen that restraints were used as far more than a response to isolated incidents of sporadic outbursts or "illness flare ups."

Other family members felt less confidence in staff expertise and justified restraint use for their loved ones by trying to imagine themselves in their loved ones' places. As the middle-aged daughter of another resident reflected on why she understood restraints being used in her mother's care, she explained:

> [If] you don't restrain her…in the middle of the night, she gets out of bed if [she] can't sleep. Once [she] gets out of bed, she goes to use the toilet, [but] she's unstable standing…[it's a] very likely possibility that she'd break a bone. Because at night she's not clearheaded. [Even] us, getting up in the middle of the night to use the toilet isn't as [easy] as during the day like this…you need to wave [your] hands around, need to look around for a moment…'Oh, the toilet is over there' and then go over. Them? It's even more, even more difficult to do…So I feel like [the staff] restraining [residents] also comes from [wanting to] protect [residents'] safety.[135]

While the conclusion that staff are making the best judgement call they can in order to protect residents' physical safety seems to echo the previous family member's statement on the surface, the degree to which this daughter was trying to imagine things from her mother's perspective is clear not only in her explicit comparison between what her mother does waking up

[135] "你不给她约束。。。半夜，睡不觉的话她就要下床。下床她就去解溲，她站不稳。。。很有可能就要骨折。因为晚上她是不清晰的。像我们，半夜地起来解溲也没有白天这种好 。。。你要挥挥手，要看一会儿。。。哦，厕所在那边，再过去。他们呢，就更，更老火。。。所以我觉得他约束的也是从保证他们安全的前提出发。"

in the middle of the night and what "us" or "we" might do but also as she continued her response. She said:

> [One] needs to restrain [residents]. But…[one] also has to be careful. [You] don't want to tie [them] too tightly…[if you] make it so [someone] in bed can't move around, all old people will make noise, [they'll] call out because [they're] very uncomfortable. [It] really is uncomfortable. Back when my Mom came they just…restrained [her]…[they] tied her up [so she was] kept in one spot. My mom wanted to turn over but couldn't move at all. [She was] really unhappy. That was it. That's just to say, [using] restraints [should] start from a place of…watch[ing] old people more…[and considering] how to make them reach a degree of comfort…without needing to let them…get out of bed and stumble. This point, hm, this skill I feel they still need to really seriously work on.[136]

In this woman's view, there is a middle ground and a degree of skill needed in *how* restraints are used, rather than *whether* they are used, and this is a key area of growth for staff in Unit 1. When I asked this woman what her biggest concern was related to her mother's care, she replied that she wanted staff to keep her mother from falling in order to preserve her mother's quality of life. Once again, restraints emerge as a tool for protecting residents from themselves. Specifically, protecting residents from misunderstanding their own physical abilities or the consequences of their actions and injuring themselves. As this daughter points out, her mother's discomfort when restrained was both real, she was "very uncomfortable," and to be expected, "all old people will make noise" and "call out" if restrained. And yet, even recognizing this experience, this daughter still sees restraints as necessary to protect her mother given that limited staff meant her mother could injure herself if she got up in the night. The key for this daughter is that restraints not be "too tight."

[136] "需要约束。但是。。。也要小心。不要拴得太紧了。。。让他在床上不能动的，所有的老人他要闹，他要叫因为他很不舒服，确实很不舒服了。我妈曾经来时候他们就是。。。约束的。。。把她拴起来，固定的。我妈想翻身都不动，特别不高兴，就这样。约束就是说从那种出发。。。多看老人。。。要怎么让他们打到就是既有舒适度。。。不用让他们。。。下床摔跤。这一点儿哈，这个功课我觉得还需要她们很认真去做。"

Even if one accepts that restraints were used as a form of care, in some ways a caring *guan*, that still does not address the question of what made the difference between staff ignoring resident experiences of restraints versus responding to them. This, I would argue, is part of the "skill" the daughter is describing, and it is worth consideration in its own right.

Care without kindness?

Both in understanding restraints as a form of care through *guan* and in thinking about a more "skillful" use of restraints that keeps residents both comfortable and safe, there is an assumption that staff would make decisions first and foremost in residents' long-term interest. While this was primarily the case in Unit 1, there were also many instances where staff seemed to ignore residents such as Zhao Wang Yi for unnecessarily long periods of time and sometimes even seemed to use restraints in decidedly unkind ways. Though no one ever said this was how care *should* look in Unit 1, it was still sometimes accepted as one iteration of how care *might* look in practice.

There were multiple examples of care that seemed to lack a degree of kindness. For instance, there was a husband and wife pair who had both moved to Unit 1 when the wife's dementia became too much for the husband and their children to handle at home. Over time, the husband's physical health deteriorated, and he fell and injured himself. During his recovery, staff used physical restraints to keep him from standing, and he persistently called out for someone to untie him. When staff refused to help him (because they believed he would only further injure himself if he were untied) he would call his wife's name, and she would come from across the room or across the ward to be by him. After staff saw her trying to untie his restraints (at his request), they eventually simply tied her in a separate chair just out of reach of where he was

sitting so that she could no longer go over to help him when he called. Another example that stands out is the two residents I saw put in back-to-back chairs and then restrained by being tied to each other's chair backs and chair legs, effectively holding one another in place.[137] The difficulty of such situations stems less from questions about whether restraints were necessary to protect residents' safety, than from an unanswered question around why these residents were treated *the way* they were while being physically restrained. Such situations not only seemed to threaten the mental health of the individuals being restrained but also to potentially chip away at the mental wellbeing of other residents (and staff) around them, raising the question: why would Unit 1 leadership allow such unkind uses of restraints to occur?

It would be easy to describe such events as abuse and seek no further explanation. Hanna Brown's description of nurse-patient relationships in a resource-poor Kenyan hospital offers a useful counter to such an approach. She writes:

> I do not wish to make a judgement about the quality of care that Carolyn [a nurse] gives Pamela [a patient]…However, I maintain that it is helpful to think about the interaction between Carolyn and Pamela as a relation of care. To do so may be contentious given the potential for and reality of abuse in such kinds of relationships, but one thing that it does allow is to draw attention to divergent registers of meaning around care which are helpful for contextualising the meaning of care and abuse in this setting. If we dismiss Carolyn's behaviour as uncaring I argue that we risk misunderstanding important ways in which care is practised in this hospital. (Brown 2010, 128-129)

In other words, even seemingly unkind actions can be manifestations of care. Brown's call to pay attention to "divergent registers of meaning around care" is central to understanding "important ways in which care is practised" in Unit 1, as well. Ultimately, unless a person on staff was actively upsetting other staff or family members to the point that they were considering leaving the ward altogether, leadership prioritized having sufficient numbers of people on staff,

[137] While one might be tempted to find a clinical justification for something like this, the fact that staff who saw these two residents restrained to/by one another commented and joked about it whenever they entered the room made it seem clear that this was done primarily for staff amusement.

even if some of those people were not always kind to the residents. In part, this made sense because even an unkind staff person still could fill in and provide *guan* when other more skilled, or perhaps kinder, staff members were busy providing care in other ways. Moreover, there was always the possibility that an unkind staff person could be trained over time to provide care in more patient and compassionate ways. Given how difficult it was to find and retain staff, particularly nurse's aides, leadership in Unit 1 were willing to accept a fairly wide range of behaviors from anyone willing to do (even the most basic, disengaged version of) the work.

Perhaps because physical restraints were such a powerful tool for staff to use when trying to decrease their immediate workloads, they also made disengaged staff more identifiable. In the instance where two residents were tied to each other's chairs, for example, some staff responded with awkward facial expressions and uneasy questions like "what's going on here?" Others laughed and tried to ignore it. In contrast, those who had tied the residents loudly joked and called attention to their cruelly inventive approach. Leadership in Unit 1, and the head nurse in particular, were acutely aware of the wide range of staff personalities and bedside manners. On one level, the head nurse accepted the inevitability that not all the people on her staff would be perfect caretakers. As she initially explained it to me:

> There are some workers [who] aren't good to the old people. Then there are some with very bad tempers…[they] will admonish the old people or have some other bad behaviors…[it] seems like any place has this kind of [thing]…[it's] impossible that all are, ai, [that] ten people would all be perfect in every way.[138]

While accepting that not everyone would be "perfect in every way," the head nurse also described going to great lengths to try to train and improve behavior among the nurses and nurse's aides she supervised in Unit 1. She described messaging some nurse's aides one-on-one

[138] "有一些工作人对老人不好。然后有一些脾气很大。。。会训老人，或有一些不好的行为。。。这个好像在任何地方都会有。。。不可能都是，啊，十个人都是十全十美。"

via WeChat[139] to discuss their attitudes and behavior toward the residents – sometimes continuing exchanges with them as late as 11 or 12 o'clock at night. She explained how she had worked to get a problematic nurse's aide reassigned to another less skilled ward in Summit Care and then gone out of her way to check in with both that nurse's aide and her new supervisor on a regular basis to see if the nurse's aide would adjust her behavior over time. When it seemed that had occurred, the head nurse then got the woman transferred back to Unit 1, and, as she described it, "after [she] came back up [to Unit 1], everything [was] better, much better." Rather than seeing kindness as a personality trait that one simply did or did not possess, the head nurse actively worked to cultivate the type of caring behavior she wanted from her staff. This inherently meant accepting that a person on staff might miss the mark in a given interaction and still be worth retaining and investing in, overall.

While it was possible for staff to be fired from jobs in Unit 1, the process generally took a long time. At the time of my fieldwork, the head nurse explained that the last person fired from the ward had been a female nurse's aide. She described this woman as never smiling, getting angry with the residents, and getting noticed not only by leadership within Unit 1 but also by higher-level administrators within Summit Care. At one point, the head nurse said an administrator even confronted this woman, asking her "Why do the old people all fear you when they see you?"[140] Some residents refused to go with this woman on bathroom trips. Even so, it took eight months before she was told to leave[141]. The head nurse explained this woman's firing not in terms of why she had been allowed to stay for so long, but why leadership on the ward had

[139] While others have documented WeChat being used as a training tool within hospitals (Luan et al. 2020, 7), the head nurse used it as a way of pursuing 1:1 training or improvement with her staff by strengthening her relationships with them.
[140]为什么老人看见你都害怕你？
[141]喊她走

ultimately felt they had no choice but to ask her to go. As the head nurse put it, the woman was fired:

> Because she had too many people who didn't like her…doctors didn't even like her. So that's to say, there was nothing to be done…if someone else had this kind of behavior [toward residents], but everything else about her was really good, for example [she] got along with other workers, and then got along with the doctors, got along with the families, [and] she just sometimes got mad at the old people…that's just to say [she] intermittently lost her temper a little, right, even this kind [of person] [you] can still make her change [for the better].[142]

Because this woman did not get along with other people on staff, the situation was *mei banfa*: "there was nothing to be done." In this way, as described in Chapter 2, the head nurse illustrated her willingness to prioritize the needs of the institution over the experiences of individual residents. A nurse's aide who "intermittently lost her temper a little" could still offer a net positive contribution to the ward if she got along well with families and other people on staff because her presence in the ward could still draw others to continue working there or continue keeping their loved ones there, and she could still provide basic support for other staff. In that scenario, treating individual residents unkindly would be unfortunate but still something which could theoretically be improved and which would still be within the site's best interest to improve. However, since this woman "had too many people who didn't like her," she risked a dual threat to the facility. Not only might she cause problems for the site by mistreating residents, but she also risked driving away families who felt uncomfortable with her, or, perhaps even more dangerously, staff who did not want to work with her.

Keeping as many people on staff as possible was a key "register of care," as Brown might describe it. Fewer staff meant less staff engagement for residents and more risk of injury, neither

[142] "因为她有太多的人都不喜欢她。。。医生都不喜欢她。所以说，就没有办法。。。其他人如果有这种行为的话，但是她各个方面其他还可好，比如说跟工作人员相处也好，然后跟医生相处也好，跟家属相处好，她就是有时候跟老人发脾气。。。只是说间断性要发一些火嘛，这种都可以把她变过来。"

of which was in residents' best long-term interests. At the same time, prioritizing keeping staff as long as possible meant accepting that a degree of unkindness, lack of patience, or general disengagement might slip into daily care practices. It meant that issues with staff were sometimes resolved one-on-one in late night text exchanges, even if they produced an in-ward environment that made it seem unclear whether or not any actions were being taken against staff who behaved poorly. The head nurse was working to improve staff attitudes and behaviors in Unit 1, but, like so many aspects of Summit Care, that change could only happen through a slow, ongoing process.

Conclusion

Li Ying's first description of Summit Care as, "the death rate was just too high" gives a clear sense of just how far the institution had come in terms of the care it provided. Relative to her description of staff "using too many medications" and responding to subsequently increased fall risks by tying and binding residents to their beds, Zhao Wang Yi's situation suggests that there had already been substantial changes in care practices just in the time between Li Ying's first visit to Summit Care and the start of my fieldwork there. When I saw Zhao Wang Yi that night, he was sitting in a common area, not bedridden in a private room. He was lucid enough to call out for help, not so heavily medicated that he could not communicate. His calls were not met with additional medication or physical restraints, but with seeming indifference and, eventually, compassion. The process of change within Summit Care and Unit 1 may have been very slow, but it did seem to be happening.

There were limitations to what anyone involved in care could offer. Residents could only communicate and tolerate so much. Families could only afford to pay the facility a limited

amount of money for their loved ones' care, and this in turn meant that the facility could only hire and retain a limited number of staff, who could only be held to a limited standard of caregiving. In one way or another, everyone's hands were tied.

The result was that people tried to find workarounds. Some family members bought special bed restraints that could be tied tautly over resident beds at night to prevent them from getting up, while still allowing them to turn and shift their bodies lying down. Some residents simply got used to having chest restraints. Some stopped trying to get up as frequently so that restraints would no longer be seen as necessary in their care. Some became experts at escaping physical restraints. A couple fought their physical restraints so persistently that they ultimately found themselves receiving chemical restraints – dazed, drooling, uncommunicative, and sitting still at last. For staff, workarounds could involve everything from taking the time to sit with favorite residents – either keeping them company while restrained or effectively preventing them from needing physical restraints in the first place – to learning to restrain particular residents in different ways depending on what kinds of restraints seemed most comfortable or effective for them.

Each of the uses of restraints I consider in this chapter were arguably instances of care. Whether for staff themselves, for the residents, for families, or for the institution, these uses of restraints provided support or assistance. Brown writes, "it might also be profitable to stop trying to pin care down by thinking about boundaries around care or within care and instead to recognise that what is so useful about care is precisely its slippery and enigmatic character" (Brown 2010, 130). In Unit 1, I would add that audiences are another element of care that can be "slippery or enigmatic," as well. Ultimately restraints in Unit 1 served many actors in different and sometimes conflicting ways.

A recent podcast, *Nice White Parents*, offers one potential inroad for understanding why it seemed so difficult for staff in Unit 1 to provide kinder care. This podcast focuses on the difficulties of creating equitably integrated and functioning public schools in the United States. Near the end of the series, the reporter, Chana Joffe-Walt, cites Derrick Bell's concept of "interest convergence"(Joffe-Walt 2020). As the podcast's website explains, this term is used "to describe the theory that Black people achieve an expansion of civil rights only when white Americans benefit, when interests converge" (Daniels, Nicole and Michael Gonchar 2020). I would argue that this concept is eerily applicable to Unit 1. Applicable because it did seem like decreased use of physical restraints or more compassionate use of physical restraints tended to happen when there was an "interest convergence" between family wants, staff capacity, institutional standards, and resident desires. Eerie because it seemed that residents' abilities to express their desires and staff and family willingness to take those desires seriously were so tenuous.

When asked how she would describe the rights of older people, Li Ying replied:

> Ai, right now we don't have any…Chinese people today simply haven't paid attention to old people's rights. This is a very big weakness of ours. This old person really doesn't have rights. He/She can have demands…that's not even saying old people with dementia, [the demands of] normal old people can't be paid attention to. Our old people with dementia get even less attention.[143]

If old people's rights are not "paid attention to," if they can only "have demands" without expectation of action in response, it becomes difficult to imagine how their interests will ever be represented, let alone able to converge, with those of the individuals and institutions charged with their care. As their caregivers focus on "safety" and doing what they believe is in residents'

[143] "哎，我们现在就没有。。。中国人现在就没有去关注老年人的权利。这一块儿是我们很大的一个弱点。这个老年人真的没有权利。他/她会有诉求。。。 还不要说痴呆老人，脑正常老人又是不能关注。我们的痴呆老人更没有关注。"

best interest long-term, they risk missing the demands and priorities of those individuals. As one man in Unit 1 said to me when struggling with a chest restraint, he understood that staff were trying to keep him safe, "but their safety is my freedom"[144].

[144]但是他们的安全是我的自由

CONCLUSION

By the end of my four-day Dementia Care Mapping (DCM) training in London, I felt like the instructor was struggling to see Unit 1 in a nuanced way. When I asked her questions about the specifics of DCM tools, pushing her to talk through examples of how terms or concepts from the class materials might relate to situations I had observed back in the ward, she seemed open to considering a wide range of possibilities. For example, the DCM observational coding framework categorized different activities residents might do throughout the day, but it was designed with Euro-American eldercare models in mind. When I asked, "How should I code calligraphy?" and explained that it seemed like a hybrid of "Expressive" (expressive or creative activities), "Leisure" (leisure, fun and recreational activities), and especially for residents who described practicing characters as *xuexi* (学习, studying), "Vocational" (work or work-like activity) and "Intellectual" (Prioritising the use of intellectual abilities) (University of Bradford 2016, 17), she eventually replied that it would depend on how the person I was observing seemed to be approaching the activity. And yet, when I spoke with her about difficult care practices in Unit 1, more generally – changing diapers in common areas, using restraints – her understanding seemed to instantly become more black-and-white. She described it as Tom Kitwood describes non-person-centered care sites in his work: part of the "old culture of care" (Kitwood 1997, 46). This characterization seemed to flatten the complex caregiving interactions I had observed, and it was also strikingly at odds with the role Summit Care and Unit 1 played as part of a decidedly "new" kind of eldercare in China.

Summit Care and Unit 1 were part of the thousands of newly built or constantly evolving eldercare facilities defining and redefining contemporary institutional eldercare in China through

their daily practices. By dismissing the challenges they encountered as "old culture care"[145], the DCM instructor seemed to foreclose any possibility that she and my classmates might have something to learn from the people I knew back in Sichuan. In this dissertation, I have tried to complicate and undercut that assumption.

In Chapter 1, I examine the many terms used for "care" in Chinese and suggest that they were used in Unit 1 to describe residents as particular kinds of care recipients (e.g. patients, quasi-children, consumers). As part of exploring why defining "good care" was so complicated in Unit 1, I then turn to ways in which different individuals in the ward – staff, family members, residents, and I – offered care to one another and shaped one another's behavior through telling stories. Focusing particularly on the stories told through semi-staged photos of residents that staff took and then sent to a family WeChat group, I draw on Susan Blum's work to argue that these stories provided care even when those who received the images knew they were somewhat fictionalized. For medical anthropologists, I see this chapter as an attempt at complicating and destabilizing understandings of who care recipients are in institutional care; it suggests that all involved in care institutions are providing and receiving care to/from one another and shaping how one another engage in care as a direct result of the stories they each tell. It also contributes to medical anthropology debates around what "care" or "good care" really mean – I imagine that

[145] Despite the ethnocentric connotations of this term, Kitwood uses it to juxtapose what he sees as "the old culture of care" present even in Euro-American care settings and the new culture of care for which he is advocating. He writes, "The[se] two cultures see dementia care in fundamentally different ways. The old culture generally denied the existence of psychological need in people with dementia, or blanked it out with tranquilizing medication. The old culture involved only minimal interaction, and then largely around basic physical tasks. The new culture, however, is committed to engaging with psychological need. The surprising and delightful discovery is that in many cases needs can be sufficiently well met to bring a new phase of relative peace and relaxation. The new culture has a highly positive view of interaction, viewing it as the truly healing component of care" (Kitwood 1997, 135). My concern with the instructor's use of the term is therefore not that I could not see how it applied in some ways or at some times in Unit 1, but rather the way she seemed to use it as an all-encompassing descriptor, as if Unit 1 could not simultaneously have aspects of both Kitwood's "old culture" and "new culture" of care involved in its practices.

there is as much variety, or more, in how care is practiced in Euro-American eldercare sites as there was in Unit 1, so what is lost in distilling those different approaches down to the singular word "care"? When I think about my research participants or other individuals connected to institutional care settings, my hope is that this chapter might help staff and families see care in Unit 1 as happening through (sometimes fictional) stories, and that this might raise questions around whether there are opportunities for engaging with residents more as if they were functional adults, rather than engaging with them as quasi-children. If there is power in even fictional stories of care, what impact might such a "re-casting" of dementia ward residents have on the way care work is approached in these settings? Similar approaches already exist in the "citizen"-focused dementia care described in Denmark (Gjødsbøl and Svendsen 2018; Svendsen et al. 2018), but I wonder what such models might look like in a Chinese setting.

In Chapter 2, I explore differentiated care as an institutionalized part of Unit 1 and Summit Care, and examine how these sites operated as flexible institutions. I show that institutional flexibility relied upon and reinforced a *mei banfa* (没办法, nothing to be done) ethics of engagement among staff and family caregivers. For medical anthropologists, this chapter underlines the importance of thinking seriously about how institutional care operates as care for institutions. It points to the importance of staying attentive to when and how institutional needs might limit the degree to which patients' needs can be addressed. This chapter also raises questions for people working in eldercare settings. As Euro-American eldercare seems to be increasingly specializing and professionalizing – creating sub-divided care institutions with "independent living" separate from "assisted living" separate from "memory care" – the flexible institution poses a provocative alternative model. It raises the question: might something be lost in separating residents and staff based on these medicalized designations? Care in Unit 1 was far

from perfect, but if there had been more resources available to support it, perhaps unseen benefits might have emerged from having residents with different physical and cognitive levels of ability living together in one space. Perhaps they could be supported in supporting one another in meaningful ways? Even for institutions committed to keeping residents with different levels of ability separate from one another, this chapter raises questions about where those institutions are currently being "stretched" in terms of their care offerings and whether they might be stretched further to more fully meet their residents' needs. Relatedly, I wonder if there are opportunities for care workers in Euro-American sites to learn from a *mei banfa* ethics of engagement that could help decrease burnout. For all involved in Unit 1, I see this chapter as a dual reminder: that those needs designated as *mei banfa* can often still be responded to if the institution is stretched to meet them, and that stretching and responding to select needs for one person often comes at the expense of decreased flexibility and resources being available to meet the needs of another.

In Chapter 3, I explore the needs and experiences of Unit 1's young female nurse's aides. I show that the social networks and opportunities that often drew these women to nurse's aides' jobs in Unit 1 were both harnessed and strengthened by Summit Care leadership even as those same social relationships also made these women inherently more at risk of going to other sites as they heard about new opportunities through their networks. For medical anthropologists, this chapter raises questions about how relationality shapes care, not only in terms of interpersonal relationships between caregivers and care receivers, but also in terms of a relationality among staff. I would suggest that this is a defining difference between institutional care and in-home care, and I believe there is significant opportunity for anthropologists to look more closely at how relationships among staff shape institutions and caregiving practices. For eldercare providers, and particularly for administrators at Summit Care, this chapter raises questions about

how institutions might support and strengthen staff relationality to serve care recipients in wards and not just to attempt to build staff cohesion through activities and bonding events outside of regular working hours. In other words, it raises the question: how might staff cohesion be built and sustained alongside strengthening connections between staff and residents?

In Chapter 4, I turn to the use of physical restraints in Unit 1 and examine them as a kind of care for the institution, the staff, the resident, and the family. I focus on how the need to provide a baseline form of care through *guan* (管, to oversee/have a care for/manage) sometimes led leadership in Unit 1 to keep seemingly unkind individuals on staff, at least in the short-term. For eldercare providers, especially those in Euro-American care settings, I see this chapter as a call to reflect upon whether and how they restrain residents in different ways through their care practices (e.g. with sedatives, with heavy chairs pushed in next to tables so people cannot stand, with wheelchairs that recline back to prevent someone from getting up unassisted) and to consider who is being served through those practices. For medical anthropologists, this chapter raises questions about what values are being centered in eldercare practices that restrain. What can approaches to restraint tell us about how needs are understood for people living with dementia, their families, the staff who care for them, and the institutions where they live?

Overall, this study emphasizes the significant gravitational pull family members had in Unit 1, even though Summit Care operated as a private hospital and was therefore technically a non-family-based care site. The degree of impact family members had – for better and worse – raises questions about the possibilities and limitations of care in institutional settings. As different as this care site seemed from high-end dementia care facility where I took my DCM class in London, I see tremendous potential for collaboration around fundamental ethical questions: how do you balance safety with quality of life? How do you engage family members

in residents' care (particularly as a source of continuity in the face of staff turnover)? Are institutions losing something important in their push for increased specialization and professionalization of care (e.g. opportunities for residents to help one another)?

My hope is that participants in this study felt seen in my interviews with them and that they gained more empathy for one another's struggles in our conversations. Here, I have tried to offer my perspective on a complicated and constantly changing institution, to be honest about what I learned there, and to acknowledge the difficulties of writing about my experiences.

Giving and receiving feedback

Staff and administrators at Summit Care and Unit 1 regularly asked me for input into how care in the ward might be improved, but they were sometimes wary about what that input might be. Toward the end of my fieldwork, I was finishing an interview with one of the leaders of Unit 1, and, after a pause, this person asked something to the effect of, "What are you going to write? Are you going to write about the bad things?" At the time, the question caught me off-guard. I answered that I was not sure yet what I would write about, that it would depend on how my analysis went, and that I was starting to feel like "good" and "bad" were not really accurate descriptors for care in the ward, that I was interested more in why things happened the way they did than in labeling them as "good" or "bad." I hope those intentions still come through in this writing.

Though I side-stepped giving a direct answer most times I was asked how care in the ward could or should be improved, I gave more concrete replies on two occasions. The first time was through a two-page sheet of preliminary reflections that I put together at the end of my long-term fieldwork in 2018 and shared with the Director, an assistant director at Summit Care,

leadership in Unit 1, and any Unit 1 staff who asked to see it. Although I was deeply aware that what felt like the most important recommendations to make also seemed the most impossible to implement, I gave them anyway. I emphasized the importance of supporting current staff with more time off and stronger bottom-up communication channels for nurse's aides and other lower-level workers to provide feedback and suggestions to those above them in the institutional hierarchy. I recommended investing in hiring more staff to provide support: a social worker who could advocate for residents and help staff communicate more effectively with residents' family members, a therapist who could offer psychological support to staff, residents, and possibly families, and, if hiring more full-time staff for Unit 1 was impossible, hiring a "floater" nurse or nurse's aide who could be called into Unit 1 or other wards in Summit Care as needed. I suggested ways of strengthening communication between different groups – possibly investing in training several Unit 1 staff in more advanced techniques like DCM, creating more formalized opportunities for residents to mentor and support one another as new arrivals adjusted to living in the ward, and conducting an anonymous survey of the staff to more accurately gauge their priorities (e.g. would salary increases be seen as more valuable than additional time off).

The second time I provided feedback, it was via a PowerPoint that I presented to the Director, staff, and leadership in Unit 1 when I returned to Summit Care for a two-week follow-up trip in 2019. Though I included a brief summary of my preliminary recommendations, this presentation was focused primarily on my data analysis – discussing Unit 1 as a site of "family-centered care" more than "person-centered care," discussing it as a "flexible institution," and discussing quality of life and safety tradeoffs as part of what it meant for Summit Care and Unit 1 to try to sell peace of mind to residents, and especially, their families.

Both times, the recommendations I made seemed well-received and easily ignored. When discussing my recommendations at the end of long-term fieldwork, the Director was extremely solicitous, even offering to pay for me to return to the site as a consultant (a polite offer, that I politely refused). He said the recommendations were insightful, and he and I discussed challenges to implementing them: the difficulty of finding professionally trained, qualified social workers and therapists in Sichuan relative to more coastal regions, the added expense of staff time off or additional staff hires, and more. At the same time, he seemed committed to the idea of working with leadership in Unit 1 and other administrators to see what changes might be possible. When I returned over a year later, the Director's positive comments seemed more like performative praise. The main changes that had been made in the interim were: newly added, brightly colored metal poles and railings in the Summit Care courtyard, large-print staff nametags in Unit 1, and a shift toward older, less educated nurse's aides in the Unit 1 ward. I laughed when leadership in Unit 1 told me the Director had called them in the days before my visit and more or less said, "Lillian is coming back. Do you still have that sheet of recommendations she made? We should find something we can implement from that list so that she doesn't feel like we didn't use them." It seemed the recommendations were not so useful after all.

Staff, particularly nurse's aides, had much more consistent responses to the feedback I gave the site. They were curious how those above them in the institution's hierarchy had responded to my recommendations about further valuing and supporting their work. They asked what the Director had said when I recommended giving nurse's aides two days off each week, and I told them that he had agreed it was important for them to have downtime, but also mentioned that the one day off per week that Summit Care gave nurse's aides was already more

than many of its competitors offered, and that the facility could not currently support the added costs of hiring additional staff to cover for nurse's aides taking an extra day off every week. When I gave my PowerPoint presentation to Unit 1 staff in 2019, the majority of group discussion involved nurse's aides adamantly agreeing that they needed more time off and talking about why the administrators were not providing it. The primary explanation these staff discussed was the very one the Director had mentioned to me the previous year: not enough money to hire the additional staff who would be needed to cover open shifts. On the whole, staff, administrators, and residents' families seemed to understand that their needs and priorities did not always align, and so, while they were sometimes frustrated with one another, they were rarely at a loss for identifying one another's motivations.

For residents in Unit 1, however, needs could easily be called into question or rendered illegible, particularly for residents with moderate to advanced dementia. If their cognitive impairment was seen as severe enough to keep them from remembering their own experiences from one moment to the next, then, as Luo Jinsheng's sister described (Chapter 2), a resident who was "in his own world" could be presumed inherently "fortunate" or contented by default. For more lucid residents, even staff who were willing to make exceptions – letting someone stay in their room to watch TV in relative privacy rather than bringing them to the main activity room, bringing someone on errands to other parts of Summit Care to give them time outside the ward, etc. – could easily feel those residents simply had other, greater needs (e.g. for independence) that were beyond what the ward could offer. The reason changes did not happen readily in the ward was not that people could not imagine potential improvements, but rather because individuals lacked the ability to make larger-scale changes.

Ultimately, it felt like my biggest contribution to the ward was simply being there and helping to give further voice to the needs different people in Summit Care expressed to me. My recommendation that nurse's aides receive a second day off each week came not just from observing how tiring their work was or feeling (a fraction) of its physical toll in my own body when I shadowed them on night shifts, but also from nurse's aides in Unit 1 telling me how much they wanted it. My recommendation that Summit Care employ a social worker and a therapist came not just from my trust in those disciplines and from observing staff struggling to communicate with "difficult" family members in Unit 1, but also from interview sessions with staff who not-so-jokingly recommended that their friends talk to me because it "felt good" to discuss their work, from interviews with family members who described agonizing feelings of guilt and concern related to their relatives' care, and from residents expressing deeply depressed and sometimes suicidal thoughts when I spoke with them in the ward. Whether or not Summit Care ever made tangible changes, there was value even just in reiterating to all involved that those around them were also struggling and striving in the face of tremendous challenges.

Moving from care to connection

I returned from my fieldwork at Summit Care grappling with the questions: What can we hope for from institutional care settings? What makes care "good" or at least "good enough"? What were the costs and benefits of care happening the way it did in Unit 1? Exploring the last question helped me to see care in Unit 1 as the constantly shifting balance of priorities: protecting the institution and its ability to operate successfully in a competitive market, satisfying residents' families, retaining and cultivating staff, and providing for and accommodating residents. Given that, I realized that nearly every caregiving interaction I observed could be seen

as arguably "good" or "good enough" simply by shifting the perspective from which one viewed it. Ignoring Grandpa Fei's calls to go to the bathroom seemed like "bad care" from a Euro-American, person-centered care model, but if doing so allowed staff to attend to other residents' more immediate safety needs or to take a break that would allow them to be more effective at their jobs overall, or attend to other institutional needs, then perhaps it was "good enough" care so long as someone eventually helped him?

In terms of what could be hoped for from institutional care, it seemed like the most one could hope for was finding a kind of synergy between the needs of all involved. There were moments of genuine connection between people in Unit 1 – times when young, female nurse's aides would joke with the older men and women living in the ward, or talk in mixed staff-resident groups about questions of marriage, work, love, and more. These kinds of interactions allowed young staff to learn from and reflect upon the experiences of Unit 1 residents, and for residents to be and feel valued for having had those experiences. As Arthur Frank summarizes Nancy Mairs' insights, "*all* persons have abundances, and all have lacks" (Frank 2013 [1995], 149) and thus "Genuine services…[are] a matter not of being nice but of recognizing that one's own lack can only be met by the other's abundance of need" (Frank 2013 [1995], 150). In these moments of connection between staff and residents, it seemed like the "paradox" Frank and Mairs describe was being enacted: "as we serve we are also being served" (ibid). The laughter and openness in those moments seemed to defy questions of what was or was not "good care." They were not scripted or intentionally produced interactions, nor could they have been. They were a meeting of abundances and lacks. This raises a question: how might institutions facilitate or support such fundamentally unstructured interactions? These were moments when the staff actually had a concern in their own lives that felt so pressing that they could not help but discuss

it with the older residents, people who were desperate to share their life experiences and to have those experiences valued.

In their own ways, staff, residents, and families in Unit 1 all seemed to be searching for a sense of connection. They wanted to believe that the institution could offer more than a last resort, more than a bare minimum. Sometimes they had the physical and emotional bandwidth to contribute to efforts to bring that "more than" institution into being and sometimes they did not. Some nurses and doctors talked to me about ideas they had for research projects and papers they might write related to working in Unit 1. They wanted feedback on their ideas, and they wanted to think of ideas that seemed useful, capable of making a tangible impact on the ward. One nurse's aide told me that she was compiling notes on the residents in her assigned room. She said she was writing down their likes and dislikes, how one should interact with them to limit resistance to daily institutional routines and timetables, where they had pain or sensitivity in their bodies. She said she wanted to be able to pass those notes along if she was ever assigned to a different room, so that the new nurse's aide would know about the people for whom she cared.

Looking to the future

Particularly early on in my fieldwork, family members and staff connected to Unit 1 tended to talk about Summit Care as an institution in the midst of development and with a bright future. The Director told me about external investors who had been identified and plans to build a new, cutting edge facility that would more than double the number of beds Summit Care provided. There would be training opportunities for staff to become increasingly skilled and funds available for bringing in new staff and new technology. The mock-ups and 3-D illustrations of the shining new building seemed exciting and full of promise. Nearly every time,

when I asked staff or family members if they had heard about the expansion plans, they said, "yes."

And yet, I was surprised at how they seemed more hesitant than excited about the plans. When I asked what they thought about the proposed expansion, the reply was often some version of "The plans sound great. We'll see what's it's like once it's built." When pushed further, one family member expressed concern about still being able to afford the facility's fees if the new building was a success. One nurse's aide said she would be excited to get promoted more quickly to being a full nurse if the new facility opened, and that she would likely quit if such advancement opportunities did not materialize. The overall sense I got was that people were excited about the idea of a fancy, new facility, but they were uncertain whether or not it would ever impact their lives, in particular. A new building sounded great, but it would not matter if the fees were so high one had to look elsewhere for care. Expanded staff training and opportunities would be wonderful but only really counted if one was included in the group being trained and promoted. It seemed like people had faith in the idea that such changes would happen for the institution, but they were more tentative than hopeful about how, if at all, those changes would touch their lives as individuals (Chapter 2).

For residents (who often had not heard that there were expansion plans underway), the idea of a new care facility was even less certain. Each time I left Unit 1 to return to the United States at the end of a fieldwork trip, some residents would mention that they might not be there when I returned. The combination of old age and illness made these residents' time horizons uncertain in many ways, but many seemed confident that "several years" could be a prohibitively long time off in the future for them to experience. Perhaps some also intuited what one resident's family told me: they were not planning to relocate their relative to the new facility even if it was

built in the next few years. They assumed Summit Care would continue operating in the current building at the current rates regardless of what happened with a new second site, and, as long as that was the case, they did not plan to switch locations.

What seemed most certain about the future was that China would have tremendous need for eldercare infrastructure[146]. As one nurse's aide told me, her family encouraged her to stay in this line of work even though she did not especially enjoy it because there would be so many opportunities in eldercare in the coming decades. Though that remains true, now, approximately a year-and-a-half into the COVID-19 pandemic, I wonder what the data will ultimately show regarding how many older adults in China and globally will have died prematurely by the time this is all done. Certainly, there will still be tremendous need for eldercare support in China, but I wonder how deeply facilities like Summit Care were or were not transformed by the pandemic and its aftershocks. Though I had only limited contact with staff and families via WeChat, from what they described, it sounded like Unit 1 dramatically restricted family members' access to the ward during the peak of the pandemic in China[147]. Staff told me that families dropping off supplies would either leave them at the Summit Care gate or message a staff person to meet them downstairs outside the hospital in order to hand off supplies there. For a facility that seemed to rely on family members to provide not only oversight and guidance on care priorities for particular residents, but also assistance with daily care and social stimulation, I imagine that Unit 1 was transformed during that period.

[146] This seems even more true following China's 2020 census. As Reuters reported, "China 2020 census shows population growth slipped to lowest ever" (Yao and Woo 2021). With fewer babies being born, it seems likely that the need for non-family-based eldercare infrastructure will increase as families have fewer young people available to support their aging relatives.

[147] It is worth noting that strict lockdowns and containment measures translated into a "peak" that was documented as lasting only six weeks in Sichuan (Liu et al. 2020). Even so, the degree of family involvement in Unit 1 during my research makes me think that six weeks of virtually no family contact could still have had a lasting impact on daily care practices in the ward.

For over year now, when I message with family members and staff connected to Unit 1, they describe a China that has returned to "normal life." I wonder what that looks like for the residents in Unit 1. My hope is that they found more ways to connect with one another and to have meaningful moments of connection with staff, as everyone in the ward faced the uncertainty of a global pandemic together. I hope to someday read articles written by the Unit 1 staff describing their experiences.

REFERENCES

Alzheimer's Association. 2021a. "Medical Tests." Alzheimer's Disease and Dementia. 2021. https://alz.org/alzheimers-dementia/diagnosis/medical_tests.

———. 2021b. "What Is Dementia?" Alzheimer's Disease and Dementia. 2021. https://alz.org/alzheimers-dementia/what-is-dementia.

Aulino, Felicity. 2019. *Rituals of Care: Karmic Politics in an Aging Thailand*. Ithaca: Cornell University Press.

Bear, Laura, Karen Ho, Anna Lowenhaupt Tsing, and Sylvia Yanagisako. 2015. "Generating Capitalism." Society for Cultural Anthropology. 2015. https://culanth.org/fieldsights/series/generating-capitalism.

Biehl, João. 2013. *Vita: Life in a Zone of Social Abandonment*. Berkeley, CA: University of California Press.

Bird-David, Nurit, and Tal Israeli. 2010. "A Moment Dead, a Moment Alive: How a Situational Personhood Emerges in the Vegetative State in an Israeli Hospital Unit." *American Anthropologist* 112 (1): 54–65. https://doi.org/10.1111/j.1548-1433.2009.01196.x.

Blum, Susan Debra. 2007. *Lies That Bind: Chinese Truth, Other Truths*. Lanham: Rowman & Littlefield Publishers.

Brijnath, Bianca. 2014. *Unforgotten: Love and the Culture of Dementia Care in India*. Life Course, Culture and Aging ; v. 2. New York ; Oxford: Berghahn Books.

Brown, Hannah. 2010. "'If We Sympathise with Them, They'll Relax' Fear/Respect and Medical Care in a Kenyan Hospital." *Medische Antropologie* 22 (1): 125–42.

Buch, Elana D. 2013. "Senses of Care: Embodying Inequality and Sustaining Personhood in the Home Care of Older Adults in Chicago." *American Ethnologist* 40 (4): 637–50. https://doi.org/10.1111/amet.12044.

———. 2018. *Inequalities of Aging: Paradoxes of Independence in American Home Care*. Anthropologies of American Medicine. New York: University Press.

Chan, Kam Wing. 2013. "China: Internal Migration." In *The Encyclopedia of Global Human Migration*, 2:980–95. Oxford: Blackwell Publishing Ltd. https://doi.org/10.1002/9781444351071.wbeghm124.

Chao, Ruth K. 1994. "Beyond Parental Control and Authoritarian Parenting Style: Understanding Chinese Parenting Through the Cultural Notion of Training." *Child Development* 65 (4): 1111–19.

Chen-Bouck, Li, Changming Duan, and Meagan M. Patterson. 2017. "A Qualitative Study of Urban, Chinese Middle-Class Mothers' Parenting for Adolescents." *Journal of Adolescent Research* 32 (4): 479–508. https://doi.org/10.1177/0743558416630815.

Cheng, Si. 2021. "Retirement Age Reform Vital to Development." China Daily. 2021. https://www.chinadaily.com.cn/a/202103/23/WS60592a42a31024ad0bab0d4b.html.

Chou, Rita Jing-Ann. 2011. "Filial Piety by Contract? The Emergence, Implementation, and Implications of the 'Family Support Agreement' in China." *The Gerontologist* 51 (1): 3–16. https://doi.org/10.1093/geront/gnq059.

Chu, Leung-Wing, and Iris Chi. 2008. "Nursing Homes in China." *Journal of the American Medical Directors Association* 9 (4): 237–43. https://doi.org/10.1016/j.jamda.2008.01.008.

Clausen, Thomas, Pernille Tufte, and Vilhelm Borg. 2014. "Why Are They Leaving? Causes of Actual Turnover in the Danish Eldercare Services." *Journal of Nursing Management* 22 (5): 583–92. https://doi.org/10.1111/j.1365-2834.2012.01484.x.

Cohen, Lawrence. 1998. *No Aging in India: Alzheimer's, the Bad Family, and Other Modern Things*. Berkeley: University of California Press.

Daniels, Nicole and Michael Gonchar. 2020. "'Nice White Parents' Discussion Guide." The New York Times. August 31, 2020. https://www.nytimes.com/2020/08/27/learning/lesson-plans/nice-white-parents-discussion-guide.html.

Das, Veena. 2007. *Life and Words Violence and the Descent into the Ordinary*. A Philip E. Lilienthal Book in Asian Studies. Berkeley: University of California Press.

Driessen, Annelieke. 2018. "Pleasure and Dementia: On Becoming an Appreciating Subject." *Cambridge Anthropology* 36 (1): 23–39. https://doi.org/10.3167/cja.2018.360103.

Fang, Lijie. 2018. "China's Experience in Funding Long-Term Care: Case Studies of Three Cities." In *The Chinese Health System in Transition*, 135–61. Research Series on the Chinese Dream and China's Development Path. Singapore: Springer Singapore. https://doi.org/10.1007/978-981-13-0758-4_8.

Fassin, Didier. 2020. “Inequality of Lives, Hierarchies of Humanity. Moral Commitments and Ethical Dilemmas of Humanitarianism.” In *In the Name of Humanity: The Government of Threat and Care*, edited by Ilana Feldman and Miriam Ticktin, 238–55. Durham, NC: Duke University Press. https://doi.org/10.1515/9780822393221-010.

Feng, Jin, Lixin He, and Hiroshi Sato. 2011. “Public Pension and Household Saving: Evidence from Urban China.” *Journal of Comparative Economics* 39 (4): 470–85. https://doi.org/10.1016/j.jce.2011.01.002.

Feng, Zhanlian, Elena Glinskaya, Hongtu Chen, Sen Gong, Yue Qiu, Jianming Xu, and Winnie Yip. 2020. “Long-Term Care System for Older Adults in China: Policy Landscape, Challenges, and Future Prospects.” *The Lancet* 396 (10259): 1362–72. https://doi.org/10.1016/S0140-6736(20)32136-X.

Feng, Zhanlian, Chang Liu, Xinping Guan, and Vincent Mor. 2012. “China’s Rapidly Aging Population Creates Policy Challenges in Shaping a Viable Long-Term Care System.” *Health Affairs (Project Hope)* 31 (12): 2764–73. https://doi.org/10.1377/hlthaff.2012.0535.

Folbre, Nancy. 2012. *For Love and Money: Care Provision in the United States*. New York: Russell Sage Foundation.

Folbre, Nancy, and Julie A Nelson. 2000. “For Love or Money -- Or Both?” *The Journal of Economic Perspectives* 14 (4): 123–40. https://doi.org/10.1257/jep.14.4.123.

Fong, Vanessa L. 2004. *Only Hope: Coming of Age under China’s One-Child Policy*. Stanford, Calif.: Stanford University Press.

Foucault, Michel. 1973. *The Birth of the Clinic; an Archaeology of Medical Perception.* [1st American ed.]. World of Man. New York: Pantheon Books.

Frank, Arthur W. 2013. *The Wounded Storyteller: Body, Illness, and Ethics*. Second edition. Chicago: The University of Chicago Press.

Frazier, Mark W. 2010. *Socialist Insecurity: Pensions and the Politics of Uneven Development in China*. Ithaca: Cornell University Press.

Fu, Teng. 2008. “Pension Reforms in China: An Institutional Pursuit of Stability for the Rapidly Aging.” In *China in Search of a Harmonious Society*, edited by Sujian Guo and Baogang Guo. Challenges Facing Chinese Political Development. Lanham, MD: Lexington Books.

Gjødsbøl, Iben M., Lene Koch, and Mette N. Svendsen. 2017. “Resisting Decay: On Disposal, Valuation, and Care in a Dementia Nursing Home in Denmark.” *Social Science & Medicine* 184 (July): 116–23. https://doi.org/10.1016/j.socscimed.2017.05.022.

Gjødsbøl, Iben M., and Mette N. Svendsen. 2018. “Recognizing Dementia: Constructing Deconstruction in a Danish Memory Clinic: Constructing Deconstruction.” *Medical Anthropology Quarterly* 32 (1): 103–19. https://doi.org/10.1111/maq.12365.

Glenn, Evelyn Nakano. 2010. *Forced to Care: Coercion and Caregiving in America*. Cambridge, Mass.: Harvard University Press.

Glinskaya, Elena, and Zhanlian Feng. 2018. “Options for Aged Care in China : Building an Efficient and Sustainable Aged Care System.” Text/HTML. Washington, D.C.: World Bank Group. https://documents.worldbank.org/en/publication/documents-reports/documentdetail/171061542660777579/Options-for-Aged-Care-in-China-Building-an-Efficient-and-Sustainable-Aged-Care-System.

Goffman, Erving. 1961. *Asylums; Essays on the Social Situation of Mental Patients and Other Inmates.* [1st ed.]. Anchor Books ; A277. Garden City, N.Y.: Anchor Books.

Good, Mary-Jo DelVecchio, Paul Brodwin, Byron J. Good, and Arthur Kleinman, eds. 1994. *Pain as Human Experience: An Anthropological Perspective*. Comparative Studies of Health Systems and Medical Care. Berkeley: University of California Press.

Greenhalgh, Susan. 2008. *Just One Child: Science and Policy in Deng’s China*. ACLS Humanities E-Book. Berkeley: University of California Press.

Hellström, Ingrid, Mike Nolan, and Ulla Lundh. 2005. “‘We Do Things Together’: A Case Study of ‘Couplehood’ in Dementia.” *Sage Publications* 4 (1): 7–22.

Hendriks, Ruud. 2012. “Tackling Indifference—Clowning, Dementia, and the Articulation of a Sensitive Body.” *Medical Anthropology* 31 (6): 459–76. https://doi.org/10.1080/01459740.2012.674991.

Hu, Tianlong. 2017. “TOWARD HEALING AND RESTORATION AGAINST MEDICAL DISTURBANCE (YINAO) IN CHINA: RECONSIDERATIONS AND PROSPECTS OF RESPONSIBILITY SEARCH AND MALPRACTICE RESOLUTION.” *Frontiers of Law in China* 12 (4): 561–83. https://doi.org/10.3868/s050-006-017-0030-6.

Hu, Xin, Bo Xia, Yi Hu, Martin Skitmore, and Laurie Buys. 2019. "WHAT HINDERS THE DEVELOPMENT OF CHINESE CONTINUING CARE RETIREMENT COMMUNITY SECTOR? A NEWS COVERAGE ANALYSIS." *International Journal of Strategic Property Management* 23 (2): 108–16. https://doi.org/10.3846/ijspm.2019.7436.

Huang, Zhiling. 2018. "Sichuan to Roll out More Steps for Non-Public Enterprises." Chinadailyhk. 2018. https://www.chinadailyhk.com/articles/67/49/44/1543294103860.html.

Hull, Matthew S. 2012. *Government of Paper: The Materiality of Bureaucracy in Urban Pakistan*. 1st ed. Berkeley: University of California Press. https://doi.org/10.1525/j.ctt1pppk9.

Jarmin, Ron. 2021. "The 2020 Census: Our Growing Nation." The United States Census Bureau. 2021. https://www.census.gov/newsroom/blogs/director/2021/04/2020-census-our-growing-nation.html.

Joffe-Walt, Chana. n.d. "Nice White Parents." Accessed October 1, 2020. https://www.nytimes.com/2020/08/20/podcasts/nice-white-parents-school.html?action=click&module=audio-series-bar&region=header&pgtype=Article.

Kaufman, Sharon R. 2005. --*And a Time to Die: How American Hospitals Shape the End of Life*. New York: Scribner.

Keimig, Rose K. 2021. *Growing Old in a New China*. New Brunswick: Rutgers University Press.

Kitwood, Tom. 1997. *Dementia Reconsidered: The Person Comes First*. Rethinking Ageing Series. Buckingham [England] ; Philadelphia: Open University Press.

Kleinman, Arthur. 1988. *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.

Kleinman, Arthur, Jing Jun, Yunxiang Yan, and Everett Zhang. 2011. *Deep China: The Moral Life of the Person*. Berkeley, CA: University of California Press.

Kontos, Pia. 2006. "Embodied Selfhood: An Ethnographic Exploration of Alzheimer's Disease." In *Thinking About Dementia*, edited by ANNETTE LEIBING and LAWRENCE COHEN, 195–217. Rutgers University Press.

Kulick, Don, and Jens Rydström. 2015. *Loneliness and Its Opposite: Sex, Disability, and the Ethics of Engagement*. Durham: Duke University Press.

Lamb, Sarah. 2014. "Permanent Personhood or Meaningful Decline? Toward a Critical Anthropology of Successful Aging." *Journal of Aging Studies* 29 (April): 41–52. https://doi.org/10.1016/j.jaging.2013.12.006.

Lazzari, Carlo. 2018. "Sleep Deprivation in Healthcare Professionals and Medical Errors: How to Recognize Them?" *Sleep Medicine and Disorders: International Journal* 2 (1). https://doi.org/10.15406/smdij.2018.02.00034.

Lee, Ching Kwan. 1998. *Gender and the South China Miracle: Two Worlds of Factory Women*. Berkeley: University of California Press.

Lee, Jieun. 2019. "Living with/out Dementia in Contemporary South Korea." *Medical Anthropology Quarterly* 33 (4): 501–16. https://doi.org/10.1111/maq.12532.

Levitsky, Sandra R. 2014. *Caring for Our Own: Why There Is No Political Demand for New American Social Welfare Rights*. New York City: Oxford University Press, USA.

Li, Fengyue, and Junko Otani. 2018. "Financing Elderly People's Long-term Care Needs: Evidence from China." *The International Journal of Health Planning and Management* 33 (2): 479–88. https://doi.org/10.1002/hpm.2488.

Li, Heng, Xiangcheng Wu, Tao Sun, Li Li, Xiaowen Zhao, Xinyan Liu, Lei Gao, Quansheng Sun, Zhong Zhang, and Lihua Fan. 2014. "Claims, Liabilities, Injures and Compensation Payments of Medical Malpractice Litigation Cases in China from 1998 to 2011." *BMC Health Services Research* 14 (1): 390. https://doi.org/10.1186/1472-6963-14-390.

Liebman, Benjamin L. 2013. "MALPRACTICE MOBS: MEDICAL DISPUTE RESOLUTION IN CHINA." *Columbia Law Review* 113 (1): 181–264.

Lindemann, Hilde. 2014. *Holding and Letting Go: The Social Practice of Personal Identities*. Cary: Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199754922.001.0001.

Liu, Quan-Hui, Ana I. Bento, Kexin Yang, Hang Zhang, Xiaohan Yang, Stefano Merler, Alessandro Vespignani, et al. 2020. "The COVID-19 Outbreak in Sichuan, China: Epidemiology and Impact of Interventions." *PLOS Computational Biology* 16 (12): e1008467. https://doi.org/10.1371/journal.pcbi.1008467.

Livingston, Julie. 2012. *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic*. Book Collections on Project MUSE. Durham [N.C.]: Duke University Press.

Lora-Wainwright, Anna. 2017. *Resigned Activism: Living with Pollution in Rural China*. Urban and Industrial Environments. Cambridge, Massachusetts: The MIT Press.

Luan, Hui, Miao Wang, Rebeccah L. Sokol, Shiyou Wu, Bryan G. Victor, and Brian E. Perron. 2020. "A Scoping Review of WeChat to Facilitate Professional Healthcare Education in Mainland China." *Medical Education Online* 25 (1). https://doi.org/10.1080/10872981.2020.1782594.

Mather, Mark. 2020. "Aging and Health in China: What Can We Learn From the World's Largest Population of Older People?" *Population Reference Bureau* (blog). January 31, 2020. https://www.prb.org/aging-and-health-in-china-what-can-we-learn-from-the-worlds-largest-population-of-older-people/.

Mattingly, Cheryl. 2010. *The Paradox of Hope: Journeys through a Clinical Borderland*. 1st ed., 1. Berkerley: University of California Press. https://doi.org/10.1525/j.ctt1ppw0s.

McDonell, Stephen. 2021. "China Allows Three Children in Major Policy Shift." *BBC News*, May 31, 2021, sec. China. https://www.bbc.com/news/world-asia-china-57303592.

McIntosh, C. J., J. Westbrook, R. Sheldrick, C. Surr, and D. J. Hare. 2012. "The Feasibility of Dementia Care Mapping (DCM) on a Neurorehabilitation Ward." *Neuropsychological Rehabilitation* 22 (6): 920–41. https://doi.org/10.1080/09602011.2012.711642.

McKearney, Patrick. 2020. "Challenging Care: Professionally Not Knowing What Good Care Is." *Anthropology and Humanism* 45 (2): 223–32. https://doi.org/10.1111/anhu.12302.

Mol, Annemarie. 2002. *The Body Multiple: Ontology in Medical Practice*. Science and Cultural Theory. Durham: Duke University Press.

———. 2008. *The Logic of Care: Health and the Problem of Patient Choice*. MyiLibrary. London ; New York: Routledge.

Moser, Ingunn. 2010. "Perhaps Tears Should Not Be Counted, But Wiped Away: On Quality and Improvement in Dementia Care." In *Care in Practice: On Tinkering in Clinics, Homes and Farms*, edited by Annemarie Mol, Ingunn Moser, and Jeannette Pols, 277–300. Bielefeld, GERMANY: Transcript Verlag. http://ebookcentral.proquest.com/lib/washington/detail.action?docID=2026182.

Nguyen, Vinh-Kim. 2010. *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS*. Body, Commodity, Text. Durham, NC: Duke University Press.

OECD. 2021. "Purchasing Power Parities (PPP) (Indicator)." 2021. http://data.oecd.org/conversion/purchasing-power-parities-ppp.htm.

Ong, Aihwa. 1991. "The Gender and Labor Politics of Postmodernity." *Annual Review of Anthropology* 20 (1): 279–309. https://doi.org/10.1146/annurev.an.20.100191.001431.

Osburg, John. 2013. *Anxious Wealth: Money and Morality among China's New Rich*. Redwood City: Stanford University Press.

Pang-White, Ann A. 2011. "Caring in Confucian Philosophy." *Philosophy Compass* 6 (6): 374–84. https://doi.org/10.1111/j.1747-9991.2011.00405.x.

Pérez-Olmos, Isabel, and Milcíades Ibáñez-Pinilla. 2014. "Night Shifts, Sleep Deprivation, and Attention Performance in Medical Students." *Int J Med Educ* 5: 56–62. https://doi.org/10.5116/ijme.531a.f2c9.

Petryna, Adriana. 2002. *Life Exposed: Biological Citizens after Chernobyl*. Princeton University Press.

Pinto, Sarah. 2014. *Daughters of Parvati: Women and Madness in Contemporary India*. Contemporary Ethnography. Philadelphia: University of Pennsylvania Press, Inc.

Pols, Jeannette. 2005. "Enacting Appreciations: Beyond the Patient Perspective." *Health Care Analysis* 13 (3): 203–21. https://doi.org/10.1007/s10728-005-6448-6.

Potts, Malcolm. 2006. "China's One Child Policy." *BMJ* 333 (7564): 361–62. https://doi.org/10.1136/bmj.38938.412593.80.

Redfield, Peter. 2005. "Doctors, Borders, and Life in Crisis." *Cultural Anthropology* 20 (3): 328–61. https://doi.org/10.1525/can.2005.20.3.328.

———. 2013. *Life in Crisis the Ethical Journey of Doctors without Borders*. Berkeley: University of California Press.

Rhodes, Lorna A. 1991. *Emptying Beds: The Work of an Emergency Psychiatric Unit*. Comparative Studies of Health Systems and Medical Care ; No. 27. Berkeley: University of California Press.

Robbins, Jessica C. 2021. *Aging Nationally in Contemporary Poland: Memory, Kinship, and Personhood*. New Brunswick: Rutgers University Press.

Rodriquez, Jason. 2014. *Labors of Love: Nursing Homes and the Structures of Care Work*. New York: NYU Press.

Rouse, Carolyn. 2009. *Uncertain Suffering: Racial Health Care Disparities and Sickle Cell Disease*. Berkeley, CA: University of California Press.

"Rubicon Strategy Group." 2016. 2016. http://rubiconstrategygroup.com.

Santos, Gonçalo D., and Stevan Harrell. 2017. *Transforming Patriarchy: Chinese Families in the Twenty-First Century*. Seattle: University of Washington Press.
Seaman, Aaron T., and Anne M. Stone. 2015. "Little White Lies: Interrogating the (Un)Acceptability of Deception in the Context of Dementia." *Qualitative Health Research* 27 (1): 60–73. https://doi.org/10.1177/1049732315618370.
Seim, Josh. 2021. "Participant Observation, Observant Participation, and Hybrid Ethnography." *Sociological Methods & Research*, 4912412098620-. https://doi.org/10.1177/0049124120986209.
Shea, Jeanne L. 2019. "Dominant Chinese National Policies on Aging and Their Degree of Attention to Eldercare by Seniors." *Ageing International* 44 (4): 331–51. https://doi.org/10.1007/s12126-017-9318-2.
Shea, Jeanne L., and Yan Zhang. 2016. "Ethnography of Eldercare by Elders in Shanghai, China." *Ageing International* 41 (4): 366–93. https://doi.org/10.1007/s12126-016-9262-6.
Solomon, Harris. 2017. "Shifting Gears: Triage and Traffic in Urban India." *Medical Anthropology Quarterly* 31 (3): 349–64. https://doi.org/10.1111/maq.12367.
Song, Yuting, Ruth A. Anderson, Kirsten N. Corazzini, and Bei Wu. 2014. "Staff Characteristics and Care in Chinese Nursing Homes: A Systematic Literature Review." *International Journal of Nursing Sciences* 1 (4): 423–36. https://doi.org/10.1016/j.ijnss.2014.10.003.
Stewart, Nancy H., and Vineet M. Arora. 2019. "The Impact of Sleep and Circadian Disorders on Physician Burnout." *Chest* 156 (5): 1022–30. https://doi.org/10.1016/j.chest.2019.07.008.
Sufrin, Carolyn. 2015. "'Doctor, Why Didn't You Adopt My Baby?' Observant Participation, Care, and the Simultaneous Practice of Medicine and Anthropology." *Culture, Medicine and Psychiatry* 39 (4): 614–33. https://doi.org/10.1007/s11013-015-9435-x.
———. 2017. *Jailcare: Finding the Safety Net for Women behind Bars*. 1st ed., 1. Berkeley: University of California Press. https://doi.org/10.1525/j.ctt1pd2kb3.
Svendsen, Mette N., Iben M. Gjødsbøl, Mie S. Dam, and Laura E. Navne. 2017. "Humanity at the Edge: The Moral Laboratory of Feeding Precarious Lives." *Culture, Medicine and Psychiatry* 41 (2): 202–23. https://doi.org/10.1007/s11013-017-9519-x.
Svendsen, Mette N., Laura E. Navne, Iben M. Gjødsbøl, and Mie S. Dam. 2018. "A Life Worth Living: Temporality, Care, and Personhood in the Danish Welfare State." *American Ethnologist* 45 (1): 20–33. https://doi.org/10.1111/amet.12596.
Taylor, Janelle S. 2010. "On Recognition, Caring, and Dementia." In *Care in Practice : On Tinkering in Clinics, Homes and Farms*, edited by Jeannette Pols, Annemarie Mol, and Ingunn Moser, 1. Aufl., 8:27–56. Bielefeld: Transcript Verlag. https://doi.org/10.14361/transcript.9783839414477.27.
The World Bank. 2019. "Mortality Rate, Infant (per 1,000 Live Births) - China | Data." 2019. https://data.worldbank.org/indicator/SP.DYN.IMRT.IN?locations=CN.
The World Bank Group. 2021a. "Life Expectancy at Birth, Total (Years) - China." The World Bank. 2021. https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=CN.
———. 2021b. "The World Bank in China: Overview." Text/HTML. World Bank. 2021. https://www.worldbank.org/en/country/china/overview.
Tronto, Joan C. 2013. *Caring Democracy: Markets, Equality, and Justice*. New York: NYU Press.
Tsing, Anna Lowenhaupt. 2015. "Salvage Accumulation, or the Structural Effects of Capitalist Generativity." Society for Cultural Anthropology. 2015. https://culanth.org/fieldsights/salvage-accumulation-or-the-structural-effects-of-capitalist-generativity.
University of Bradford. 2016. *DCM(TM) 8: User's Manual*. Bradford: University of Bradford School of Dementia Studies.
———. 2021. "Dementia Care Mapping." University of Bradford. 2021. https://www.bradford.ac.uk/dementia/dcm/.
Uretsky, Elanah. 2016. *Occupational Hazards: Sex, Business, and HIV in Post-Mao China*. Stanford, California: Stanford University Press.
Wang, Feng, Baochang Gu, and Yong Cai. 2016. "The End of China's One-Child Policy." *Brookings*, March 30, 2016. https://www.brookings.edu/articles/the-end-of-chinas-one-child-policy/.
Wang, Junping. 2018. "未来中国养老模式是'90+7+3.'" 人民日报中央厨房. March 11, 2018. https://www.hubpd.com/c/2018-03-11/707804.shtml.

Wang, Mengxiao, Gordon G. Liu, Hanqing Zhao, Thomas Butt, Maorui Yang, and Yujie Cui. 2020. “The Role of Mediation in Solving Medical Disputes in China.” *BMC Health Services Research* 20 (1): 225. https://doi.org/10.1186/s12913-020-5044-7.

Wang, Wei, Xin Zhuang, and Peng Shao. 2020. “Exploring Health Information Sharing Behavior of Chinese Elderly Adults on WeChat.” *Healthcare* 8 (3): 207. https://doi.org/10.3390/healthcare8030207.

Westerberg, Kristina, Jacobus Pienaar, Maria Nordin, Marina Romeo, and Montserrat Yepes-Baldó. 2018. “Organizational Change and Commitment: Effects on Well-Being, Turnover Intent and Quality of Care in Spanish and Swedish Eldercare.” *Economic and Industrial Democracy*, November, 0143831X18815970. https://doi.org/10.1177/0143831X18815970.

“What Is Go?” 2021. American Go Association. 2021. https://www.usgo.org/what-go.

Whyte, Martin King, Wang Feng, and Yong Cai. 2015. “Challenging Myths About China’s One-Child Policy.” *The China Journal (Canberra, A.C.T.)* 74 (1): 144–59. https://doi.org/10.1086/681664.

Yan, Hairong. 2008. *New Masters, New Servants*. Duke University Press. https://doi.org/10.1215/9780822388654.

Yan, Yunxiang. 2016. “Intergenerational Intimacy and Descending Familism in Rural North China.” *American Anthropologist* 118 (2): 244–57. https://doi.org/10.1111/aman.12527.

Yao, Kevin, and Ryan Woo. 2021. “China 2020 Census Shows Population Growth Slipped to Lowest Ever.” *Reuters*, May 11, 2021. https://www.reuters.com/article/us-china-society-census-idUSKBN2CS07T.

Zelizer, Viviana A. 2005. *The Purchase of Intimacy*. Princeton: University Press.

Zeng, Yi, and Therese Hesketh. 2016. “The Effects of China’s Universal Two-Child Policy.” *Lancet* 388 (10054): 1930–38. https://doi.org/10.1016/S0140-6736(16)31405-2.

Zhang, Hong. 2017. “Recalibrating Filial Piety: Realigning the State, Family, and Market Interests in China.” In *Transforming Patriarchy: Chinese Families in the Twenty-First Century*, edited by Gonçalo D. Santos and Stevan Harrell, 234–50. Seattle: University of Washington Press.

Zhang, Yan. 2020. “Debating ‘Good’ Care: The Challenges of Dementia Care in Shanghai, China.” *Anthropology & Aging* 41 (1): 52–68. https://doi.org/10.5195/aa.2020.266.

中国新闻网. 2017. “三问中国养老‘9073’格局 ‘及人之老’如何实现？.” [Xin Hua Wang] 新华网. January 5, 2017. http://www.xinhuanet.com//politics/2017-01/05/c_1120252385.htm.

华律网整理. 2020. “2017 年成都市城镇全部单位就业人员平均工资-平均工资|华律办事直通车.” 2020. https://www.66law.cn/laws/126349.aspx.

每日经济新闻. 2019. “全国六省市迈入深度老龄化 山东‘最老’_新浪山东_新浪网.” Xin Lang Shandong [新浪山东]. May 14, 2019. http://sd.sina.com.cn/news/2019-05-14/detail-ihvhiews1708752.shtml.