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Making a case for “Careful storage”: Dementia care in Denmark and China

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A R T I C L E   I N F O

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A B S T R A C T

The word “storage” may initially seem antithetical to “good care,” evoking a sense of objectification and spatial othering. And yet, dementia care institutions empirically function as spaces that physically separate, or “store,” their charges as part of the care they provide. In this paper, we propose what we call “careful storage” as a way of analytically engaging with the interrelationship of care and storage in dementia care institutions. Drawing on ethnographic research at dementia care sites in Denmark and in China, we argue for the concept of “careful storage” (1) as a way of understanding how our ethnographic sites materialize care institutions through the preservation of both those stored within their walls and the institutions in themselves, and (2) as a productive analytic tool for juxtaposing and studying care sites across cultural contexts, specifically in terms of the simultaneous processes of crafting personhood and institutionhood.

1. Introduction

The word storage can easily seem at odds with the notion of good care, or with care altogether. And yet, care and storage stand in relationship to one another. In Denmark, the word “storage” enters eldercare conversations in descriptions of worst case scenarios, as facilities that cease to provide good care are understood as reduced to sites of “mere storage” [ren oppevaring] (Pedersen, 2016). This term refers to a situation in which care only covers residents’ basic needs of food, shelter, and personal hygiene, yet does not include activities of conversation, physical exercise, cooking, music, or reading, and thus does not treat residents as thinking, acting, or interacting human beings. “Mere storage” echoes long-standing English-language literature related to “warehousing” care recipients in medical or psychiatric institutions that provide their charges a bare minimum of care while primarily operating to keep them secured and separate from wider society (Henry, 1965; Kayser-Jones, 1995; Kitwood, 1997).

The negative connotations of “mere storage” and “warehousing” relate to the fact that acts of storage imply profoundly different expressions of agency between a subject who stores and an object which is stored (Bennett, 2010). The presumed lack of agency of that which/who is stored feeds into assumptions about inherent incompatibilities between care and storage. In the last decades, social science studies of institutionalized eldercare have documented the meticulous relational work—both formal and informal—involved in taking care of people with dementia and turning them into persons (see e.g. Allison et al., 2019; Kemp et al., 2013; Leibing, 2006; McLean, 2007; Moser, 2011; Næss et al., 2016). In this way, the social sciences have themselves contributed to upholding distinctions between care and storage by putting forward descriptions of care for subjects that is inherently opposed to storage of objects. Bringing the concepts of care and storage into the same analysis, we do not intend to contribute to reductionist understandings of dementia, depicting people with dementia as dehumanized, ‘living dead’ or even zombies (Basting, 2009; Behuniak, 2011; Kitwood, 1997). Rather, in thinking care as storage and storage as care, we aim for a more nuanced understanding of how people with dementia—who do not conform to “dominant forms of personhood” (McKearney & Zoanni, 2018, p. 11)—become enacted as persons through the care performed within the institutions ‘containing’ them.

Therefore, as clear as the tensions between care and storage may seem, in this paper we aim to trouble them to take seriously and thus scrutinize the notion of storage in connection to institutionalized eldercare. After all, people only need care when there is something they cannot do alone that another person or institution can help accomplish; limited agency and capacities for rational autonomy are, in this way, an accepted prerequisite to requesting and receiving care. Moreover, people with dementia are moved into institutions, sometimes against their wills, and enormous efforts are put into keeping them within institutional walls and preventing them from accessing wider society, where they might put themselves and others in danger. We suggest that investigating how
institutionalized dementia care operates within bounded spaces enables us to see how institutions’ outside edges are materialized and sustained in the process of providing care to people within them. This approach allows us to explore what care becomes possible through storage, and what is stored (and what is allowed to flow) through care at the institutions we study.

We build these arguments by examining two care sites: a prominent dementia care institution in Copenhagen, Denmark, that we refer to as Sun Vale and a private dementia unit in a hospital in Sichuan, China, that we call Summit Care. While these institutions operate in markedly different cultural, economic, and political settings, attempts to connect such facilities in China and Denmark have been developing for nearly a decade (Lund, 2018; Marcincowski, 2015). At Sun Vale, visits from a wide range of eldercare providers from China and other Asian countries were common at the time of our research. As the director of Sun Vale, a woman we call Lene, described it, “we have a lot of visitors. I think we have a visit once a week or once [every two] weeks … from China, Japan, Singapore.” She explained that these visitors, eldercare providers from around the world, were “going shopping” and looking for Danish care practices they could learn about and then replicate “in their way” when they get back” to their home countries. At Summit Care in China, administrators often spoke of Danish care practices as among the gold standards for eldercare around the world. This echoed Lene’s description and underscored that Danish care models offer lucrative potential “exports” as the Danish government works to finance social services within its borders by packaging and exporting “welfare technologies” beyond them.

Traveling between Sun Vale in Denmark and Summit Care in China, we wondered how we may approach these institutions not as sites of care or sites of storage, but rather as sites of “careful storage” where care is enacted as and through practices related to maintaining entities in institutional space? With the term careful storage, we demonstrate how practices of care and storage cannot be separated, rather they constitute two sides of the same coin. Our aim is to emphasize that good, effective storage rarely if ever simply happens: Institutions can only successfully maintain and support those in their charge through substantial investments and expressions of care—both for the entities they store and for themselves—which makes storage integral to the materialization of institutions of care. By juxtaposing our two sites, we explore the specificities of careful storage in each context to approach in a new way the question of what constitutes good care. While previous research has brought forth the interpersonal care practices and shown that an attention to care privileges the need to hold people with dementia enacted the boundary. Careful storage, we thus argue, allows for recognizing simultaneously the individual and the institution as the ‘matters’ of care and concern (cf. Puig de la Bellacasa, 2017).

In the sections that follow, we first introduce our empirical sites and our methodology, and then our analytical framework of juxtaposition and “careful storage”. The analysis falls in two parts. First, we address the temporal aspect of storage in our two institutions highlighting how care practices aimed at preserving people with dementia enacted the boundaries of the institutions. Second, we investigate how staff in both sites actively represent to specific audiences the value of the care institution to those cared. We end by suggesting that destabilizing presumed distinctions between care and storage pushes us to see where care might be happening as and through storage, particularly in institutional care settings.

2. Dementia care in China and Denmark

Despite radically different local histories, care infrastructures and resource availabilities, in both Denmark and China people are grappling with how to provide eldercare and dementia care in efficient, moral, and medically effective ways. Since the majority of Danish public nursing homes were built in the 1960’s and 1970’s (Ploug et al., 2004), Denmark currently has a more established history of institutional eldercare and dementia care infrastructure relative to China. And yet, the Danish system is still being negotiated. Eldercare facilities in Denmark are becoming increasingly specialized or closing down as the state works to reserve institutional eldercare for its most physically and/or cognitively impaired citizens, with approximately 60% of all residents of Danish elder care facilities having dementia diagnoses in 2016 (Ministry of Health, 2016a). As new facilities and new kinds of facilities are still being built, existing institutions like Sun Vale also continue to develop their caregiving environment and refine their practices through iterative techniques such as Dementia Care Mapping (DCM™). These institutional changes are also echoed in broader Danish society, with new eldercare related policies put forward and negotiated by the Danish state and eldercare stakeholders (Ministry of Health, 2016b). Even within Denmark, ‘imports and exports’ between care sites are common. Lene, for example, explained that she regularly gives talks and professional consultations related to dementia care throughout Denmark, promoting Sun Vale, in particular, as an institutional model for other care sites to emulate.

In China, the speed and degree of demographic change is spurring dramatic developments in eldercare on an even larger scale. According to the National Bureau of Statistics of China and the Chinese Ministry of Civil Affairs Report, the percentage of the Chinese population over age 65 is projected to triple, rising from approximately 8.87% in 2010 to 27% by 2050 (Yeung & Xu, 2012). In the midst of this demographic shift, societal values and eldercare expectations and practices are likewise fluctuating (Kleinman et al., 2011; Zhang, 2016). As demand for eldercare services increases, this population aging is also expected to drive a change in China’s elder care workforce. Currently, many primary care workers or “nurses’ aides” (护理员) in Chinese care facilities are largely untrained, middle-aged women from the countryside. However, as these women age themselves, younger people or immigrant workers will likely be needed to staff eldercare facilities. Responding to these expected shifts, the director at Summit Care explained that he was striving to make his site into a local standard-bearer for more professionalized care and more sustainable staffing by hiring young, often female, trainees from new 2-year technical certificate programs to be “nurses’ aide” staff in the facility’s dementia care ward.

3. Methodology

This paper draws on ethnographic data collected in Denmark between 2014 and 2016 and in China between 2015 and 2019. Data related to Denmark and Sun Vale comes from three months of fieldwork Iben conducted there in 2014 as part of a multi-sited study of what constitutes a life worth living in Denmark headed by Mette, from a joint visit and interview all three authors carried out there in 2016, and from limited site visits and interviews Lillian conducted at another eldercare site in Denmark in 2016. As the majority of Danish nursing homes (85%), Sun Vale is run by the state. In Denmark, the state subsidizes some of the expenses for citizens living in nursing homes, and referral happens after an assessment of the individual’s needs, undertaken by an employee in the local municipality (Ministry of Health, 2016a). The financial situation of the individual is thus less decisive for eligibility for nursing home care than care needs. This was reflected in the composition of Sun Vale’s residents, representing the broad Danish middleclass.

Data related to the Chinese site, Summit Care, was collected over 16 months of fieldwork in Sichuan carried out by Lillian. Unlike Sun Vale, Summit Care is private. Though the facility receives subsidies from the government and many residents’ care is paid for in part (or entirely) by using funds from their state provided pensions, a fundamental relationship exists between the degree of care particular residents receive and the funds they (and/or their families) spend. In Summit Care’s dementia care...
ward, residents come from a range of financial backgrounds. A bed in its dementia ward costs nearly twice as much as one its general wards, and the majority of dementia ward residents are therefore unsurprisingly middle-to-upper-middleclass. Though some families negotiate lower monthly rates on a case-by-case basis and others push staff to provide more individualized care irrespective of what they pay, there is no denying that, far more than at Sun Vale, residents and families “get what they pay for” at Summit Care.

At both Sun Vale and Summit Care, ethnographic data were generated through observation, participant observation, semi-structured interviews, and unstructured conversations with administrators and managers at the care sites, caregiving staff, families of residents and residents themselves, and doctors. In total, we have conducted over 65 h of audio-recorded formal interviews, covering 25 h in connection to fieldwork at Sun Vale and over 40 h in connection to fieldwork at Summit Care. Hand-written fieldnotes were taken in both locations. The negotiation of access to do fieldwork in Sun Vale, Denmark, was easy as Lene and her mid-level managers were accustomed to have people observe and discuss their care practices, always aiming to improve them. Yet as Iben, a native Dane living only a few miles from Sun Vale, arrived in the specific care units, it took her time to build trust and relationships to some of the caregivers who felt burdened and stressed by the huge practical and existential task of caring for frail residents—keeping their bodies nourished and clean while also holding their personhood—with too little time and resources (see also Gjødsbol, 2022). This, in turn, allowed Iben to step into the caregiving role as any other substitute in Sun Vale. At Summit Care, Lillian also experienced what others have referred to as an “awkward union of participation and observation” (Seim, 2021:2). Despite being a non-Chinese, White, American PhD student without medical training, Lillian slowly became integrated to daily life in the Summit Care dementia ward. Drawing on professional proficiency in Mandarin and over 10 years of Chinese language and cultural studies, she built relationships with residents, families, and staff connected to the site.

Throughout the article, we use pseudonyms to ensure participant anonymity. The Danish study was approved by the Danish Data Protection Authorities; formal ethical approval was not required under Danish law. The Chinese study was approved by the University of Washington Institutional Review Board (IRB), and by Sichuan University’s IRB equivalent through an approval that the research center Lillian was affiliated with had received from the West China Research Center for Rural Health Development.

4. Juxtaposing cares

There is a long history of anthropological comparison ([Boas, 1896; Lévi-Strauss, 1969; Morgan, 1870; Radcliffe-Brown, 1940] in Closser et al., 2016), and studies of globalization frequently tend toward comparison across cultural contexts. This is seen whether considering how people’s experiences of labor and time are shaped by living in different cultural contexts (Syring, 2009), how concepts like ‘inactivey’ are perceived and responded to differently in clinical mental health settings in the United States and Romania (Friedman, 2012), or in multi-site ethnographic studies expressly designed to study global projects (Closser et al., 2016; Tsing, 2015). Rather than seek to produce a systematic comparative analysis of our ethnographic sites (Closser et al., 2016), we choose instead to analytically juxtapose the Danish and Chinese sites to explore how storing practices constitute crucial vehicles of care. Juxtaposition is a method of moving back and forth which raises questions about potential synergies or points of friction (Tsing, 2005) more than it asserts definitive answers about similarities and differences. Using this method, social science studies of care have demonstrated how awkward juxtapositions trouble dominant categories and divisions (Friesen & Latimer, 2019), how juxtapositions reveal a multiplicity of care stories (Coopmans & McNamara, 2020), and how they show the various edges of a phenomenon (Svendsen et al., 2017).

In our analytical process, Situational Analysis (Clarke et al., 2017) has been an inspiration to juxtapose the different care practices around residents in Sun Vale and Summit Care as situations in which not only human actors but also non-human actors, such as the physical arrangements of the care environments, and discursive practices, such as conversations on safety or the person, help us see what is being preserved in each site. Juxtaposing the institutional approaches to people with dementia in Danish and Chinese care sites becomes an investigative possibility for uncovering crucial aspects of the co-construction of care and storage, thus troubling dominant understandings of these terms. Moreover, it helps us avoid slipping into meta-analyses of ‘China’ or ‘Denmark’ writ large (see Helle, 2017) and rather anchor our discussions in examinations of how everyday practices and institutional roles set up and enact their own institutional boundaries. As Candea argues, heuristics like the storage framework we put forward here are both ‘only’ a heuristic and ‘at least’ a heuristic. In other words, juxtaposing institutional approaches offers an anchoring framework that both captures an imperfect and incomplete picture of careful storage in Denmark and in China, while also still tending “to do useful work despite and even because of [its] points of failure” (Candea, 2016, p. 3). In particular, juxtaposing institutional care in Chinese and Danish sites according to a shared storage framework reveals the edges of the institutions—or what we might term the ‘storage containers’—and the ways in which relationships to the world beyond the containers shape care within them. Rather than only putting Sun Vale and Summit Care into particular and already given Danish and Chinese contexts, juxtaposition allows us to analyze how careful storage in the two sites engages different audiences, thus establishing very particular contexts for their work.

5. Why discuss storage at all?: Seeing institutions as containers

Just as sociologist Kevin Hetherington describes searches for ‘disposal’ bringing up ‘pamphlets on slurry and sewage’ (Hetherington, 2004:158), a literature search for “storage” likewise brings up a host of object-oriented papers: museum studies research, archeological findings on ancient food storage practices, and carbon storage studies. This assumed objectification of that which/who is stored can seem especially “un-caring” when we consider that storage often implies a kind of spatial othering. That is, storage happens within a discrete environment, a container, that represents a change for that which is stored. In order for something to be stored one must often take the action of putting or moving it away and into storage. In this sense, storage seemingly implies cutting off ties between oneself and the stored. At the same time, it is this attention to the bounding of a discrete storage site that makes it such a productive analytic tool for exploring institutional care: Just as the presence and maintenance of a container is essential to acts of storage, so too is the presence and maintenance of an institution essential to acts of care being possible within its walls.

Institutions have been studied in many different ways within the social sciences. From Erving Goffman’s “total institutions” (1961), to sociological critiques of such “closed system” approaches to institutions (McEwen, 1980:148), to anthropological ethnographies examining experiences of workers navigating and bending institutional rules (Hull, 2012; Rhodes, 1991), researchers have grappled with how to capture the interplay between institutions influencing and becoming influenced by those within and outside them. In medical anthropology, studies of healthcare facilities have traced people’s pathways through hospital systems (Kauffman, 2005), explored how resource availabilities and histories of colonialism shape biomedical care practices (Livingston, 2012; Street, 2014), and shown how phenomena like mass incarceration can produce new forms of institutional care (Safirin, 2017). Inspired by these rich descriptions of institutions situated in broader socioeconomic and political contexts, here we explore the relationship between care sites and their surroundings by explicitly thematizing institutions as sites of storage. Many studies of care (particularly for older adults and those with dementia) orient toward understanding care practices as tools for supporting or engaging personhood (Buch, 2017; Lee, 2019) or considering
how institutional spaces shape care practices and persons within their walls (Driessen, 2020; Gjødsbol, 2022; Gjødsbol & Svendsen, 2019; Jeong, 2020; Moser, 2011). Attention to storage helps us take the next step to consider not only the practices and systems creating persons in institutional spaces or the institutional “porosity” allowing movement of people and resources across institutional boundaries (Sufrin, 2017:25), but also how these factors come together in defining a sense of “institution-hood” for a given care setting. In other words, we call attention to the work of building and maintaining these institutions as bounded spaces; how care operates not only to support personhood, but also a kind of institution-hood as and through storage, as well.

By calling attention to how residents’ value to those outside the institution was preserved and represented—“what it takes,” in other words, for value-enhancing care to be asserted in these settings (Svendsen et al., 2018:21)—storage directs attention to the power of having a boundary between institutions and their environments. It helps reveal that caregiving institutions should be understood not only in terms of the relational practices of “good” care within their walls (Mol, 2008; Pols, 2005), but also as settings defined by their abilities to store and hold some things separate from the world outside those walls. This fact of an institutional container produces care practices geared to distinct audiences within and beyond the care site. A storage approach pushes us to trace these different collectivities and their roles in performing institutional edges. Across both, storage renders visible how institutions negotiate and produce their edges through relationships with those who belong to them and the audiences that evaluate them.

Examining care as storage also reveals that storage, like care, is a preservation tool for those preoccupied with the promises and risks of passing time (Harrison, 2017; Parry, 2004). People may store in the present, but we generally do not store for the present. We store food hoping to access and eat it later. We store meaningful images and objects in the hopes of dusting them off and revisiting them in the future. And with this hope and expectation about what will happen to that which is stored also comes an acceptance of temporal risk. The food might go bad. The images and objects might be lost or forgotten or damaged while in storage. Likewise, for those in a dementia facility, “storing” involves the hope of protecting residents from threats outside the institution while also supporting and preserving them within institutional walls. And yet, as we will demonstrate, juxtaposing Sun Vale and Summit Care in terms of storage highlights the fact that what is being preserved or extended (as well as understandings of what beyond institutional walls might threaten the stored) can vary between institutions even if they are all engaged in preservation oriented storage, more broadly.

Storage and time also intersect in terms of the potential storage has to represent transformation; its ability to change the perceived value of that which is stored over time. Even if the physicality of that which is stored remains the same, its relevance, usefulness and value to whomever put it in storage may fluctuate. We store money and collectables with the expectation that they will not only be protected while stored but also perhaps become more valuable whenever we try to access them at a later date. And yet, money and collectables can depreciate over time, too. Rather than holding something in stasis, storage instead operates, as Karen Barad’s agential realist framework would push us to consider, through constant intra-actions between that which stores and that which is stored (Barad, 2007). Such an understanding of storage cuts directly against both a reductionist subject-object understanding of storage and the idea of bad or under-resourced institutional care as “mere storage.” It demonstrates how highlighting the way elder care institutions create a boundary—a container—that fundamentally shapes residents’ connections or relations to the world outside an institution even as it shapes that institution itself. Remaining attentive to this spatial aspect pushes us to consider how “storage” will always have an outside or create a (generally physical) barrier to “contain” that which is stored.

In the following sections, we analyze the temporal possibilities and threats and representational de/valuations needed for effective storage to occur in our different care sites. In so doing, we demonstrate how care and storage—that is, “careful storage”—establishes not only personhood within but also institution-hood of these care facilities.

6. Storage oriented towards preserving the person

Literature on care tends to focus on interpersonal interactions in the present—how to create worthiness, dignity, pleasure, or personhood from one moment to the next. And yet, Annemarie Mol (2008:54) also describes practitioners whose care “folds time” as they make caring recommendations in the present that are aimed at allowing patients to have the best possible experiences in the future, as well. Considering institutional care sites in relation to storage uncovers and highlights such orientations to the future inherent in care practices. When it comes to juxtaposing sites, this orientation raises the question: In dementia care, what exactly is being preserved in care institutions that operate through storage?

At Summit Care in Sichuan, one answer to this question is captured in the phrase “安全第一” (safety first), frequently used by families and staff to describe the Unit 1 dementia care ward. Whether related to keeping residents from leaving the locked unit, keeping residents from falling and injuring themselves, or managing residents’ acute and chronic health conditions effectively, the meaning of this phrase was clear: Unit 1 was first and foremost supposed to preserve residents’ physical wellbeing. Heritage Studies Professor Rodney Harrison’s work on the Svallbard Global Seed Vault (SGSV) in Norway offers a useful perspective for unpacking what it means for care settings like Unit 1 to operate through storage in this way. Harrison describes the SGSV as “equal parts bunker and frozen ‘ark,’” (Harrison, 2017, p. 6). Unit 1, likewise, operated as a site that simultaneously functioned as a “bunker” protecting against possible “hazards” outside its walls and as an “ark” offering a highly controlled and “robustly secured” environment to preserve those within its walls (ibid). While caring for older adults in a dementia ward and caring for seeds in the SGSV are clearly different, attention to storage reminds us that it takes care work to establish the boundaries of the container required to preserve the “safety” or wellbeing of entities in storage. Harrison’s description of the SGSV leads us to consider how our two ethnographic sites likewise operated as both “bunkers,” keeping outside threats at bay, and “arks,” keeping the stored safe and sound within their walls.

The physical boundary enacted between Unit 1 and its environment was clear even from outside the facility. Located on an upper floor, Unit 1 looked somewhat like a “bunker” and was easily identifiable as the only part of the private hospital with barred windows (see Fig. 1). Unlike the rest of Summit Care where residents tended to be either bed-ridden or fairly lucid (and thus, in one way or another, not generally perceived as at risk of wandering away or injuring themselves), the dementia care unit...
was flanked by locked, sliding, metal doors that required an electronic fob to open and automatically closed on a timer. If a resident tried to escape through these doors, then tracking devices, and brightly colored vests could quickly become tools used in that person’s storage/care to help reinforce the unit’s and the doors’ abilities to keep him or her physically contained in the ward and safe from threats in the outside world.

Within the institution, an ark-like emphasis was then placed on maintaining residents’ wellbeing by attempting to erase signs of the physical barriers between Unit 1 and the outside, which were understood by staff and families to be distressing for residents. Barred windows (though common features in older buildings) were partially obscured from within the ward by potted plants or stickers. The sliding metal doors were kept underneath stickers of full-size bookcases to help camouflage them. Any tracking devices were carefully attached at the back of residents’ collars so they might not be aware of them and brightly colored vests were presented as gifts of new clothing rather than safety.

Across sites, we thus see that care aims to ensure both the physical, social, and psychological safety of residents by keeping them separate from, while also (seemingly) connected to, the wider, “normal” environment beyond institutional walls. Both “bunker” and “ark” aspects of preservation oriented storage existed in these care sites. Although the question of what constituted good care was not a simple binary between preserving physical wellbeing in the Chinese case and biographical persons and active citizens in the Danish case, the difference we identify reflected discrete understandings of care that occurred through practices of storing.

For those outside a storage site, there is often inherently a degree of opacity and uncertainty around what exactly happens inside it. For institutions aspiring to provide good care, documenting the positive effects of their care, or presenting themselves as offering positive or value-adding transformations for those they store, can be essential to their own institutional survival. In other words, the separation between caregiving environment and the outside world—the institutional container—creates opportunities for staff to claim these institutions as sites of good care to external audiences and thereby help to ensure institutional survival. In what follows, we explore how residents were made to ‘appear’ (Zoanni, 2019) in the everyday care practices in Sun Vale and Summit Care and demonstrate how staff representations of care enact institutional boundaries, sustaining not just their residents but also the institutions where they work.

7. Storage oriented towards preserving the institution

The idea that storage can represent transformation has roots even in archeological studies of burial sites and religious caches. For example, Julia Hendon argues that, while the act of storage “does remove [items world that might feel less familiar (see Figs. 2 and 3). Just as the bookcase sticker attempted to dissolve institutional separations between Unit 1 and its environment along its institutional edge, so too did the basement scenery in Sun Vale enact and make visible the institution’s boundedness precisely through attempts to obscure separations between those stored in the institution and the outside world.

Like Summit Care, making the separations between the care setting and the outside world as invisible as possible then became essential to the “ark”-like care work that occurred within the facility. For example, on Main Street, the controlled environment allowed staff to support residents behaving as active citizens—“going shopping” with staff or socializing in a Main Street café or the library. Staff strived to give residents opportunities to interact as citizens participating in daily life, rather than as care recipients intentionally held separate from society. This parallels the attempts made at Summit Care in China to erase signs of the physical barriers between Unit 1 and the outside. Across sites, we see that care aims to ensure both the physical, social, and psychological safety of residents by keeping them separate from, while also (seemingly) connected to, the wider, “normal” environment beyond institutional walls. Both “bunker” and “ark” aspects of preservation oriented storage existed in these care sites. Although the question of what constituted good care was not a simple binary between preserving physical wellbeing in the Chinese case and biographical persons and active citizens in the Danish case, the difference we identify reflected discrete understandings of care that occurred through practices of storing.

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that are stored] from exchange,” they are not removed “from continuing to be part of ritual events carried out after their deposition. If they are remembered, objects in caches are not out of circulation, they are inalienable” and the way in which they are conceived of “transform [s]” (Hendon, 2000:48–49). Put another way, storage can not only transform that which is stored, but also does so specifically by changing how stored items are valued or seen as useful by virtue of the storage site. When it comes to dementia care, this dynamic is also seen in studies like Selberg’s examination of the Meet Me program at the MoMA where the perceived personhood of those living with dementia is transformed and asserted through curated experiences of modern art that are made uniquely possible within the physical space of the museum (Selberg, 2015).

A small, specialized unit for people with very advanced dementia made Sun Vale stand out as a distinct care institution. Lene had established the unit based on the knowledge that even advanced mental and physical decline did not prevent responding to, and thus benefitting from, meticulous care and therapy targeted at residents’ senses. As opposed to the more common conviction that decline in the residents’ level of function constitutes a natural process of withering away, the care provided in Sun Vale’s specialized unit strived to counteract residents’ declines. For Lene and staff in the specialized unit this was an important way of upholding its 7 residents as active agents who, according to one caregiver, were able to still “act in their own lives.” As the residents in this unit were too frail to go into the basement scenery and engage socially, Sun Vale staff maintained their agency through specialized forms of care that constituted another way of recognizing the residents as legitimate citizens (Gjødsbøl, 2022; Gjødsbøl et al., 2017).

To accomplish this kind of care, the specialized unit was distinctly decorated and equipped compared to the rest of Sun Vale’s units. The walls were painted in light colors, and several mobiles hung from the ceiling in the residents’ private rooms and in the shared kitchen. A huge aquarium decorated the kitchen space with a sensory swing for residents hanging in front of it. In a separate room there was a ball shower that would stimulate the residents’ tactile sense, and several of the residents’ rooms had equipment for smell therapy. In addition to the basement community, these special features of care made Sun Vale stand out as an institution extraordinarily committed to care for agitative subjects when Lene showed around visitors, including the public authorities, who are subsidizing and overseeing the quality of institutionalized eldercare in Denmark. This is critically important as these public authorities could issue sites like Sun Vale an enforcement notice [påbud]—in severe cases a command to temporarily suspend the operation of the institution—if their assessments deem sites to be providing a sub-standard quality of care which puts residents at risk (Danish Patient Authority, 2022).

And yet during Iben’s fieldwork in Sun Vale, she rarely experienced the special equipment in use. Some caregivers did occasionally supply the machine for smell therapy with fragrant oil or turn on music during care sessions, but she never saw the ball shower in use. This was not due to resistance among staff; rather they lamented the tight schedules and lack of time and staff during the day that would actually allow for the provision of such extraordinary care. Several caregivers expressed in interviews their frustration about only having time to care for the bodily basics of food, drinks, and personal hygiene without being able to nurture the quality of life of the residents. Yet regardless of the extent to which Sun Vale’s special facilities and basement scenery were actually in use in daily care, these facilities and sceneries created powerful representations of Sun Vale to the outside world as an institution offering transformations of its charges from passive, abandoned patients due to their limited life prospects to agentive, valuable subjects of care with an open future. As visitors and political authorities overseeing the quality of care are walked through these spaces, representations of the value of Sun Vale as care institution were created and made to travel outside the facility, consolidating the edge of the institutional container in the process. A distinction emerged between those within the institution who knew the way daily care operated in practice and those outside it who saw only the narrative—or what Henderson has termed a “soteriological fantasy” (Henderson, 2003)—of the specialized unit.

At Summit Care in China, the institutional boundary separating life inside and outside the facility was also used to strengthen and support the institution itself, but the key external audience was different. Rather than appealing to visitors and political bodies to assert the legitimacy of the care they offered, staff at Summit Care primarily focused on convincing residents’ families of their institution’s value. For families that often only brought their loved ones to live at Summit Care after doing everything within their power to keep them at home, (re)integrating the residents into their families became one of the most significant ways in which the institution could provide care and operate as a valuable storage site. Families had the power to threaten Summit Care’s survival on an institutional level if they felt being “stored” in the facility produced (or appeared to represent) negative changes for their loved ones. Not only could family members file complaints against individual staff members or wards within the facility, but it was also widely acknowledged by staff and administrators that families could sue the facility as a whole if they felt dissatisfied with the level of care it provided. Families could (and sometimes did) easily move their relatives to competing care sites if they were unsatisfied, so demonstrating the transformative potential of the facility and its care to residents’ families was critical to Summit Care’s institutional survival.

In their efforts to convince residents’ families of the value of Summit Care, staff in Unit 1 used the facility’s institutional edge to their advantage. Even the most engaged family members were rarely in the Unit 1 dementia care ward 24/7, and staff were thus able to present curated images of life in the ward to family members outside its walls. One way this happened was through the use of photos, which staff took of residents living in Unit 1. In this way, the photos attempted to highlight the quality of care the ward offered. Similar to the equipment in Sun Vale’s specialized unit and the basement scenery, photos of residents taken in Summit Care’s wards enacted ‘soteriological fantasies’ (Henderson, 2003) of the institution’s ability to improve residents’ lives, simultaneously validating families’ decisions to bring their loved ones to Unit 1 in the first place. And yet, also like Sun Vale’s specialized unit, the accuracy of these representations of the institution’s value depended on whether they were viewed from inside or outside the institution’s edge.

The photos were an attempt to not only allow families to feel more comfortable, but also to allow them to assert their own roles in providing care when interacting with people further removed from the facility. As some family members described to Lillian, these photos could be circulated and forwarded onto other friends or relatives, offering everyone peace of mind that the person in Summit Care was doing well and that, by
extension, the family had made the right choice in bringing him or her there originally. As the photos circulated, not only were some family members’ anxieties about the institutional care setting quieted, but the facility itself gained a kind of advertising and word of mouth that could potentially bring even more residents into its wards. In these ways, the photos provided a kind of care for and support of the institution, as well as an influence on the daily care practices happening within it as staff were assigned to take and share resident photos as part of their daily workload. This, even despite the fact that the photos were curated to picture the residents remaining within institutional walls in the most favorable light and only representations of them (e.g. photos) traveled beyond those walls. Even with highly staged photos that did not actually document standard care practices, an opportunity was still created for staff to leverage institutional separations between those inside and outside Unit 1 in ways that served the institution. These representations of the value of the institution thus became part of its care/storage—similar to the unused special care equipment in Sun Vale’s specialized unit.

Buying specialized equipment and describing how it could be used to support residents as agentive subjects and citizens in the Danish setting and sharing semi-staged photos of residents with families in the Chinese setting both became forms of care that allowed for symbolic transgressions of the institutional container while simultaneously confirming and reinforcing its presence. While the different care practices analyzed could easily be described through stereotyped narratives and understandings of “East” and “West”, importantly it is not the case that the Chinese dementia care unit in Summit Care was oriented towards caring for “the collective” and the Danish dementia care offered by Sun Vale was oriented towards caring for “the individual.” Our careful storage perspective, recognizing the simultaneity of practices of care and storage, instead reveals how these two sites’ approaches to people with dementia involved different means to recreating or re-presenting the value of the institution. As a private hospital in a country with comparatively less structured government oversight for healthcare facilities, Summit Care’s most important audience for asserting and enacting its value as a site of good care was residents’ families. This might of course be different in public nursing homes in China subordinated to supervisory authorities like those in Sun Vale in Denmark. Yet in contrast to Sun Vale, families had the power to threaten Summit Care’s survival on an institutional level if they felt that the institution did not provide proper care for their loved ones.

In Denmark, family satisfaction also remained important, but it held less power. Relatives can complain to local and state authorities when experiencing low quality care, and these authorities might initiate their own investigation of the problem raised and then decide if and what measures must be taken (The Danish Alzheimer’s Association, 2022). For example, during Iben’s fieldwork, a daughter of a resident in Sun Vale explained that before her father came to the specialized unit, he had suffered from dehydration and thus care failure while living in another unit in Sun Vale. The daughter ended up complaining to the municipality. Subsequently, one caregiver was dismissed and the resident was transferred to a different unit. The daughter was highly disappointed. She had hoped for a more thorough handling of what she experienced as a fundamental problem with the quality of care in that specific unit. After all, the key audience for enacting the institution as a site of “good care” and positive transformation for its charges was the Danish authorities. Our juxtaposition reveals that in both China and Denmark, enactments of “fantasized staged photos and special equipment and scenery) materialize the institution in relation to particular audiences (the family and the state), thereby securing legitimacy and institutional survival. Considering nursing homes as sites of care and storage, we come to see how the establishment of “good care” is not simply a question of holding individuals with dementia in personhood—equally important for care facilities is to create and nurture a certain kind of institution-hood, embracing simultaneously those inside and outside the ‘container’.

8. Conclusion

Distinctions between care and storage in public discourse seem to make sense intuitively, and yet we suggest here that moral discomfort with “storage” primarily reflects a disconnect between how institutional care settings operate and the roles they are portrayed as filling. Empirically, these sites are built to contain, to hold, to store. At the same time, they are characterized as caring for interactive subjects. By unsettling this distinction, rather than taking it for granted, we may begin to understand the affinities between these concepts and practices—that is, how care is necessarily storage and how storage is necessarily care. Furthermore, we become attentive to the ways in which care sites enact their boundaries and materialize as institutions, and how this boundary work also then becomes inextricably linked with interpersonal care work in these settings. Whereas discussions of care practices may accept or take for granted the existence of institutional boundaries as mere “context,” we have explored how institutional boundaries materialize through practices of care and storage. We have argued that this careful storage approach offers a productive framework for juxtaposing and understanding caregiving institutions in different settings.

In exploring careful storage as a framework for juxtaposition, we do not claim to speak for “Danish care” or “Chinese care” as generalized, “knowable” constants. Instead, we propose careful storage as an inroad for grounding our analysis of practices within these sites in the present. As such, it also offers a starting point for increased analytic attention to how care practices may move between such sites in the future. In both settings, space and care become co-constituting elements of how Sun Vale and Summit Care are enacted as institutions and as distinct yet related sites of storage. By taking a step back to consider what and who is stored within such institutional spaces and how institutions respond to a range of audiences, one begins to see the various relationships that emerge between individuals and storage institutions. These relationships, and their simultaneous crafting of personhood and institution-hood, become visible in activities and exchanges taking place at the interfaces between storage containers and their environments—ordering and connecting those inside institutional walls with those outside them.

To think care as storage and storage as care renders visible how the answer to the question “what constitutes good care?” is not only to be found in intimate care practices within a given institution but also at the very edge of it, materializing and mediating its inside from its outside (the audience). As more visitors arrive at Sun Vale to “go shopping” for Danish care models and more Chinese-Danish eldercare collaborations develop, care sites initially relating to one another as “importer” and “exporter” may become steadily influenced by one another and by their interactions. It may very well be that new or reimagined care models from China eventually flow back into Denmark, offering unique opportunities to study how care approaches and institutional settings co-create one another over time. Careful storage offers one potential analytic framework for juxtaposing, and generating productive uncertainty around, what care is and how different understandings of “good care” might be practiced and actualized in these different settings. In so doing, careful storage shifts analytical attention from the question of how to constitute or ‘hold’ personhood towards how institution-hood is successfully crafted.

Notes

[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” from C. J. McIntosh, J. Westbrook, R. Sheldrick, C. Surr & D. J. Hare (2012): The feasibility of Dementia Care Mapping (DCM) on a neurorehabilitation ward, Neuropsychological Rehabilitation: An International Journal, DOI:10.1080/09602011.2012.711642.
Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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