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Surveillance, Intervention and The Politics of Care

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Abstract

This paper connects with debates about the use of surveillance technology to detect, report and prevent abuse in care settings. Grounded in a Heideggerian theorisation of care as intervention, it argues that care unfolds in people's deliberations and decisions about whether and how to intercede when abuse is suspected. Such reflections reveal the politics of care, because they are contingent on how the need for care is constructed, and actions subsequently legitimised. From this perspective, surveillance can be seen as a manifestation of care, involving choice and responsibility for framing both the problem of, and solution to, abuse.

Keywords: Care, surveillance, intervention, power

Introduction

Analyses of surveillance are dominated by metaphors of Orwell's Big Brother and Foucault's reworking of Bentham's panopticon (Essen, 2008; Haggerty and Ericson, 2000), with surveillance traditionally associated with monitoring people to prevent or punish wrongdoing. Those under surveillance often seem stigmatised - they *need* watching and, as a result, come to lack the human dignity associated with privacy (Niemeijer et al, 2011). Indeed, practices of surveillance trigger fundamental questions about the nature, even the possibility, of the private self and the changing values of privacy in post-modernity (Lyon et al, 2012).

The general use of surveillance technology in public spaces has now extended into institutionalised health and social care (Macnish, 2016; Powell and Biggs, 2000). Applications include deterring crime and securing convictions in hospitals (Stolovy et al, 2015), investigating critical incidents (SCIE, 2014) and nursing observations of service users considered at risk to themselves or others (Warr et al, 2005). Although CCTV (closed circuit television) is perhaps the best-known surveillance technology, it is only one in an ecosystem of monitoring tools used in care settings, which include GPS tracking for people with dementia and personal activity monitors.

One of the most striking applications of surveillance in health and social care relates to the detection, reporting and prevention of abuse. In recent years, there have been several accounts of CCTV surveillance in care homes in the UK (Fisk, 2015), including media stories of covert filming to uncover the abuse of loved ones (eg BBC, 2018). The deployment of video surveillance to tackle abuse takes us away from assumptions of a binary surveillant / surveilled relationship and demands a more nuanced understanding of surveillance as involving and implicating a nexus of actors, activities and concerns. As Ball (2005: 93) explains, contemporary surveillance theory highlights 'the disparate arrays of people, technologies and organisations that become connected to make "surveillance assemblages", in contrast to the static, unidirectional panopticon metaphor'. Such assemblages see surveillance as both the few-watching-the-many and the many-watching-the-few, drawing together metaphors of panopticon and synopticon in a multi-directional 'viewer society' (Mathiesen, 1997: 215). In the case of care homes, the surveillants might include management, staff, family members and other concerned stakeholders such as specialist surveillance services. The surveilled could be both care recipients (i.e. care home residents) and individual professional caregivers.[1]

Appreciating the complexities of using CCTV to tackle abuse involves making a connection with developments in surveillance theory which both accommodate a range of actors and targets, and move beyond understandings of surveillance as passive monitoring activity. Surveillance scholars are increasingly arguing for more multi-faceted definitions of surveillance practice, which emphasise the links between observation, deliberation, decision and action (Haggerty and Ericson, 2000; Lyon et al, 2012). Ball (2005) presents different functions and outcomes of surveillance, including: surveillance as knowledge; surveillance as information; and surveillance as protection from threat. Building on Ball (2005), we are specifically interested in the question of surveillance as intervention, that is, in the ways in which surveillance activities are enveloped in questions of whether, why and how to step in if abuse is either detected or suspected. Thus, the focus of our interest in surveillance technology is twofold: as a form of intervention in its own right (i.e. as a literal insertion into a care recipient's world) *and* as a trigger and enabler of a range of deliberations and decisions about other forms of action.

Given the burgeoning literature on the complexities of surveillance, and the crucial importance of finding ways to prevent and tackle abuse, it is perhaps somewhat surprising that surveillance practices in care settings have not, to our knowledge, been considered specifically through a theoretical framing of care. Others have laid the groundwork for such an approach: Randall and Munro (2010), for instance, examine institutionalised surveillance through the Foucauldian notion of *self*-care; and Friedman (2015) uses an ethic of care to consider government surveillance programmes aimed at national security. But our work takes an explicitly two-pronged approach to care in the relations between people and institutions, considering care *both* as organisational context *and* as theoretical framing. Thus, this article develops three vignettes on the issue of CCTV to explore how practices, relations and challenges of surveillance in institutionalised care might be informed by a theorisation of care. Located at the intersection of the literatures on surveillance and on care, the question motivating this paper is: can surveillance be an act of care?

Conceptualising care

Care has been a philosophical concern for millennia, going to the heart of some of our most fundamental questions about the nature of the human condition. For instance, the connection between self-care and care for others informs Socratic and Platonic philosophy (Nehamas, 1998) and Aristotle's virtue ethics contain seeds of contemporary care ethics, with their emphasis on the dependency and relationality of human experience (Thomas, 2011). There has also been vibrant debate about the relationship between Western understandings of care

and the Eastern tradition of Confucianism (Herr, 2003). In short, many of the world's most influential philosophies have made care central to what it means to be human.

In relation to Western understandings, care has been the focus of many different conceptual analyses over recent decades (Bowlby et al, 2010). In the 1980s care tended to be viewed as a 'homogenous activity focused around the provision of instrumental support, and understood as one person "doing care to" another' (Ray et al, 2009: 116). Feminist writers at this time were critical of how caring is associated with women and consequently devalued (Gilligan, 1982; Barnes, 2006). This body of work also distinguished between 'caring about' and 'caring for': emotions are central to the former, while the latter concerns the tasks of tending (Dalley, 1996). Others writing from this perspective argued that care is a matter of both labour and love, and that these two dimensions are inseparable (Graham, 1983).

Since the 1990s, analyses have emphasised care's relationality, challenging the traditional caregiver / care recipient dichotomy (Walmsley, 1993). The mutuality and attachment that imbue many care relationships have also been underscored in the growing body of literature on the ethics of care. This work sees care as moral orientation and highlights the interest that both caregivers and care recipients have in their shared being (Tronto, 1993). Post-modernist interpretations of power have informed another strand of care discourse, proposing that 'power in caring relationships is constantly (re)created and (re)negotiated through interaction' and is therefore 'fluid, complex, and constantly shifting' (Dominelli and Gollins, 1997: 412). From this perspective, care and caring evolve over time as a result of changes in the caring relationship and other contextual factors (Bowlby et al, 2010). This focus on power poses a provocation to care ethicists by suggesting that the asymmetry in care relations can be one of dominance and exploitation (Kittay and Feder, 2002).

Care as intervention

From the wealth of such different perspectives on care in diverse intellectual traditions, we focus in this article on one particular theorisation which sees care as intimately related to the question of intervention. We thereby make the conceptual link between care as intervention and an understanding of surveillance as intervention, as already indicated. This approach to care is inspired by the phenomenological-hermeneutic philosophy of Martin Heidegger (1889-1976), for whom care is fundamental, indeed, ontologically *prior*, to human experience.[2]

Heidegger (1962) describes two modes of caring relations, 'leaping-in' and 'leaping-ahead', which have been translated as instruction and intimation (Glendinning, 2007) and direction

and empowerment (Tomkins and Simpson, 2018). 'Leaping-in' is a kind of substitution, where the caregiver 'leaps in' to take over responsibility for a problem and direct its resolution as he / she sees fit, often in response to what is perceived as a crisis. This approach assumes that the caregiver knows what needs to be done, and can apply the appropriate expertise. 'Leaping-ahead', on the other hand, is a kind of care which empowers and enables the care recipient to find his/her own way through a situation. It is not geared towards achieving a specific solution so much as at inspiring the care recipient to have the courage to work through the various options on his / her own terms.

Within the field of healthcare, Benner (2000) has equated the Heideggerian 'leaping-in' with systems of accounting and targets, and 'leaping-ahead' with engagement in authentic nurse-patient relationships. She argues that 'leaping-in' is based on abstract, theoretical expertise concerning patients-in-general, which runs counter to a view of nursing as practical, intuitive expertise geared towards this patient-in-particular. For Benner, 'leaping-ahead' reflects a kind of relationship where one cannot control how care will evolve, requiring openness and attunement to the care recipient's desires and aspirations as well as needs.

Tomkins and Eatough (2013) build on this analysis in relation to familial care. They argue that 'leaping-in' and 'leaping-ahead' are not either / or choices, but rather, suggest the complexity of the lived experience of the deliberations and decisions of care. For instance, 'leaping-in' during an elderly parent's medical consultation to talk *over* the parent directly to the doctor may save time and produce a factually accurate account, but risks infantilising and disenfranchising the care recipient. However, holding back to allow the parent to talk things through in his / her own way and time may compromise the emergence of a correct analysis of the situation, and therefore disadvantage the care recipient in a different way. Such are the everyday, often anguished, dilemmas of care relationships. Care unfolds in the process of gauging how best to intervene, or not intervene, and bearing the responsibility for the consequences of these choices.

Decisions of care: tame, critical and wicked problems
These Heideggerian analyses of care as intervention emphasise the importance of decision-making in care.[3] This has led Tomkins and Simpson (2018) to develop a view of care based on the notion of tame, critical and wicked problems, an idea that exerts considerable influence over both academic and popular understandings of decision-making. Drawing on Grint (2005) and Rittell and Webber (1973), they outline how caregivers' decisions to intervene or intercede depend on whether the problem being experienced by a care recipient is tame, critical or wicked.

Tame problems may be complicated, but they are ultimately solvable, because they have occurred before and therefore have some sort of 'best practice' template for resolution. When we attempt to tame a situation, we are operating on the assumption that there is a best way of approaching it based on theory or on data from past experience. As such, tame problems require the mobilisation of appropriate resources and the application of correct processes, tools and techniques. For Grint (2005), this problem-type requires and invokes a managerial, technical and / or procedural response. In terms of the notion of care as intervention (Tomkins and Simpson, 2018), tame problems call for, and justify, 'leaping-in' to fix things.

A second set of problems are critical problems, requiring strong, emphatic decision-making in the face of crisis. Here there is very little uncertainty about what needs to be done. Any nuanced reflection on alternative ways forward is shelved, as the nature of decision-making becomes one of providing not just answers, but *immediate* answers, to the problem. For Grint (2005), this problem-type requires and invokes a military-style 'command' response. With respect to care as intervention (Tomkins and Simpson, 2018), critical problems also call for, and justify, 'leaping-in', but with a sense of urgency and determination which brooks no opposition or delay.

In contrast, wicked problems are often intractable. Each has unique challenges, thereby preventing the application of known solution templates. An apparent solution to a wicked problem can generate further problems, and at no stage can one be confident that any actions or decisions are the right ones, or even the best ones. Wicked problems involve coming to terms with uncertainty and complexity and require collaborative processes of questioning, exploring and co-operating to make any sort of progress. For Grint (2005), this problem-type requires a response akin to 'leadership', that is, engaging with multiple stakeholders using techniques of reflection, persuasion and empowerment. Wicked problems therefore invoke issues of 'soft' rather than 'hard' power (Nye, 2008), that is, they involve the influencing of others by appeal and attraction rather than through force and coercion. In relation to Heideggerian care as intervention (Tomkins and Simpson, 2018), wicked problems call for, and justify, 'leaping-ahead'.

From this perspective, there is a spectrum of decision-styles available to caregivers when confronted with a problem for someone in their care. At one end, there is a decisive and fixing-style intervention ('leaping-in'); at the other, there is a more enabling and collaborative style of engagement ('leaping-ahead'). Tame and critical problems tend to invoke the former, while wicked problems demand more of the latter. So, returning to the question of whether

surveillance can be an act of care, we suggest that care unfolds with the interpretations a caregiver makes about whether a particular situation is tame, critical or wicked. It is on these interpretations or framings that choices about intervention are based and different caring responses evoked. To illustrate this, we now present three vignettes of surveillance in care institutions, viewed through the prism of tame, critical and wicked problems.

Three vignettes of caring surveillance

The following vignettes represent different responses to the problem of abuse and the use of surveillance technology in institutionalised care: covert surveillance; campaigns for mandatory surveillance; and the issuing of guidance for surveillance practice. They reveal how the issue can be framed as critical, tame, or wicked, and the styles and implications of intervention which result. They are summarised in table format at Appendix One, and described in detail below.

1. The hidden camera in the care home: The framing of a crisis

The use of covert CCTV to detect the abuse suffered by Freda Jobson has been well documented by the BBC (2018), Hudgell Solicitors (2016a) and several other news outlets. Freda, who suffers from dementia, lived at the Keldgate Manor residential care home in England from 2012 until 2015, when her family began to worry about the quality of her care. She had developed serious pressure sores on her lower back, hips and feet, but her family's initial efforts to raise their concerns with the care home proved frustrating. As Freda's physical and emotional condition deteriorated, her daughter installed a hidden 'spy' camera in her room. The camera captured a horrific catalogue of abuse. Not only were Freda's physical needs ignored, she was also subjected to taunts and mockery at the hands of her 'caregivers'.

As documented by the BBC (2018), Freda was moved to another facility. The video evidence of Freda's abuse resulted in criminal prosecution of her abusers, and the abuse was considered so severe that the family were advised to claim for compensation. Several press outlets carried the story and it was shared on Facebook and other social media outlets. Freda's daughter appeared on national television, describing the anguish of the decision to intervene, her feelings of guilt at not having acted sooner, and her ongoing anxiety about whether releasing the video footage into the public domain had been the right thing to do.

The decision to install a hidden camera to monitor and then expose the abuse reflects an interpretation of the situation as so critical that it requires a decisive intervention. The sense of imminent threat is central to the interpretation of this situation as a crisis, which legitimises such an approach (Grint, 2005). This form of care reveals an underlying assumption that Freda was unable to navigate the difficulties of the situation herself, and therefore needed others to

assume responsibility for resolving the problem. In other words, this example illustrates the framing of a problem as a crisis which invokes 'leaping-in'.

In terms of power dynamics, this case illustrates an argument, from surveillance theory, that we can no longer assume surveillance is necessarily the monitoring of the powerless by the powerful (Mathiesen, 1997). Although Freda herself was relatively powerless, her 'caregivers' wielded the power of institutional position and access, against which Freda's family were relatively powerless, initially at least. However, while the family lacked formal, institutional power, the placement of the hidden camera allowed them to exert a different form of control over that space. Such power dynamics share many characteristics with the notion of 'sousveillance' (Dennis, 2008), which inverts the traditional relation of the powerful monitoring the powerless, and presents the concept of surveillance from-within, rather than from-above. It emphasises that the power dynamics of surveillance are complex and multi-faceted (Ball, 2005), highlighting an important distinction between institutional power and evidential power.

This example also suggests some of the ethical complexities of 'leaping-in', when problem-resolution takes priority over all other considerations. For Freda's family, the urgency of the problem and the need to prevent further suffering outweighed the issue of the deprivation of privacy. However, it is unclear how much capacity Freda had to give consent for this very invasive form of intervention, or how much she understood its potential consequences. Her story was turned into material for public broadcast, and there is a permanent documentary record of her humiliating treatment on-line.

This case highlights the risk of prioritising 'fixing' things over the rights, dignity and self-determination of the person in the situation 'being fixed'. If it is to be an authentic form of care in a Heideggerian sense, it needs to incorporate an act of restoration of these rights, dignity and self-determination once the immediate crisis has passed (Tomkins and Simpson, 2018). Whilst this feels almost axiomatic from a theoretical perspective, it seems harder to imagine how such restoration might be achieved in practice. The price of this care is that Freda's privacy has been compromised forever: there is no way to recall the footage from the internet now that its crisis management purpose has been served. Thus, CCTV may well be justifiable as an effective caring intervention, but its morality is more complex than its efficacy. In prioritising some of the care recipient's needs over others, it reveals an 'ethics of care' to be an 'ethics of compromise'.

2. Mandatory camera use in care homes: Attempts to tame the problem

The success of CCTV in cases like Freda's has led to calls for more widespread use of surveillance technology in institutionalised care. Indeed, there have been public campaigns and petitions for CCTV in residential care to be made compulsory. For instance, Hudgell Solicitors' 'Love Our Vulnerable and Elderly' (LOVE) campaign (Hudgell Solicitors, 2016b) suggested that 88% of care workers have witnessed or suspected abuse, and that compulsory surveillance is the only way to solve these issues.

The urge to identify and implement 'best practice', that is, to find a general solution that can be replicated across different situations, reflects an interpretation of the problem as tame. As Grint (2005) emphasises, this means that it is complicated, rather than complex. In other words, the problem is fixable if one intervenes with the right methods, tools and techniques. Campaigns such as LOVE highlight the success of CCTV approaches in individual cases to make the case for their use in all care institutions. They cultivate the impression that surveillance technology is foolproof and that the problem of abuse can, and therefore will, be fixed. Moreover, the rhetoric of such campaigns suggests that the link between problem and solution is self-evident; it is simply common sense to apply the solution more generally.

Both tame and critical framings are manifestations of care as 'leaping-in'. Critical framings involve more urgency and focus attention on a single pressing case; whereas tame framings involve more consideration and planning and focus attention on the connection between the single case and general application. Approaching a problem as tame is therefore a less dramatic intervention than one involving crisis management, and may initially look less costly in terms of the rights and dignity of the individual care recipient. Nonetheless, the power dynamics are no less asymmetrical. 'Leaping-in' to tame a problem still means that care recipients have their physical and psychological space invaded and their needs determined and ranked by others. Thus, this form of care reinforces power asymmetry and risks infantilising, even dehumanising, the care recipient (Benner, 2000).

Both forms of 'leaping-in' are attempts to protect the care recipient's well-being. However, both are also interesting for what they reveal about the psychology of the caregiver. Framing a situation as a crisis involves anxiety, but it also involves something of an adrenalin rush, as one strips away ambiguities and doubts to take decisive action (Grint, 2005). Framing a situation as tame provides a slightly different form of enjoyment, namely the relief of being able to take control and apply a tried-and-tested technique to reduce risk and predict outcome (Tomkins and Simpson, 2018). This is not to suggest that there is anything wrong with these

9

emotions, but they do remind us that the motivations of care are complex, and not always completely altruistic (Simpson et al, 2013).

Significantly, efforts to tame a problem are rarely successful over the longer term, because in downplaying the complexities of the problem to mobilise a solution, they become blind to the wider context in which the problem has emerged (Grint, 2005). Thus it is interesting to note that efforts to force a change in care home regulation have so far been unsuccessful. In 2016, the UK Government's response to one petition, which had received over 12,000 signatures, argued that although they did not object to its use on a case-by-case basis, the question of surveillance technology raises significant issues with respect to privacy (UK Government and Parliament, 2016). The report concluded that CCTV should not be regarded as a substitute for proper recruitment, training, resourcing or management. So far, therefore, efforts to tame the problem of abuse have proved somewhat ineffectual.

3. The CQC guidelines: Acknowledging wickedness

The limitations of the taming approach suggest the need to resist simplistic one-size-fits-all solutions to the problem of care home abuse. Perhaps, therefore, the question of surveillance intervention makes greater sense when viewed as a wicked problem, acknowledging that methods and outcomes that were appropriate in one situation may not necessarily be appropriate in all instances. In other words, it may be that this particular manifestation of care is complex rather than complicated, requiring deep reflection, consultation and collaboration to even come to terms with the problem, let alone agree on possible paths towards a solution. Connecting back to our Heideggerian framing, this would call for care as 'leaping-ahead'.

The actions of the Care Quality Commission (CQC, 2013) seem to reflect such wickedness with their first major engagement with the debate, 'A fresh start for the regulation and inspection of adult social care', which proposes an open conversation about the use of hidden cameras.[4] Recognising both the significance of the issue and the diversity of opinion surrounding it, the CQC consulted with a wide range of stakeholders, including care providers, representative organisations, service users, academics and other experts. While there was widespread agreement that guidance for both the public and care providers was urgently needed, there was no clear steer on what that guidance should actually *be*, and no consensus on the overall question of whether covert surveillance should be encouraged or discouraged.

Two sets of guidance were eventually developed. The advice for providers (Care Quality Commission, 2015a) emphasises lawful, fair and proportionate use of surveillance; but use is

neither encouraged nor discouraged. The guidance does not establish the legality of surveillance but advises providers to seek their own independent legal advice. It recommends that any provider considering implementing surveillance should consult widely with residents and their families, staff, regular visitors and unions; assess the impact on privacy; and consider data protection and mental capacity legislation. The advice for the public (Care Quality Commission, 2015b) runs through some of the ethical issues associated with surveillance. Careful to neither condone nor condemn hidden surveillance, it prompts families to reflect on issues such as privacy, consent, the service providers' rights to confiscate equipment and how to act on evidence. Given that both reports emphasise the complexities of the issue rather than providing direction or condoning the practice altogether, it is perhaps unsurprising that their release received an extremely mixed response from across the sector (Sutcliffe, 2015).

The issues raised in the CQC reports are difficult and multi-faceted, seemingly justifying a framing of the problem as wicked. The development of guidelines that ask more questions than they answer dovetails with the definition of wicked as meaning that the framing of the problem *is* the problem (Rittell and Webber, 1973). The CQC response also shares other characteristics of wickedness. For instance, any guidance that shifts most of the responsibility for deciding what to do on to others must surely raise questions about whether this is an abrogation of responsibility for the issue. The CQC reports do not give any sense of 'best' or even 'reasonable' practice, and any advice is accompanied by heavy caveats. This ambiguity reminds us that 'leaping-ahead' is a seductive form of care that plays to liberating discourses of empowerment and democratic participation, but also risks being open to the charge of *laissez-faire* (Tomkins and Simpson, 2018). In contrast to the decisiveness of tame and critical approaches, the CQC's guidance delegates responsibility for decision-making to such an extent that it forces the question: at what point is 'guidance' so consultative and open that it ceases to really *be* 'guidance'? And by extension, at what point is this approach to intervention so 'hands-off' that it ceases to really *be* care?

Such challenges do not mean that no progress can be made towards developing policy and practice guidelines which represent a reasonable balance between care recipients' right to protection and their right to privacy. Acknowledging the wickedness of a problem does not mean abandoning hope of ever making progress with it. However, wickedness makes every step feel tentative, and one never knows whether what one is doing is a step forward or a step backwards (Grint, 2005). Despite (or maybe because of) efforts to build a collective sense of engagement and 'buy-in' for a common approach, the CQC has found itself in the midst of a complex and frequently intractable set of disagreements and dilemmas. The way forward for

care home surveillance seems wicked indeed.

Discussion: The politics of care

In the analysis above, we have suggested that a range of deliberations relating to CCTV use can represent actions and decisions of care. Viewed through the Heideggerian prism of caring interventions, the three vignettes can be seen as attempts to provide caring surveillance. The technology itself is a form of intervention, *and* it enables a range of other decisions and actions in response to the suspicion or reality of abuse. The first two vignettes illustrate a kind of 'leaping-in' to assume responsibility for problem resolution without requiring the involvement of care recipients themselves in the decision; whereas the third can be characterised as 'leaping-ahead' to foster consultation and collective problem-ownership amongst care providers, care recipients and other stakeholders. Although they represent different forms of agency (the first is individual, at least initially; the second and third are more collective and institutional), they all say something about how a caring instinct can be manifested in action.

In this analysis, we are suggesting that the juxtaposition of theories of care with theories of surveillance might be mutually illuminating. Seeing these vignettes of surveillance through the prism of care helps to humanise the debate, lending weight to the argument that surveillance is not necessarily repressive or reductive. As Ball (2005: 105) suggests, surveillance creates new patterns of relationship between individuals, groups and society and is 'primarily productive: it synthesizes and conjoins'. Such an approach nudges the debate over care home surveillance away from an emphasis on guidelines or issues of technology, and towards a more ethnologic notion of surveillance with real consequences for the people involved, both behind and in front of the camera. It reinforces Niemeijer's (2015) suggestion that the debate about care home surveillance needs to take care, rather than principles or checklists, as its starting point.

Niemeijer (2015) emphasises considering what a 'good life' under surveillance might mean. Our analysis posits that it is precisely by seeing the deliberations and decisions about intervention as *acts of care* that we might begin to unpack what this 'good life' could comprise. Such a framing acknowledges the tensions involved in the relationships between caregivers and care recipients, and the difficulties of weighing up other people's rights to privacy, dignity, safety and autonomy (Noddings, 1984). That such weighing up is required is not new to the literature on care home surveillance (Fisk, 2015), but our theoretical framing of the 'leapings' of care helps to bring out both the challenges and consequences for all parties involved.

Our analysis reveals that the two literatures on surveillance and care are experiencing several parallel developments. In both, there is a shift away from binary relationships (caregiver / care recipient and surveillant / surveilled) towards a much broader nexus of actors, intermediaries, practices and concerns. Indeed, just as surveillance theorists now talk about 'surveillance assemblages' (Haggerty and Ericson, 2000), perhaps there is merit in thinking about 'care assemblages' to reflect the disparate and distributed arrays of people, technologies and organisations, both inside and outside the care sector, that interact to deliver care. In this article, we have seen how care interventions can involve both individual and institutional responses, and implicate families, front-line 'caregivers', care home managers, technology suppliers, policymakers, lobbyists, legal specialists and others.

One of the most striking of these parallel developments is that both literatures have taken a 'corporeal turn'. This reflects their indebtedness to Foucault, who emphasises the individual body and the 'body politic' as co-constituted and grounded in both surveillance and care (Foucault, 1977). Within care theory, Kittay (2013: 205), for instance, describes the body as 'the place for care', while Hamington (2004: 3) argues that care 'shifts ethical considerations to context, relationships, and affective knowledge in a manner that can be fully understood *only* if care's embodied dimension is recognised'. Within surveillance theory, Ball (2005) emphasises the politics of surveillance seen through the prism of the body, problematising the claims of biometrics that the surveilled body is the source of a single truth. Our analysis builds on such arguments and suggests that bodies under surveillance are the site of negotiation and compromise rather than any unidimensional ethics. For example, as seen in vignette number one, some of Freda Jobson's corporeal rights and feelings have been foregrounded and privileged over others.

If the juxtaposition of surveillance and care helps to humanise the former, it serves to politicise the latter. Here our analysis connects with work on the politics of care (Frost et al, 2006; Hamington, 2015) and the multiple ways in which power is negotiated and renegotiated through interactions between caregivers, care recipients and others (Dominelli and Gollins, 1997). While the political aspects of care have traditionally focused on 'power-over' care recipients (Barnes, 2011), our analysis extends the scope of this to include 'power-over' care-providers, too - both individual and institutional. Just as we can no longer assume that surveillance always means the monitoring of the powerless by the powerful (Mathiesen, 1997), so we should not assume that care recipients are the only people over whom such power is wielded.

It is axiomatic to argue that power is not a homogenous concept linked only to role-based authority. In this article, we have seen power explicitly characterised in terms of 'hard' versus 'soft', and institutional versus evidential; and implicitly cast as something exercised by, on and between both individuals and institutions. Indeed Haugaard's (2012) taxonomy of power is strongly reminiscent of Heideggerian 'leapings', with 'power-over' capturing a kind of 'leaping-in', and 'power-to' and 'power-with' indicating a kind of 'leaping-ahead'. As Simpson et al (2013) suggest, each of these three power modes has distinct implications for the care relations it inspires, enables and prevents.

A significant theoretical point of our analysis is that these individual manifestations of power are exercised within an overarching framework of *construction*, that is, the primary exercise of power relates to the *framing* of the situation as critical, tame and wicked. Following Grint (2005), we suggest that the interpretation of any situation as tame, critical or wicked derives *both* from the concrete realities of that situation *and* from the way the problem is framed in order to legitimise a specific approach to its resolution. Thus, if a situation is framed as a crisis, the only available option for intervention appears to be command, i.e. immediate 'leaping-in'. This means the automatic dismissal of other options, such as engaging in processes of planning, co-ordination and resource management (as if the situation were tame), or engaging in reflection, conversation and coalition-building (as if the situation were wicked). Seeing these intervention decisions in terms of their framing as much as the inherent properties of the situation casts a crucial spotlight on the agency of care. It reinforces the argument that care is always a choice (Hamington, 2015; Simpson et al, 2013) and begins to unpack the nature and consequences of such choices.

From this perspective, therefore, the politics of care unfurl with the power, opportunity and responsibility to define both the problem and the solution to the question of whether intervention to tackle or prevent abuse is justified, helpful or ethical. Most situations could probably be defined in a range of different ways, invoking a range of different caring actions. In Freda Jobson's case, her daughter's decision to intervene was not her first instinct; it was in the framing of the situation as a crisis that the intervention became self-evident and self-justifying. Thus just as power is enmeshed in the continual renegotiation of caring relationships (Dominelli and Gollins, 1997), so it unfolds in the fluidity and contingency of interpretation of the need for care (Tomkins and Simpson, 2018). Power is also flexed in the tactics deployed to convince and mobilise people to act in some way; for instance, convincing a care home manager that abuse has occurred, or motivating the public to sign a petition. In short, the politics of care revolve around the capacity to construct a convincing account of a problem which motivates both oneself and others to act.

In reality, there are probably elements of crisis, tameness and wickedness in any relationship between people and institutions. While it is tempting to conclude that a tame problem gets more wicked simply through the addition of more stakeholders, even the most apparently straightforward of situations could probably be interpreted by drawing on ideas from all three framings of the problem. For instance, although we have presented Freda Jobson's case to illustrate the framing of a situation as a crisis, other interpretations are also possible. The family used the 'hard' facts on the video to invoke a law enforcement response, i.e. a 'hard' power. However, as the case developed, a 'softer' power also emerged through the release of this footage on social media. Such exposés are so headline grabbing that they constitute a public shaming of both the individual transgressors and the care facility itself. Public shaming exposes the transgressors to public disapproval and loss of reputation by holding them to a broadly shared standard of behaviour, thereby exposing the workings of normative power (Jacquet, 2015). Thus, the story of crisis management intervention could easily be re-told as the story of a much 'softer' power of shame.

In emphasising the politics of care, we do not wish to contradict our argument that the juxtaposition of care and surveillance is fundamentally a humanising endeavour. As Rittel and Webber (1973) argue, the complexities of wicked problems, in particular, lie in the anxieties created by the fear of not being able to address problems competently, and the resultant effects on personal and professional identities. Professionals have a reputational stake in dealing with the problems of their profession and representing themselves as competent in doing so. Families have a personal and societal stake in being the sort of people who would not let the abuse of their relative go undetected. Problem framing is therefore not only a question of convincing and mobilising others to take a particular form of action, it is also linked to the question of how to maintain one's own standing, whether as a competent care home manager or a concerned family member. Thus, in our three vignettes, social identities and relationships also contribute to the framing of the need for a particular kind of care. This is not a cool or dispassionate appraisal of facts, but a complex blend of self-image, self-justification and self-legitimacy. In short, care involves complex, sometimes contradictory, identity work (Abel and Nelson, 1990; Hamington, 2015).

Finally, it is worth noting that the humanising effects of the care discourse on the issue of surveillance has not shifted the basic association between surveillance, wrongdoing, criminality and conviction. The cameras in our examples are, after all, pointed first and foremost at the professional 'caregivers' rather than the care recipients, who could be said to be 'collateral damage'. These professional 'caregivers' are cast as real or potential suspects

who need an ever-watchful eye to ensure that they do not abuse those in their care; and that if they do, they are punished. As the debate about surveillance in care settings progresses, it will be interesting to see whether such practices can be further developed as positive acts of care, rather than just a corrective to the problem of 'un-care'. If care is to deliver on its promise to help us 'rethink the nature and purpose of politics and the political vocabulary of justice, freedom, [and] privacy' (Engster and Hamington, 2015: 1) then such a shift is surely necessary.

Concluding thoughts

In our viewer society (Mathiesen, 1997), in which observation and critique are increasingly enabled in every direction and every place, the ethics of human relations evolve as technologies become more sophisticated. Technology-facilitated possibilities for caring surveillance challenge us to ask what sort of society we want for ourselves and others, and probe the extent to which we are willing to trade privacy and dignity for care. As artificial intelligence threatens to overtake human intelligence in reach, speed and capacity, such questions and compromises become ever more complex. But while the specific care assemblages may flex for each era and each technological innovation, Heidegger's (1962) philosophy of care as ontology goes to the heart of the human condition. Care not only shapes our possibilities of engagement with the world; without care, there would be no world for us at all.

Notes

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Appendix One: Aspects of Caring Surveillance

Heideggerian care practices	Problem framings	Vignettes	Qualities of care
Leaping-in	Crisis	Installation of surveillance technology in a specific crisis	Urgency; decisiveness; safety overrides privacy / dignity; caregiver has responsibility / expertise to decide for care recipient
Leaping-in	Tame	Campaign for general, potentially mandatory use of surveillance technology	Consistency; invocation of 'best practice'; needs are common; caregiver groups have responsibility / expertise to decide for care recipient groups
Leaping-ahead	Wicked	Policy consultation and development of guidelines	Multiple perspectives; uncertainty about the nature of the issue, let alone the solution; no clear responsibility / expertise to resolve the issue; care needs might be unique

¹ A note on terminology: We use the term *caregiver* generically to describe anyone in a position to provide (or withhold) care to others. Where caregivers are family members rather than professionals, we indicate this in the text; we do not dwell on the fact that they might not use this moniker for themselves. We use '*caregivers'* (inverted commas) to emphasise a failure of care amongst so-called professionals. We use the term *care recipient* both generically for anyone who is in receipt of care, and specifically to refer to care home residents.

² Heidegger's concept of *Sorge* is ontological. It concerns the role of care in making any sort of human experience possible in the first place. In this analysis, we connect mostly with those (eg Benner, 2000; Tomkins and Simpson, 2018) who draw on care's *ontic* characteristics (*Fürsorge*), that is, how care is manifested in concrete human practices (see Paley, 1998).

³ We use the language of decision making not in an individualist or narrowly cognitive sense, but rather in the richer phenomenological sense that these deliberations reflect the lived experience and multiple modes of our engagement with the world, involving pre-reflective hunches and intuitions, as well as more reflective, thematic sense-making; and revealing this sense-making as contextual and relational (Gallagher and Zahavi, 2007). Just as we refer to 'surveillance assemblages' and 'care assemblages', we see 'decisions' unfold in and as assemblage.

⁴ The Care Quality Commission (CQC) is the independent regulator of health and social care in England. The CQC's main duties are to register care providers; monitor, inspect and evaluate care services; take action to safeguard people who use care services; and publish research and the results of consultation on major quality issues in health and social care.