CHAPTER EIGHT

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NURSING WORK, HOUSEKEEPING ISSUES, AND THE MORAL GEOGRAPHY OF HOME CARE

For millions of elderly people and in particular, elderly women, the home is a major place for health care delivery. In the United States in 1996, 7.2 million individuals received home care services and, of this number, 63% were over 65 and 65% were women (National Association of Home Care). While nurses, who are overwhelmingly women, are the largest professional providers, family members and other unpaid help perform the majority of care work. Not surprisingly, 75% of these informal caregivers are women and nearly one third are themselves over the age of 65 (National Association of Home Care). Thus, in home care, the elderly are caring for the elderly, and the majority of both recipients and providers of care work are women. With the baby boomers reaching retirement age and the fastest growing portion of the population are those over age 85, the issues of home care will only assume greater importance in health care.

As the heart of the private domain, the “home” mediates between the larger culture and families, however they are defined. “Home,” as an idea and a material reality, reveals the cultural value of the care work necessary for human life from birth to death and the gender, class, and race relations that structure that work. Care work, whether done by professionals, non-professionals, or un-paid workers, is ordinary, that is, concerned with the body and with mundane aspects of life in contrast to the production of knowledge typically recognized as culturally significant. Contemporary bioethical discourse has little relevance to and little interest in the moral concerns arising from this ordinary work. This is not surprising given that contemporary bioethics did not originate in concerns with the everyday care of the sick and the elderly but as a response to the ignominious actions of physicians in concentration camps. These actions, articulated as the abuse of research practices, the moral responses they generated at the time, and the evolving course of history have resulted in a bioethical discourse that essentially confines itself to the implications of medical and scientific research. Perhaps if the circumstances of origin had been different, bioethics would attend more to the conditions of the ordinary, that is, conditions common to all of us.

D.N. Weisstub, D.C. Thomasma, S. Gauthier & G.F. Tomossy (eds.), Aging: Caring for our Elders, 123-137.
As it is, bioethical discourse privileges the cognitive authority and political and social power of institutionalized medicine over that of other health care workers in nearly all contexts and sites of health care practice. Disturbing effects follow in that the highly influential voice of bioethics has been virtually silent on the issues of race, class, and gender that so significantly effect care work. For example, in home care, physicians control access to help for patients that is provided by other disciplines. Family members, who are often older women, provide a majority of care for the elderly and receive little help at the societal level. Few in bioethics have attended to the low status of non-professional home care workers (Holstein 1999), also mostly women, and many of whom are women of color. They do the most care work at the most intimate level, are paid the lowest wages, and are frequently the recipients of exploitative, punitive, unjust practices (Liaschenko 1998). These groups rarely experience an opportunity to voice their moral concerns. As for nurses, all too often, their ethical concerns are heard as trivial or sentimental and are thereby excluded from the formulation of moral problems. As a consequence, they experience their concerns as illegitimate, as lacking in moral authority because their concerns lie beyond the range of typical bioethical discourse. Both of these lapses have negative implications for what issues attain the status of genuine, legitimate, ethical concerns, for who is entitled to define them, and for the variety of social responses to those concerns. This limitation deprives society of moral knowledge inherent in other work and sites of care, knowledge that may inform more appropriate approaches to both the recipients and providers of care work.

As a corrective to this lack of legitimacy, this chapter highlights the not uncommon plight of the elderly receiving care in the home and the moral concerns of the nurses who work with them. The title, “Moral Geography,” is intended to draw attention to the two major points of the paper, that places are contexts for action and that the idea of “moral geography” suggests an expanded way of thinking about some bioethical issues, a way that expands our vision of what counts as a moral concern, how it arises from a given place in health care, who is authorized to voice it, and the social response generated to answer it.

Geography is an increasingly common metaphor in scholarly writing reflecting the “situated knowledge” that inheres in various practices. Spatial metaphors serve to illuminate human activities across physical distances as well as at micro and macro levels of social organization and complexity. These metaphors have even found their way into moral philosophy (Walker 1998) and bioethics (Walker 1993) where “geographies of responsibilities” and “moral space” are used to argue for new approaches within the respective disciplines. This chapter builds upon earlier work that followed my newfound appreciation for how geography influences action (Liaschenko 1994; 1997). In those papers I addressed how the knowledge and discourse of medicine might effect patient agency in the move from hospital to home care and structural factors in the nurse patient relationship that nurses identified as moral concerns. There is a dialectical structuring relationship between a place and knowledge, perception, discourse, and practices. In this way, places are not morally neutral but reflect normative significance (Entrikin 1991).