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Attributions of Agency and the Construction of Moral Order: Dementia, Death, and Dignity in Nursing-home Care

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Abstract

Using evidence gathered during 18 months of participant-observation in 2 nursing homes and 65 interviews with staff, this article examines how nursing-home staff use agency as a rhetorical resource to construct a dignified workplace. Staff attribute agency to dying residents, saying they choose the timing and conditions of their death. Staff equally insist that aggressive residents do not have agency. These two sets of attributions are used as counterpoints. Both go well beyond the available facts of the situation and reflect unspoken assumptions and interests of nursing-care workers. Through these attributions, the staff achieves a situated moral order in which compassionate care is provided to deserving residents in caring nursing homes. Staff attributions of agency are collectively shaped by professional philosophies, training and education, and regulatory guidelines. Finally, this article shows how it is analytically and theoretically productive to recast agency as a cultural object, whose use is subject to empirical investigation, rather than as a theoretical construct.

A central theoretical issue in the social sciences is the fundamental mystery of how individuals act meaningfully—with intent, with the feeling of freedom, with variability according to actors' understanding of the situation—yet nonetheless reproduce what looks very much like social structure, something that persists over time and appears to have its own organization and logic. This exhausted debate has often, and ironically, reified agency as some *thing* which individuals may or may not possess. Agency is a theoretical construct in sociology, but it is more than that. Agency is also, in practice, a set of understandings, ascribed to a set of behaviors, deployed to grasp the meaning of interactions.

This article reveals the power and limits of agency beyond current debates by treating it as a cultural object instead of a state of being. The issue of whether individuals have agency is besides my point; rather, I examine how people use a rhetoric of agency—as a conceptual resource—to describe, classify, and understand social action. People make attributions of agency to construct a situated moral order. From this fresh perspective, agency moves from a reified experience to a social process of attribution, and becomes the subject of empirical inquiry.

Nursing-care workers ascribe agency to dying residents and deny the agency of aggressive residents. I use these two sets of ascriptions as counterpoints because both involve understandings of intent that are largely orthogonal to truth, and do not hinge on the question of whether or not individuals actually choose when to die or whether to strike the staff. Staff attributions of intent exceed the available facts of the situation, reflect the

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emotional needs of staff, and are shaped by professional philosophies, staff trainings, and changes in the regulatory structure of longterm care. The result is a particular, situated moral order in which dedicated staff provide compassionate care to dignified residents in nursing homes.

THEORETICAL FRAMEWORK

Attributions of Agency

Care organizations have been fertile ground for sociologists interested in the construction of experience. Jaber Gubrium's classic ethnography, *Living and Dying at Murray Manor* (1975), analyzed the social organization of care in a nursing home, and described how the institutional culture, and the emotional culture which supported it, constructed residents as "waiting to die." In other words, nursing-home residents were thought to have no control over the timing and circumstances of their death. Aggressive residents, on the other hand, were routinely restrained physically and sedated chemically precisely because they were thought to be acting intentionally. These attributions were shaped by an implicit belief system about agency and differ from the attributions I observed, but these differences are no contradiction. It is precisely my point that attributions of intent are historically situated, and in the years since *Murray Manor* (Gubrium 1975) was published, the professional philosophies, staff trainings, and regulatory framework of long-term care have all changed significantly. These collaborative forces shape how agency is ascribed and denied.

Pragmatic and ethnomethodological sensibilities have informed research about how people deploy a rhetoric of agency to interpret experience. Erving Goffman, in *Relations in Public* (1972) showed how families selectively applied agency to a member who becomes mentally ill. At first, families preserved the "sanity" of other members, and when those attributions became untenable, distanced themselves from the deviant behavior. Furthermore, a concept of agency even more deeply situated in interaction than Mead's (1934) is evident in caregivers' attributions of "hidden minds" to patients with advanced dementia (Gubrium 1986).

Attributions of agency also maintain social norms. Pollner and McDonald-Wikler (1985), for example, examined how a family attributed "competence" to their child, who experts judged to be severely mentally impaired. The family, convinced their child pretended to be impaired in public, employed physical and verbal techniques that reinforced their belief in the child's full competence. While Pollner and McDonald-Winkler (1985) showed how the agency of a mentally impaired child was preserved by family members, Weinberg (1997) analyzed how the agency of mentally ill individuals was attributed in twelve-step groups. At times, agency was ascribed as the willful actions of individuals, but at others the nonhuman agency of mental illness took over as the source of behavior. My research builds on this previous scholarship with an examination of how social actors use the rhetoric of agency in novel, creative ways, and as a practical resource to interpret behavior within a set of constraints shaped by workplaces.

Accounts and Emotions

Attributions of agency are a form of accounts to explain behaviors, particularly the unseemly ones, with excuses and justifications to deflect blame (Scott and Lyman 1968). For example, flight attendants accounted for rude passengers by imagining them as scared and childlike (Hochschild 1983). Flight attendants, and many other service workers, do deep acting, a more-or-less conscious strategy to make their inner emotions and outer displays consistent with feeling rules imposed by employers; but even those who are not employed in the service industry conform to norms of appropriate emotional displays. Emotions circulate in a relational economy that is provided and returned in interaction (Clark 1987). My research extends our understanding of accounts and emotions to explain the behavior of others rather than oneself, with the intent to maintain sympathy rather than deflect blame.

While Hochschild (1983) studied how emotions work for service workers who have brief customer interactions, nursing-home staff develop enduring, caring relationships that often last years. Recent scholarship has shown how emotions are built into the structure of nursing homes and leads to an organizational climate that cultivates emotionally authentic relationships between staff and residents (Lopez 2006). Emotional bonds between resident and staff are reinforced by family ideology (Dodson and Zincavage 2007), which encourages staff to view residents as if they are part of a family. In a set of observations closer to the agenda of this article, Akerstrom’s (2002) study of boundary work in nursing homes found that staff endure slaps, punches, and scratches, but do not think of them as “violent” as a strategy to preserve boundaries between staff as care givers, residents as care takers, and nursing homes as caring places.

Timing Death

Research about the extent which individuals can time their death is limited and mixed. *Final Gifts* (Callanan and Kelley 1992) explores dying from the perspective of hospice workers, and works from an assumption that patients are “individuals with control over their living and dying” (23). On a larger scale, sociologists Phillips and Smith (1990) found morbidity among the Chinese to decrease by 35 percent the week prior to the Harvest Moon Festival and increase by the same amount the following week. However, these findings are countered by epidemiological studies which have found no significant relationship between meaningful occasions and temporal variation in mortality. An analysis by Young and Hade (2004) of 1.2 million death certificates from Ohio found that the proportion of persons dying the week before a significant occasion such as a birthday or holiday was no different from the proportion of those dying afterwards. Furthermore, a review article by Skala and Freedland (2004) found no direct evidence showing that dying individuals “hold on” or “give in” around symbolically important events.

The staff in my research asserted that residents can and do “time” their deaths, but their attributions extend further than the evidence supports. Care workers invoke agency as a *folk concept*, attributions of intent spontaneously applied to behavior. The issue of whether individuals possess agency is besides my point. Rather, this article highlights a rhetoric of agency—used as a resource—to manage the emotional stress of nursing care work. Finally, agency is recast as a moral concept—rather than a theoretical construct—and is a subject for empirical inquiry as a cultural object.

SETTING AND METHODS

This article is based on 18 months of fieldwork and 65 interviews with staff from 2 nursing homes; and it is one piece of a larger project analyzing the uses of emotions among care workers. I gained access to Rolling Hills Extended Care and Rehabilitation[1] in November 2006, one of a small, regional non-profit chain of health-care facilities. The facility is a two-story, brick building which was built in the late 1980s and is set back from a quiet street by about 100 yards of grass and light forest. Just inside the front door, which is wide enough for wheelchairs to fit comfortably through, is a big, octagonal foyer leading to a hallway, often decorated with ornaments to mark an approaching holiday. The halls are spacious and wallpapered, and many residents’ doors remain open throughout the day. I conducted participant observation three or four days a week, usually in four- to six-hour stretches.

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[1] The names of nursing homes and individuals mentioned in this report are pseudonyms.

Typically, I arrived in the morning before the daily managers' meeting and left sometime in the afternoon after lunch. In February 2007 I gained access to Golden Bay Nursing and Rehabilitation Center, which is part of a large, national, for-profit chain of health-care facilities, and I began to evenly split my time between the two workplaces. Golden Bay looked a lot like Rolling Hills on the outside, but was a bit more worn on the inside. The halls, though also often decorated with holiday decorations, were darker and did not get much natural light. Residents' doors more often remained closed during the day, and at times the staff was openly hostile towards each other. Between February and May 2007, I typically visited each facility once or twice a week. I began to observe evening shifts to get a sense of temporal variation, but I usually visited during the day so I could attend meetings. In the summer of 2007 I usually frequented each facility two or three times per week. During this more intense stretch of fieldwork I began to conduct interviews with staff. In the fall of 2007, I scaled my observations back to pre-summer levels and conducted interviews up until fieldwork concluded in April 2008.

I observed in as many settings as possible to collect evidence about the character and scope of care work. I spent time in and around nursing stations, shadowed nursing assistants and licensed nursing staff in and out of residents' rooms, and I occasionally lent a hand serving meals or escorting residents to activities, the rehab gym, or meals in the main hall. I often spent several consecutive hours on the units to get a good sense for the pace of the daily routine. To hear informal conversation between staff, I observed in break rooms, at holiday parties, and other staff functions; I spent time having lunch, or outside at the "butt hut" with staff on smoking breaks. In addition, I routinely observed staff meetings, including the daily managers' meeting and nursing report, care-plan meetings with families and residents, Medicare meetings, the employee retention committee, staff trainings, and other meetings as well. While observing, I also routinely had conversations with other individuals in the organizations, from the maintenance staff, to the activities aides, to the physical therapy staff, dietary staff, and residents. I recorded my observations in detailed field notes written soon after I left the facility. To recall events accurately, I jotted down quotes or keywords in bathrooms or unobtrusive spots and expanded on them at the end of each day.

In addition to extensive observations, other sources of data are the documents, brochures, advertisements, records, websites, and other forms of material culture produced by both nursing facilities. In this article I make use of documents I collected at staff training and other educational material.

I first noticed the attributions of agency presented in this article during observations, and I followed up on my initial impressions in staff interviews. I conducted 65 interviews with staff throughout the organizations, including certified nursing assistants, licensed practical nurses, registered nurses, physical therapists, occupational therapists, speech therapists, social workers, activities assistants, unit managers, directors of nursing, and the administrators. All interviews were semi-structured, and almost all were recorded and transcribed. Nearly all the staff I interviewed are white, middle-aged women, which is consistent with the demographics of the staff at both organizations. Their ages ranged from early twenties to mid-seventies. Given the significant differences in pay scales between nursing assistants, licensed nurses, nurse managers and administrators, it is safe to assume a fair degree of class variation among my interviewees. The demographics of the staff seemed fairly consistent with the residents, and differed least by gender (that is, most staff and residents are women) and most by age (almost all residents are elderly, most staff is middle-aged).

I asked all interviewees a core set of questions, although each session was shaped by my observations and tailored to each individual, occupational group and organization. I asked about their daily job tasks; work history; the emotional bonds they've created with residents (or not); how the documentation and reimbursement process shapes their work; the problems and challenges they face in their work; and what it feels like to care for people who they could expect to pass away on their watch. I began interviews midway through my fieldwork, which allowed me time to build rapport with staff members and to gain knowledge of particular events about which I could follow up with key players and decision-makers. Combining these sources of data - field observations, documents, and interviews - allowed me to triangulate sources (Denzin 1989), which strengthens the evidentiary base for my arguments.

Although Rolling Hills is part of a small, nonprofit chain, and Golden Bay is part of a large, for-profit chain, the workplaces themselves were much more similar than different. Both facilities, like many other nursing homes in the United States, were organized as vertical hierarchies and horizontal departments. The departments and their roles were the same at each facility: nursing, housekeeping, dietary, activities, physical, occupational and speech therapy, social work, and maintenance. At each facility, department heads usually reported to the director of nursing (although sometimes with the administrator, depending on the issue), and supervised their own staff, who have clearly defined duties within a chain of command. In addition to these basic similarities, both nursing homes share other features as well: each has three units (sub-acute rehabilitation, long-term care, and dementia/ Alzheimer's); each houses slightly more than the state average 110 beds; each has a nonunionized workforce; the staff at both are demographically similar (nearly all white women, with few men or racial/ethnic minorities); both are located in rural areas; and both have similar staffing ratios and patterns.

My analytical process was consistent with the grounded theory approach (Glaser and Strauss 1967), I read and reread entire interviews and field notes, scanning for themes upon which to begin making interpretive judgments. Substantive material was grouped around broad themes, and then from those themes, more specific and limited codes were created to deepen the analysis. I began with attributions of agency around dying and then compared those attributions to the denial of agency in aggressive outbursts to generate a theoretical framework. During the process I repeatedly went back to the literature, wrote analytical memos and early drafts, and talked to people about the themes and ideas that emerged from the data.

"EVERYONE HAS THEIR OWN SCHEDULE": ASCRIBED AGENCY

Nursing homes take care of sick, vulnerable, and often helpless individuals. The staff face human suffering each day. Many grow emotionally close to individuals who then die under their care. As residents' health declines and death nears, staff change their efforts from "curative care" to "comfort care," in which all medical interventions are intended not to prolong life, but to make death as comfortable and dignified as possible. The first dying individual I saw came about five months into my fieldwork at Rolling Hills. I walked into the activities room to hang up my jacket, where I saw Debby, the activities director, and one of my closest informants. She said Mabel was "catching the bus," which, after a few seconds of puzzlement, I realized was a euphemism for dying. She asked if I wanted to see Mabel, and I skittishly accepted her offer. We walked down the hall to the locked dementia unit, and as I said hello to the nursing staff, Debby waved for me to follow her into Mabel's room. The lighting was low and Mabel's bed was against the wall. Her night stand was under the window by her left shoulder. She was covered to her neck in blankets with a homemade blue crocheted throw on top. Mabel laid motionless, pale and yellow, with her mouth agape as if she was frozen in mid-yawn. She was down to five breaths per minute, each punctuated with a surprising snort and gurgle. Her lungs were filling with fluid, and she had what staff called the "death rattle." I stood behind Debby as we watched her quietly. Soft music played in the background and two morphine-spiked lollipops rested on the night stand. With our eyes fixed on Mabel, Debby said, "she probably won't close her mouth again," and told me "there are all these stages to dying." A few quick moments passed, and as we left the room Debby straightened Mabel's blanket. A few hours later, she was dead.

To me, Mabel appeared helpless. But this is not how Debby thought of her or other dying residents. The staff do not conceptualize death as something that simply happens to sick residents. In their eyes, residents are not helpless; rather, they often choose the right time to die.

Active Dying

Both nursing homes organizationally embrace the concept of active dying. Patricia, the staff development manager at Golden Bay, described *active dying* as a set of physiological changes in the body that points toward the end of life, such as decreased eating and fluid intake, changes in breathing patterns, and mottling of the skin, particularly in the feet. This was a standard definition of active dying in palliative care, but in practice it took on a far more general and taken-for-granted meaning among nursing-care workers. I asked Patricia if active dying meant the resident has only a matter of hours or days left, and she said "well everyone has their own schedule," and active dying could last for days or months. She added that when someone is actively dying, he or she is in some sense aware the end is near. At Rolling Hills, licensed nursing staff had opportunities to gain continuing education credits by reading articles about issues in long-term care. One of them was a pamphlet called "The Last Hours of Living: Practical Advice for Clinicians" (Emanuel et al. 2006). The manual discusses the typical signs and symptoms that indicate active dying and offers advice to clinicians for how best to prepare loved ones for the loss of a family member. It encourages care workers to treat actively dying individuals as if they are more aware than they appear. The report says, "While we do not know what unconscious patients can actually hear…at times their awareness may be greater than their ability to respond. It is prudent to presume that the unconscious patient hears everything. Advise families and professional caregivers to talk to the patient as if he or she were conscious" (Emanuel et al. 2006:12, italics in original). The article also encourages family and staff to "give permission" to actively dying individuals because they may be holding on, waiting for approval to die.

Intention in Death

Active dying was the organizationally supported framework for interpreting the deaths of residents, and staff usually obliged. Active dying was the notion that residents had some semblance of awareness and control over the conditions and timing of their deaths. Depending upon the situation, residents could "hold on" for family to arrive, or for family to leave their bedside, or even for their nursing assistant to finish work before deciding to "let go."

For instance, Stephanie, a veteran nurse who has worked in a variety of inpatient health-care settings, discussed the circumstances of her patients dying. She told me, "I've noticed the residents don't want to die with a family member in the room. I don't think I've had one resident die with a family member in the room, not one. And I've only had one resident who died with the CNA in the room. They always—and I mean literally thirty seconds after you walk out of that room—they go."

One morning on the Rolling Hills dementia unit, Stephanie was the charge nurse for Peg, a resident who was actively dying. Peg's lungs were filling with fluid and she was put on comfort care. Stephanie was in Peg's room with a few nursing assistants when Peg stopped breathing. As they waited for Peg's heart to stop, suddenly she began breathing again. Stephanie later told me, "I went to get the morphine, went right back to the room. She was gone. You know, it's—they—a lot of them *like* to go alone." Stephanie added, "It must be something so personal and intimate…they need to be alone to do it, to go." In her view, Peg was aware of being watched as she stopped breathing, and was able to muster the strength to regain breathing because she preferred to die alone.

Some staff, like Danielle, the director of nursing at Rolling Hills, gave examples of residents who chose to die right after their family arrived at their bedside. She firmly stated, "Oh, it's a true thing. I've seen women hold on until that last child comes from three states away to get there to say goodbye." Ariel, a nurse at Golden Bay, who has worked in longterm care for twenty years, told me about a dying woman on the sub-acute unit whose family was coming from the west coast to see her one last time. "So we were doing—literally hour-and-a-half updates. We told her her family was coming and she said, 'Oh, I'm so happy—I'm so happy that they'll be so happy to have seen me,' past tense—past tense, 'to have seen me.' That was a little odd. You pick up on little things like that." The family arrived to see their mother in the dimly lit room. Music was playing, as it often is when residents are actively dying. Ariel said, "Literally, the family walked into the room. They said 'hello,' and ten minutes later, she was gone."

Ariel explained her theory that older people "hold on" waiting for family to see them because they understand the power of closure. She surmised that elders have a lifetime of experience with loss, and they recognize how important it is for family to see them one last time; young people would rather die than have their family see them sick. As evidence, she told me a story of a young boy she cared for who was dying of cerebral palsy. The boy's family was on vacation when his health took a turn for the worse. Against the wishes of the boy, Ariel contacted the family to inform them of his deteriorating condition, and his parents decided to come home. He did not want his mother to see him so sick, and told Ariel, "In two days they can come." Ariel told me, "He said, 'Well, I don't want my mother to cry' and literally three hours later, before they got there—gone, just gone. And he knew. I mean, he knew. He clearly knew. He had made peace with it, you know." This example underscores her belief that elderly people choose the circumstances of their death because they understand the significance of closure, while younger people would rather die than have their parents see them in such a weakened state.

Stacey, the wound-care specialist at Golden Bay, told me one of the more amazing stories about the apparent agency in death. Twenty years ago in Louisiana, by her own account, she was a charge nurse at a long-term care facility that had geriatric, psychiatric, and mentally retarded patients: "just cram 'em all together" she joked sarcastically. Stacey had a patient who had been a Baptist preacher until he had a massive stroke in his late fifties. Before the stroke he was gregarious and talkative, but after the stroke, all he could say was count from one to ten and say "fuck." "He would just sit there" she told me, "four, three, two, one fuck! six, seven, eight, nine fuck!" One day, the story goes, his wife came in to visit him, "and I'll never forget this. She turned to me and said "I can't do this anymore! That's *not* the man I married!" and walked out crying. Less than an hour later he was dead." There was no doubt in Stacey's mind that he died after he heard his wife, and decided that life was no longer worth living. This story, repeated twenty years after the events, serves as something of a cautionary tale, told not because it is representative but because it is extraordinary. The event helps Stacey stake out a position in which her residents have control over how they die, above and beyond anything she can do to save them.

It is easiest for staff to ascribe agency when a resident is thought to have lived a long, good life and quietly slips into a deep sleep, never to wake up again. For example, towards the end of my fieldwork a resident passed away just days after her 103rd birthday. The proverbial “cute old lady,” Heidi could not talk but was alert and oriented, and known for smiling while holding up her hand and raising her pointer finger, pinkie, and thumb in the ‘I love you’ sign towards staff and visitors. After she died, a nurse manager admired, “she was continent until the end.” An activities aide spontaneously told me she felt Heidi was waiting until her 103rd birthday to pass away, and when I asked why, she simply said “Because she could. Maybe it was her goal to live that long.”

Staff use the active-dying framework to ascribe agency to their residents’ deaths, and as shown above, it is robust enough to accommodate a number of circumstances. Yet these ascriptions are largely unsupported by any evidence that dying people can actually control the conditions and timing of their deaths. There is mixed evidence that certain populations can “hold on” around significant events when death is near, but the staff ascriptions go well beyond the available data. Rather, ascribing agency usefully helped staff manage the emotions involved in developing bonds with individuals who die under their care. This becomes clearer when situations arise that preclude staff from the claim that residents intend to die.

The Limits of Ascribed Agency

Sometimes the logic of ascribed agency breaks down. People die under circumstances that make it nearly impossible to claim plausibly that a resident chose when and how to go. Mary’s untimely death was one such circumstance; a well liked, basically healthy woman died in the aftermath of an accident when it was “not her time.”

Mary occupied the room closest to the main entrance in the sub-acute unit, making it a high-traffic area. She would sit in the doorway of her room, wearing a beautifully crafted, seasonally appropriate hat made by her daughter. She quietly sang or hummed in her wheelchair as the hours passed by. Everybody knew her, and many stopped to chat with her. One Saturday afternoon as she sat in the doorway a heavy food truck with 40 lunch trays inside rolled over her foot, causing enough trauma for a stay in the emergency room. Within a week of returning to Rolling Hills, Mary had a stroke. Within six weeks she was dead.

The facility developed a counternarrative to explain what had happened. The narrative suggested Mary’s stroke was caused by a change of medications. This may have helped them in the legal realm, but it did not help them mitigate the emotional toll of the accident. The reality of the circumstances was too severe to claim plausibly that Mary had intended to die like this. In the worst-case scenario, the facility was responsible for her death. Mary’s nursing assistant, Cindy, took it the hardest of all the staff members. The last night of Mary’s life, Cindy had stayed at Mary’s bedside until 11:00 p.m., a solid 4 hours after her 12-hour shift ended. Moments after Cindy went home to sleep, Mary stopped breathing. The next afternoon I saw Cindy at her coworker’s wedding, and she almost immediately told me Mary was not doing well (neither knew Mary had died). A staff member who overheard our conversation informed us that Mary had died the previous night. Cindy burst into tears, uncontrollably sobbed, and hugged the bearer of bad news. She exclaimed through tears, “She was my friend” and “I can’t believe nobody called me!” A few days later, the staff organized a public memorial to honor and remember Mary. Her room remained vacant for almost two weeks; one of her trademark hats hung in the doorway.

Mary’s death had many of the same characteristics staff use to ascribe agency, but no one dared to say she had chosen the circumstances of her death - quite the opposite. The sadness and grief focused on a relatively healthy woman who rapidly declined and died after a mistake by the staff; it was not focused on a woman who had chosen the timing and conditions of how her life would end.

The Achievements of Ascribed Agency

This counterexample illustrates what staff achieve when they speak of death as a chosen act. The rhetoric of agency makes death palatable, neutralizes organizational failure, and dignifies dying individuals. The most emotionally troubling deaths in the nursing homes were those that could not be conceptualized as an act of agency on the part of the dying. It is of course inevitable that residents will die; everybody on staff knows this. One way staff mitigates the emotional strain of seeing people they care for die on their watch is by thinking of it as a chosen path. This framework is consistent with the “revivalist discourse” of death (Seale 1998) that emerged from the palliativecare movement, which emphasizes the role of dying as an opportunity for personal growth and the restoration of dignity to the dying process.

In addition to making death palatable, the attribution of agency neutralizes organizational failure. Cynthia, the administrator at Golden Bay, told me that she actively tries to work against the idea that nursing homes are a “death sentence” and fosters an organizational climate in which the facility is seen as a place where people come to live, not die. Debby, the activities coordinator at Rolling Hills told me much the same thing. When I began my fieldwork she said, “this is a place where people come to *live*,” and she felt personally responsible for that with the activities she organized for residents. The organizational goals were to foster an emotional climate focused on dignified living; the rhetoric of agency neutralized the sad fact that most people who enter a nursing home are there until their last breath.

Finally, ascribing agency dignifies death in a total institution such as a nursing home. Nursing-home residents have been stripped of dignity in most conventional senses. They have often exhausted their life savings, sold or lost their house, have very few possessions, have lost their physical capabilities, mental capabilities, or both, and have little privacy. They also generally have a life in the nursing home that was, at one time, unimaginable to them. Furthermore, much as in “total institutions” (Goffman 1961), residents are told when and what to eat, when to shower, where to sit, and often spend hours at a time simply sitting in their wheelchairs, not doing anything. Those deemed at risk for falling wear alarms that siren when they stand or move too far on their own. They have almost no control over the circumstances of their lives, and one way staff can give residents some semblance of dignity is to say they have control over the timing and condition of their deaths, their very last choice in life.

“THAT’S THE ALZHEIMER’S TALKING”: DENIED AGENCY

Much to my surprise, physical violence was an everyday occurrence in both nursing homes I visited. Most of it occurred in the dementia unit, while staff assisted residents with personal care in the relatively private area of bathrooms and the unit’s shower stalls. I had assumed that physical outbursts were directed at residents from frustrated, impatient, and poorly trained staff. But I quickly learned it was the other way around (Snyder, Chen, and Vacha-Haase 2007). While allegations of abuse by the staff were rigorously investigated by the management and the Department of Public Health, verbal and physical violence towards the staff was a routine occurrence and not treated as a problem to be aggressively managed.

As much as the staff ascribed agency during the dying process, when it came to workplace violence, they denied residents had control over their outbursts. The denial of intent by the staff rests on neither more nor less evidence than the ascription of agency around death. In both cases, the key point is not the presence or absence of agency, but the ongoing creation of a set of understandings with which to interpret behavior.

Denial of Intention

Both nursing homes maintained an organizational silence about the workplace violence nursing assistants routinely face. In fact, the organizational leadership at both facilities seemed unconcerned with workplace violence, until it was so disruptive it altered staffing patterns due to workplace injuries. This happened at Rolling Hills, where about a half dozen staff members were injured while performing care on Bud, a large man and former athletics coach who had broken a hip. The injuries prompted the Director of Nursing to organize an educational in-service on “The Basics of Alzheimer’s Disease” led by a social worker from the local Alzheimer’s Association. This effort focused on retraining staff how to approach demented residents with a comforting tone of voice, unmistakable body language, and handling residents safely. The training was organized around these issues because management supported the idea that residents have no control over their violent outbursts. In fact, both facilities understood workplace violence in a way that denied the agency of residents and focused on continually retraining staff to minimize the chances of it happening.

In the first 15 minutes of the three-hour presentation, the trainer asked a group of about a dozen floor staff how many of them had been hit or slapped by a resident, and virtually all of them raised their hands. She said, “You may feel like they know what they are doing” and Maria, a nursing assistant whispered “No, that’s not it” loud enough so everyone could hear. She and others in attendance sat through the same training the prior year. A minute later, the trainer displayed an overhead slide of two brains scans, one normal, and the other of clearly deteriorated brain tissue, particularly in the frontal lobe. The trainer asked, “So, if someone with Alzheimer’s hits you, are you going to get mad?” “No,” Maria said, with a chuckle. For emphasis, the trainer said “this is the image I keep in my head all the time. It reminds me of who the caregiver is, and who the care receiver is.”

Staff Denials of Agency

Nursing assistants endure most of the scratching, slapping, spitting, and swearing that some residents dish out. Maria told me a story from an overnight shift on the sub-acute rehabilitation unit. A male resident was throwing things around the room, “and it was my job to go in and make sure his roommate was safe.” Maria called the police after he hurled the leg rest to his wheelchair through a window. “He was lunging at us, grabbing at us, it was very scary.” She continued, “It’s a very scary situation because you don’t know what to do. And sometimes it’s hard to deal with. But then you go to the classes and you see they have no control over those emotions, over how angry they are. Or how they’re responding to things. It’s just—it’s part of their dementia.”

Maria had worked in the dementia unit over four years and had “grown to love their explosive outbursts.” Kelly, a new nursing assistant being trained by Maria, was not so accustomed. One morning I overheard Agnes, a severely demented resident scream at Kelly while in the shower, “I’m gonna kill you!” Kelly, trying to assist Agnes, replied only a quiet “I love you.” The shower is one of the most dangerous areas for nursing assistants because residents are often embarrassed and confused about why they are naked and sitting in a chair with someone they consider a stranger cleaning them. Also, most elderly people took baths their whole lives until they moved into a nursing home, where everyone is scheduled for two showers per week. As I stood next to Agnes’s bed, listening to them struggle in the shower, Agnes alternately moaned in a confused agony and yelled at Kelly to get away. Kelly had a job to do, and part of it was to endure the moans and the yells, as well as the slaps, scratches, and occasional bites residents dish out in bewildered fright and anger. When the shower-room door opened, a clearly upset Kelly walked out, showed me her trembling hand, and told me Agnes had hit her head 16 times. A few minutes later, as she walked out of the room, Kelly whispered to me, “I just want to finish my assignments and get the fuck out of here.”

The next month I interviewed Kelly days before she was fired for working too slowly and asking for too much help. I asked her about that shower, and Kelly told me “I took a deep breath, counted to ten, remained calm, and just it’s, granted I was a little shaky on the inside, but other than that I knew if I didn’t have patience or give her the reassurance that she was OK, and why we’re washing up then I wasn’t going to accomplish anything.” Caryn, an LPN who was working that day said “they don’t understand they have feces all over them and they need to be cleaned up, so they hit.”

Kate, a nursing assistant who took care of Agnes for more than four years and grew very fond of her, told me she used to get hit or cursed at everyday on the job. I asked her what that was like, and she explained:

> It can get difficult because physically it’s harder on us because we’re getting beat on. So you’re fighting with this person in the shower, hoping that they don’t jump out of the chair and slip onto the floor, or in the process you’re getting soaked because they’re grabbing the showerhead and they’re drenching you because they’re so angry. So it’s heartbreaking, just because inside you feel frustrated, but then feel so guilty because it’s not their fault. You know, they just don’t understand.

Louise, a charge nurse at Golden Bay told me a story from years back, when she was a nursing assistant. Having worked in long-term care for decades, I asked for a story about a difficult resident, and she told me one that was “the worst I ever had”:

> He was probably about 6′3″. Climbed out of his bed, grabbed my wrist or my shoulders and was pushing me against the windowsill. And I was like leaning really hard against the window. My butt on the windowsill. And he was just pushing. Trying to push me out the window. And he was a strong guy. I don’t know what the heck saved me but that was probably about eight years ago. Other staff saw him and pulled him off me. But that was the scariest thing that’s ever happened to me. And a lot of it is they can’t understand that they’re doing it. So that’s what you have to understand. The resident probably doesn’t know that they’re doing that. That took me a long time to realize.

While Louise and others had come, over time, to think of residents who had violent outbursts as unable to control themselves, Selma, a nursing assistant at Rolling Hills for eight years viewed the outbursts as positive expressions of emotion. She said, “When a resident is attacking you, they’re venting their aggravation the only way they know how, and for them I think it’s physically better to vent than hold it in. So, if you walk by a resident and they just punch you or something, you know, they feel better even though they really didn’t mean to hurt you sometimes. You know you’ve done something for them.”

The Limits of Agency Denied

The staff rarely perceived residents to be intentionally abusive. But when they did, it was frustrating. For example, on the dementia unit at Rolling Hills, Bud, a former athletics coach who staff believed was severely demented, had repeatedly injured staff members as they assisted with personal care. But still many staff members thought his outbursts were intentional, despite his severe dementia.

Evenings on the dementia unit were often hectic because many residents are what staff call “sundowners”, meaning they experience increased confusion, agitation, and frustration in the late afternoon and early evening. One such evening I observed as the unit transformed from relative quiet to a controlled chaos as 2 nurses and 4 nursing assistants struggled to care for 40 demented, sundowning residents. They served and fed dinner, took residents to the bathroom and to bed, checked insulin levels, among other tasks as they documented everything and tried their best to control residents' agitated behaviors. Bud, for instance wheeled into other residents' rooms and slammed the doors; he spit into his hands; he ate mayonnaise directly from the packets; and he tried to open the food cart, which was filled with dirty trays. Stephanie walked past me and whispered, "He knows what he is doing," because he would smirk after she told him to stop. Later that night, he smacked Jamie, a petite twenty-four-year-old nursing assistant, in the face unexpectedly and laughed. It was not the smack that bothered her as much as the laughing, because the laughter was evidence he did it on purpose.A few days later I interviewed Stephanie and asked her about that night. She said:

> When I know somebody's doing something on purpose, that's when they'll get under my skin, you know, and the gentleman the other night, he knows what he's doing. I mean, yes, they do have dementia, not everything they do they realize but —especially when the gentleman, you know, he does it and he smirks and he laughs about it. And, you know, you'll say please not to do—you know, please don't do that and then, you know, he'll look right at you, smirk, and do it again. That frustrates me.

All the injuries from Bud's outbursts on the unit prompted the director of nursing to organize the training from the Alzheimer's Association. The three-hour training was coming to an end when Jamie, the nursing assistant who got smacked by Bud spoke up and asked, almost rhetorically, why she had been hit by this man, because she had not done anything wrong and could not comprehend why he would do that to her. This began a lengthy discussion that reframed the event to be consistent with the denial, or at least the justification, of agency.

The trainer suggested Jamie recall the brain images she put up earlier, noting that Bud most likely did not understand what he was doing when he struck her. Jamie countered though that after he smacked her he began laughing, which in her mind suggested he knew exactly what he was doing. She told the group he hit her so hard her ears rang for days. As various members of the staff spoke about Bud's disruptive behavior, the trainer refocused the discussion by calling on me. Out of about 20 people in the conference room, I was the only man, and she ostensibly wanted to get inside the mind of a man. She turned to me and asked how I would react to the situation Bud was in when he reacted violently, and I hesitantly said "I don't know because I don't have dementia." Nervous I was going to "contaminate" the data, I did not want to say anything at all. But she pressed, and told me to answer as if I did not have dementia. She asked, "How would you feel if someone was coming in your room, and it was the middle of the night, pitch black, and here you are in a strange place with an alarm going off?" I reacted, said "embarrassed, scared" and the instructor cut me off, reiterating loudly "scared," and in a very animated tone said Bud hit Jamie not because he is a bad person but because he was simply scared and "needed to be in control." There was a stranger coming into his room and fear took over, and his reaction was understandable and not his fault. She reiterated that staff need to be mindful of how they approach residents, and she asked the staff how they could approach Bud differently that would lead him to comply with care. The point was clear; Bud may have intentionally struck Jamie, but given the entirety of the situation, it was not his fault: Jamie should have approached Bud differently.

The Achievements of Denied Agency

The denial of responsibility is largely independent of whether residents “truly” intended to strike the staff; rather, it is much more dependent upon staff needs. In the staff’s stories, as in accounts more generally (Scott and Lyman 1968), responsibility is denied with justifications and excuses, and in both cases those denials deflect blame. Unlike the accounts analyzed by Scott, Lyman, and others, the staff’s accounts are about others rather than oneself, and they are deployed not to deflect blame, but to maintain sympathy. In other words, the accounts proffered to explain the bad behavior of residents is an unconscious strategy to manage themselves and their emotions while performing intimate labor.

Furthermore, the denial is useful to all parties involved because it preserves the idea that residents are worthy of care. Akerstrom (2002) made a similar argument but framed it in terms of boundaries, and asserted that staff jumped through linguistic hoops to maintain a view of themselves as compassionate caregivers, residents as deserving care recipients, and nursing homes as caring places. Rather than focus on boundary maintenance, my argument focuses on the attributions of intent that give rise to such boundaries. This approach is fruitful because it shows how agency is not only a theoretical construct, but a moral—and pragmatic—concept, used as a resource and deployed in the process of making meaning. Over and over I listened to shocking stories of physical, verbal, and even sexual assaults. The staff endure these out-bursts without anger or regret so long as they believe such events to be unintentional and not the willful action of a mean, angry individual who is unworthy of care. Making attributions about the agency of residents was an essential element in that process.

The staff resisted seeing negative emotional states, such as aggression, as part of being who someone “truly” is. Previous scholars (Irvine 1999; Stearns and Stearns 1986) have noted how people define certain emotional states as negative and then work to transform them. For the staff to find their work satisfying and meaningful, they must maintain a sense of doing care work that is wanted and appreciated. If staff thought residents intentionally slapped, kicked, and scratched, such thoughts would undermine their sense of doing meaningful, dignified work that helps people who cannot help themselves.

Lastly, the denial of agency is a mechanism to “redeem” the resident. When individuals suffer from dementia at the end of their lives, the staff do not want to think of them as bad people. Therefore, they use a mechanism of redemption (McAdams 2006) that denies agency and saves them from having to tell stories that do not fit the norm. In the process, staff redeem themselves.

DISCUSSION

Nursing-care workers used a rhetoric of agency as a conceptual resource to make sense of, and manage tensions in, their work. Their attributions of intent constructed a locally shared moral order in which sympathetic staff attended compassionately to the needs of deserving, dignified residents under the caring roof of a nursing home.

The staff invoked agency around death and denied the agency of unruly residents. These findings run counter to Gubrium’s (1975), who argued that dying residents “waited to die” and aggressive residents were routinely chemically and physically restrained because their actions were thought to be intentional. What accounts for these dramatic changes in the attribution of agency?

Ascriptions made by nursing-care workers at Rolling Hills and Golden Bay were supported by recent trends in professional philosophies around dying and dementia. The hospice movement recognizes active dying as a set of physiological changes when death is near (Corless 1994), and emphasize the role of “letting go” among patients (Callanan and Kelley 1992) when they die. Hospice developed into a modern, coherent philosophy during the 1960s (Saunders 1967) and its central idea that dying can be a dignified, comfortable and even joyous end to life has been incorporated into nursing-home care. In recent decades, the number of hospices have declined but the number of people in hospice care at nursing homes has steadily increased and been integrated into the structure of nursing-home care.

Similarly, current scientific thought about the etiology of dementia centers on impaired brain functioning (McKhann et al. 1984). Patients are viewed as unable to control or even understand their behavior due to circumstances out of their control, and this was emphasized in staff interactions and shown vividly during the Alzheimer’s Association training at Rolling Hills.

The staff were encouraged to visualize degenerated brain tissue to frame aggressive behavior sympathetically, much like the flight attendants Hochschild (1983) studied who were instructed to imagine belligerent passengers as fearful and childlike. These schemas contribute to organizational stability. The organizational cultivation of sympathy for violent residents managed the floor staff, because it mitigated the potential for staff to retaliate against residents. If staff viewed aggressive outbursts as intentional, retaliation could be plausibly constructed as self-defense. Given the terrible history of institutional abuses against vulnerable populations, allegations of mistreatment represent an enormous risk that is reduced by attributing bad behavior as unintentional. Moreover, the social organization of death as something the staff has little control over reduces the considerable potential for stress and emotional burnout. If resident deaths were constructed as something the skilled care could prevent, then dying could be conceived as the result of poor care. Lastly, if staff felt they were intentionally struck by residents, they might make demands on their employers for protection, and insist the facility not accept residents with a history of violent behavior.

The current regulatory structure of long-term care also plays a role in the way staff make attributions of intent. The Nursing Home Reform Act, part of the Omnibus Reconciliation Act (OBRA) of 1987 created a financial incentive for management to screen for, and accept, individuals with a history of violence. Medicare and Medicaid reimburse more when residents have documented aggressive verbal, physical, or sexual outbursts. Prior to OBRA 1987, the federal payment structure for long-term care did not take such behaviors into account when reimbursement rates were calculated. At Rolling Hills and Golden Bay, floor staff would complain that the management would admit poorly behaved residents because it helped the bottom line, without regard to the impact such residents had on the nursing assistants. The cultivation of sympathy towards aggressive residents helps to insulate the management from staff complaints, while boosting the bottom line and forestalling demands from staff for protection.

Furthermore, OBRA 1987 put substantial restrictions on chemical or physical restraints to subdue unruly residents. Prior to the legislation, restraint use was prevalent and widely varied across facilities (Strumpf and Tomes 1993). Staff at both nursing homes who recalled the era before OBRA 1987 said restraints were routinely used as a form of care. OBRA strongly discouraged restraint use and prohibited nursing homes from using them unless they are ordered by a physician, and established residents’ right to be free of restraints for the purposes of discipline or convenience. According to a recent Kaiser Foundation report (Wiener Freiman, and Brown 2007), the prevalence of restraint use dropped from about 40 percent since the inception of OBRA 1987 to fewer than 6 percent in 2007. The dramatic changes in the way agency has been attributed and denied to residents is consistent with changes in the social organization of nursing-home care put forth in OBRA 1987, particularly in collaboration with recent professional philosophies, trainings, and staff interactions at Rolling Hills and Golden Bay. In this respect, attributions of intent shape, and are shaped by, a historically situated, locally shared, moral order.

More generally, agency is a cultural object whose use is subject to empirical inquiry. People construct meaning from experience though a social process of attribution. My primary concern is not to reify agency as an authentic state of being; rather, it is to analyze how people invoke agency to make sense of their lives. This extends our understanding of agency out of the abstract realm of theoretical construct and into the empirical realm of social interaction.

My argument extends beyond the case of nursing-care workers presented here, not least to sociology itself. Attributions of agency are shaped and constrained by available interpretive schemas. Different schemas have different, overlapping logics; thus, the general processes to attribute agency may be universal, but they manifest uniquely based upon particular social conditions.

Much like nursing assistants, sociologists deploy agency as a rhetorical resource. Sociologists often use attributions of agency to make arguments that rest on no more or less evidence than nursing-home staff who insisted that Mabel controlled her death and that Bud did not control his outbursts. Sociological debates around inequality, deviance, and social movements, among many others, are organized around understandings of agency as if it were something that people possess. My analysis here suggests that we could as profitably look at the ways sociologists deploy the concept of agency—to what ends and under what conditions—as we look at the way others deploy the concept. We would, then, be well served to think about agency itself sociologically—as a set of understandings ascribed to a set of behaviors, used to grasp and create moral meanings in social life and to come to terms, in a variety of ways, with those meanings.

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REFERENCES

1. Akerstrom, Malin. Slaps, Punches, Pinches—but Not Violence: Boundary Work in Nursing Homes for the Elderly. Symbolic Interaction. 2002; 25(4):515–36.
2. Callanan, Maggie; Kelley, Patricia. Final Gifts: Understanding the Special Awareness, Needs and Communication of the Dying. Bantam Books; New York: 1992.
3. Clark, Candace. Sympathy Biography and Sympathy Margin. American Journal of Sociology. 1987; 93(2):290–321.
4. Corless, Inge. Dying Well: Symptom Control Within Hospice Care. Annual Review of Nursing Research. 1994; 12:125–46.
5. Denzin, Normon. The Research Act: A Theoretical Introduction to Research Methods. Prentice Hall; Englewood Cliffs, NJ: 1989.
6. Dodson, Lisa; Zincavage, Rebekeh. 'It's Like a Family': Caring Labor, Exploitation, and Race in Nursing Homes. Gender and Society. 2007; 21(6):905–928.
7. Emanuel, Linda; Ferris, Frank D.; von Gunten, Charles F.; von Roenn, Jamie H. The Last Hours of Living: Practical Advice for Clinicians. Medscape; New York: 2006. Retrieved April 1, 2007 (http://www.medscape.com/viewprogram/5808)
8. Glaser, Barney G.; Strauss, Anselm. The Discovery of Grounded Theory: Strategies for Qualitative Research. Aldine Transaction; Piscataway, NJ: 1967.

9. Goffman, Erving. Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. Doubleday; New York: 1961.
10. Goffman, Erving. Relations in Public: Microstudies of the Public Order. Penguin Press; New York: 1972.
11. Gubrium, Jaber. Living and Dying at Murray Manor. St. Martin's Press; New York: 1975.
12. Gubrium, Jaber. The Social Preservation of Mind: The Alzheimer's Disease Experience. Symbolic Interaction. 1986; 9(1):37–51.
13. Hochschild, Arlie. The Managed Heart: Commercialization of Human Feeling. University of California Press; Berkeley, CA: 1983.
14. Irvine, Leslie. Codependent Forevermore: The Invention of Self in a Twelve Step Group. University of Chicago Press; Chicago, IL: 1999.
15. Lopez, Steven Henry. Culture Change Management in Long-Term Care: A Shop-Floor View. Politics and Society. 2006; 34(1):55–79.
16. McAdams, Dan P. The Redemptive Self: Stories Americans Live By. Oxford University Press, USA; New York: 2006.
17. McKhann, Guy; Drachman, David; Folstein, Marshall; Katzman, Robert; Price, Donald; Stadlan, Emanuel M. Clinical Diagnosis of Alzheimer's Disease: Report of the NINCDS-ADRDA Work Group under the Auspices of Department of Health and Human Services Task Force on Alzheimer's Disease. Neurology. 1984; 34:939–43. [PubMed: 6610841]
18. Mead, George Herbert. Mind, Self, and Society: From the Standpoint of a Social Behaviorist. University of Chicago Press; Chicago, IL: 1934.
19. Phillips, David; Smith, D. Postponement of Death until Symbolically Meaningful Occasions. Journal of the American Medical Association. 1990; 63:1947–51. [PubMed: 2313872]
20. Pollner, Melvin; McDonald-Wikler, Lynn. The Social Construction of Unreality: A Case Study of a Family's Attribution of Competence to a Severely Retarded Child. Family Process. 1985; 24(2): 241–54. [PubMed: 4018244]
21. Saunders, Cecily. The Management of Terminal Illness. Hospital Medical Publishing; London, UK: 1967.
22. Scott, Marvin B.; Lyman, Stanford. Accounts. American Sociological Review. 1968; 33(1):46–62. [PubMed: 5644339]
23. Seale, Clive. Constructing Death: The Sociology of Dying and Bereavement. Cambridge University Press; Cambridge, UK: 1998.
24. Skala, Judith; Freedland, Kenneth. Death Takes a Raincheck. Psychosomatic Medicine. 2004; 66:382–86. [PubMed: 15184701]
25. Stearns, Carol Zisowitz; Stearns, Peter. Anger: The Struggle for Emotional Control in America's History. University of Chicago Press; Chicago, IL: 1986.
26. Snyder, Lori Anderson; Chen, Peter Y.; Vacha-Haase, Tammi. The Underreporting Gap in Aggressive Incidents From Geriatric Patients Against Certified Nursing Assistants. Violence and Victims. 2007; 22:367–79. [PubMed: 17619640]
27. Strumpf, Neville E.; Tomes, Nancy. Restraining the Troublesome Patient: A Historical Perspective on a Contemporary Debate. Nursing History Review. 1993; 1:3–24. [PubMed: 8453405]
28. Weinberg, Darin. The Social Construction of Non-Human Agency: The Case of Mental Disorder. Social Problems. 1997; 44(2):217–34.
29. Wiener, Joshua M.; Freiman, Marc P.; Brown, David. "Nursing Home Quality": Twenty Years After the Omnibus Budget Reconciliation Act of 1987. Henry K. Kaiser Family Foundation; Menlo Park, CA: 2007. Retrieved April 1, 2007 (http://www.kff.org/medicare/7717.cfm)
30. Young, Donn; Hade, Erin. Holidays, Birthdays, and Postponement of Cancer Death. Journal of the American Medical Association. 2004; 292:3012–16. [PubMed: 15613670]