

The body of the Other: to treat well or mistreat?

Tensions and mistreatment at the end of life^{1*}

Clarice E. Peixoto

Resumo

Tendo como pano de fundo as políticas públicas brasileiras criadas para diminuir os maus-tratos às pessoas envelhecidas, este artigo aponta para uma ausência de controle e de fiscalização dos órgãos públicos nas instituições asilares, o que estimula a criação contínua dos estabelecimentos privados e o seu funcionamento precário. Trata-se, aqui, de analisar as condições de institucionalização e as relações entre os residentes e a equipe médica e técnica de uma casa geriátrica privada. Ao apontar para o (não) atendimento às necessidades básicas e cotidianas das pessoas que vivem nessas instituições e, conseqüentemente, para os (des) cuidados no final da vida, o artigo busca desmistificar a percepção de que, por serem privadas, elas dão maior atenção aos seus velhos residentes.

Palavras-chave: maus-tratos na velhice, institucionalização & asilamento, violência contra velhos.

Abstract

Against the backdrop of the Brazilian public policies designed to reduce the mistreatment of aged people, this article points to a lack of control and supervision of public agencies in geriatric houses and asylums, which stimulates the continuous creation of private establishments and their malfunction. The objective, here, is to analyze the conditions of institutionalization and the relations between the residents and the medical-technical staff of a private geriatric house. Pointing to the (non) response to basic needs and

¹ *The author would like to thank Michel Alcoforado, student assistant. State University of Rio de Janeiro (UERJ-Prociência) supported this research. I am also grateful to the Carlos Chagas Filho Foundation for Research of Rio de Janeiro State (FAPERJ), and the Council for Scientific and Technological Development (CNPq).

daily life of people who live in these institutions and, consequently, to the (un) care at the end of life, the article aims to demystify the perception that, because they are private, they give greater attention to their old residents.

Keywords: mistreatment of the elderly, institutionalized care, violence against the elderly.

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Introduction

Following the example of European nations, Brazilian policy-makers have recently started paying attention to violence against the elderly. Taking as a background public policies implemented by the Brazilian government to reduce mistreatment of elderly people, this article analyses the living conditions and the relationships between residents and the medical-technical staff at a geriatric house³, located in Rio de Janeiro. The intention of this paper is to relativize the social construction that identifies public institutions to dramatic events of life asylums, and private institutions to the well-being of the end of life. Both are sent between cares and careless, between the good deal and a bad deal.

As in others European countries, since the 1980s, the French government, social planners and researchers have looked for solutions in response to what is termed the 'demographic shock', which in this case refers to the ballooning of the elderly population due to the aging of the 'baby boomer' generation, and the rapid growth of the population aged above 60 due to advancements in medical technology and increased quality of life. This has resulted in numerous imbalances in the economic and social structures of these countries.

In France⁴, public expenditure on social welfare for the elderly is not restricted to old age pensions and free medical care. It includes services to help them to stay living in their own homes because the costs are lower

² The author would like to thank Michel Alcoforado, student assistant. State University of Rio de Janeiro (UERJ-Prociência) supported this research. I am also grateful to the Carlos Chagas Filho Foundation for Research of Rio de Janeiro State (FAPERJ), and the Council for Scientific and Technological Development (CNPq).

³ Two terms are used in this article to name the institutions for the aged (ILPIs): a more general – geriatric house; and another more specific – asylum – still tied to the old system of institutionalization.

⁴ For many years I have developed comparative research between France and Brazil, they are countries with particular social policies for the family and for old age.

than the subsidies for their maintenance in a *maison de retraite* or a geriatric hospital. From the 1990s, the French Economic and Social Council encouraged greater involvement of people over the age of 65 in social activities, facilitated access to special training, implemented insurance plans to cover the risks of work accidents, and emphasized the treatment received in public institutions and, principally, guaranteeing financial support for activities proposed by individuals and associations to the elders. France's policy shift was in response to a study from the Council of Europe (1987) which revealed high rates of violence in the family directed towards elderly people. Then they realized that their country had not yet paid adequate attention to the 'abuses inflicted on the elderly', including disrespectful, aggressive and violent treatment (Hugonot 2000).

In 1992, the Council of Europe established seven categories of mistreatment, which acknowledges that violence against old people takes a multitude of forms involving 'any act or omission that harms another's life, physical or psychological integrity, or freedom, or seriously affects the development of the person's personality and/or impairs his or her financial security'.⁵

In Brazil, this concern materialized in 1994 with the *Política Nacional do Idoso* (National Policy for the Elderly)⁶, which established the national council for the elderly with the objective of assuring the social rights of people over the age of 60, and creating conditions to enhance their autonomy, integration and effective participation in society. This law sets out the principles, directives, organization, government actions and general provisions that should guide the policy in question. In 1999, this was strengthened by the creation of the *Plano Nacional de Saúde do Idoso* (National Health Plan for the Elderly, PNSI), which established directives and redefined programs, plans, projects and activities for the sector providing full-time care for the aging and the elderly.⁷ However it was only in 2001, following the creation of the Ministry of Health's national policy for reducing accidents and violence, that the categories of mistreatment were defined⁸. Seven categories were adopted to classify the various forms of violence inflicted on the elderly population. These are similar to those published by the Council of Europe in

5 See Council of Europe, 1992.

6 Law no. 8.842/1994.

7 Law no. 1.395/1999.

8 Law no. 737/2001, pp.51-3.

1992: the only difference is that the Brazilian policy explains the content of each in more details, as follows:

Physical abuse, physical mistreatment or physical violence: expressions referring to the use of physical force to compel elderly people to act against their will, to harm them, to cause them pain, incapacity or death.

Psychological abuse, psychological mistreatment or psychological violence: verbal or gestural aggression intended to terrify the elderly, humiliate them, restrict their freedom or isolate them from social interaction.

Sexual abuse, sexual violence: terms referring to the unwilling exposure of an elderly person to homosexual or heterosexual acts or play. These abuses aim to obtain sexual excitement, sexual intercourse or erotic practices through seduction, physical violence or threats.

Abandonment: a form of violence manifested by the absence or desertion of those responsible at government, institutional or family level for providing care to an elderly person in need of protection.

Neglect: refers to the omission or the refusal to provide due and necessary care to elderly people by members of the family or institution responsible for such care. Frequently occurs in association with other forms of abuse that inflict physical, emotional and social scars and traumas, especially on those who have multiple dependencies or disabilities.

Financial and economic abuse: involves the improper or illegal exploitation of the elderly, or the use of their financial resources and property without consent. This type of violence occurs primarily in the family context.

Self-neglect: conduct of the elderly person that threatens their own health or safety, when he or she refuses the necessary care of his or herself.

Over the years, the definition of mistreatment has been broadened to include 'everything contrary to good treatment'. In other words, the lack of attention and improper ways of speaking to and treating old people have become perceived as mistreatment. In France, instruments for greater control and inspection of care institutions were created to help prevent mistreatment, making supervision more systematic and less irregular⁹. Over the

9 Even so the president of Allô Maltraitance Personnes Âgées (ALMA), a Parisian NGO that works to combat mistreatment of the elderly, emphasizes the difficulty of obtaining information on the aggressions suffered in geriatric institutions. The reasons for this are manifold: "old people do not complain out of fear of reprisals, staff do not warn management out of corporatism, families out of fear of losing the place [of their elderly relative], and managers out of fear of the image of harming the establishment's image". (*Le Monde* 17/10/2008).

last thirty years or more, the French efforts to implant a geriatric policy help prolong the length of time citizens can live in their homes, and has created numerous social programs that Brazil is still far from attaining (Peixoto & Clavairolle 2005)¹⁰.

Brazil has 3,548 geriatric institutions, according to the survey of Applied Economic Research (IPEA)¹¹. The majority of them is philanthropic (65.2%), the private ones are approximately 28.2%, and the public are only 6.6%. An interesting factor is that 25.4% of these institutions were created in the last decade of the 20th century (Camarano 2010). This enquiry also shows that there has been a marked growth of private institutions, and it is unknown whether they comply with the legal requirements for operation. Thus, considering these data, we can deduce that Brazilian families are increasingly transferring the care of their older relatives to these institutions, a consequence of changes in family arrangements and the absence of public policies supporting the family and the elderly (Peixoto 2007, 2009).

Another study, conducted by the Order of Lawyers of Brazil (OAB) and by the Federal Council of Psychology (CFP), in twenty four Brazilian institutions (six public, eight private and eight charities or NGOs), shows that a large proportion of them work with insufficient number of professionals and skilled technicians, while inadequate facilities put the health of old people at risk. "Many of these situations transit between negligence and criminal practices". (CFP-OAB 2008).

The Brazilian institutions for elders involve a greater emotional distance with more impersonal care, and a fairly strict disciplinary regime that very often fails to meet the needs of the people in the institution. The situation is worsened by the failure of public authorities to control and inspect geriatric houses, whether public or private, which encourages their poor functioning. The state's lack of interest in the welfare of residents is reflected in the inadequate training for caring for the elderly, the poor physical conditions of

10 I will mention only some social services offered to remain old people in their homes: a) the home care service to help with the cleaning and clothing, follow on purchases and exits, and whose home attendants (*aides ménagères*) are trained for this role and have a Certificate of Fitness to Help Functions Household/CAFAD; b) the service of nursing care (*aide-soignante*), which offers technical care and hygiene at home; c) the family associations and/or NGOs, supported by the State, and created to help families with young children or aged persons, serving at home or in own local help; d) the delivery meals at home, which are prepared by industrial kitchens subsidized by the State, and responsible for distribution in schools, *maisons de retraite* and hospitals.

11 See Camarano, Ana Amélia. "Condições de funcionamento e de infraestrutura das Instituições de Longa Permanência para Idosos do Brasil, 2007-2009", 2010.

the establishments and the subsequent low quality of the services provided. These forms of mistreatment are also taken to be forms of violence against the life of the elderly person (Faleiros2007). This also contributes to a certain degree of consensus in Brazilian society over the institutions for the elderly. They are still perceived as the old asylums that housed those who had no family, or whose families could not care for them. Thus, there are many prejudices and stereotypes surrounding these institutions, in particular the public ones that house those who cannot afford to live in private institutions, where, it is believed, they would have better accommodation and receive better care.

The research I conducted in the geriatric house in Rio de Janeiro (public and private)¹² showed that the concerns and priorities with the treatment of old people can be very different. The largest public institution of Rio de Janeiro has based its management on a proposal to ‘humanize’ the relations between the people there, as well as improving the physical space (repairs, repainting, gardening improvements, etc.) and renewing the healthcare team (hiring doctors, geriatrician, physiotherapists, nutritionists, psychologists, speech therapists, dentists, nurses, cares and social workers). The aim is to turn this institution into a model establishment for Rio de Janeiro, a place where residents will be afforded treatment that respects their citizenship and human rights. Although this is the broader objective, the institution is faced with the ‘bad habits’ in treatment derived from the old asylum system, and with the precarious state of public funding¹³.

In the private institution where research was conducted, the prevalence of commercial and financial interests is revealed by the small group of employees, by the lack of health staff, unsatisfactory living spaces, poor food and the disrespectful treatment accorded to residents.

12 The data in this article comes from a wide-ranging anthropological study of family and institutional violence, conducted in the period 2004-2011. The research analyzes both qualitative and quantitative data on mistreatment of old people in Rio de Janeiro. Statistics were obtained from the Institute of Public Security/ISP, referring to complaints registered at police stations (2002-2006; 2011), the Senior Citizen’s Office/Delegacia do Idoso (2004-2006), the Senior Helpline (Ligue-Idoso) and the Ombudsman of the Social Welfare and Human Rights Office/SEASDH(2007-2008). The qualitative study, involving participant observation over an eight-month period, has conducted in two institutions for elderly, one public and the other private. The ethnography was also supplemented with semi-structured interviews in three others institutions: a public, a private and one philanthropic. A study in a French public geriatric hospital in the Parisian region, undertaken during an eight-month period in 2006, served as a point of comparison. This article looks at just one of the private geriatric house, which data derives from a long period of observation and interviews with the residents.

13 See Peixoto (2011) on the analysis of public institutions.

Home, Sweet Home...

It is not surprising that many geriatric houses and asylums adopt the word 'Lar' (home) in the institution's name. The term suggests a new institutionalized life not so different from their original home. Other terms are used that also transmit this notion of family coziness: *casa* (house); *recanto* (nook); *solar* (manor house); *vivenda* (villa); *abrigo* (shelter). In other words, a reference to family conviviality, the same habits and everyday surroundings of the previous life. Other institutions adopt terms like hotel, hostel, guesthouse, resort, grove (*hotel*, *pensionato*, *pousada*, *estância*, *bosque*) and so on, all transmitting the idea of leisure, pleasure and temporary stay as during travel, interrupting the daily pace of life and allowing residents to forget the problems of domestic life. This image also implies that services are provided to a temporary guest and allude to the possibility of returning to one's previous life.

The Brazilian private institution for the elderly analyzed here adopts 'home' in its administrative name to reinforce the idea of a family environment, but also uses the word 'hotel' to suggest temporary and comfortable accommodation free of everyday concerns/tasks.

The *Hotel-Lar*¹⁴ is a private geriatric institution which was founded in 1980, and acquired by its current owner ten years ago. It can accommodate up to 45 residents. At the time of the research, 43 people over the age of 60 were living there, 32 women and 11 men. According to the director and owner Dr. Maria, 22 of the residents present some kind of psychological problem, and Alzheimer's disease, the others are independents and autonomous. The average age of the residents is approximately 76 and there is an enormous disparity between the average female and male ages: the women average 82 years and the men 65, a greater disparity than among the population as a whole, where the life expectancy of women is 78.3 years and of men 71 years.

The rite of entry into the institution requires candidates to undergo various exams to assess their degree of autonomy and independence (ADL and IADL). They also determine the cost of residence. The most infirm pay more with monthly rates varying between U\$ 567,53 and U\$ 851,30 (2009 values). These exams are carried out by the director herself who classifies a resident according to their degree of independence and autonomy.¹⁵ So, for

14 All the names in this paper are fictitious, including the elderly institution analyzed. It should be noted that first names are used regularly in Brazil without any connotation of lack of respect.

15 The scales ADL (activities of daily living) and IADL (instrumental activities of daily living) are created by

Dr. Maria,

Being independent means not requiring help to take a bath, defecate and urinate, as well as getting in and out of bed unaided. The independent elderly person can use money, make phone calls, catch a bus, and so on... However, many of these who are more independent are not autonomous.

Dr. Maria certifies the mental conditions of the candidate to discover the *patient's degree of dementia*: this involves exercises of localization (where he or she is) and dates (day of the interview, his or her birthday, etc.), repetition of phrases, and memorization of words, subtraction, reading and writing exercises. This information is contained, along with personal data on age, civil status, income, family relations, etc., on a form filed in the consultation room.

The director also claims other reasons for the institutionalization of those old people: “José did not know how to deal with money, he spends too much”; “Antonio, he is an alcoholic”; “Madalena was lost in the street, she could not find her way back home”. But Antonio himself said that he had a house and a car, but one day his son took him to visit a place that was ‘wonderful’. He found a strange place with many old people, and while someone showed him the house, his son fled. Madalena said that she sold her apartment to renovate her son’s home, so she could live with him. They did not adapt and he took her to the geriatric institution. Already Hercília, aged 87, says she was interned by her daughter who thought she was too old to live alone, even being independent and autonomous¹⁶. The case of Aparecida is a good example. She said:

I lived in a very nice and spacious apartment. It was mine, and I gave it to my niece when my husband died, because I have no inheritors, and this niece was the most needy. She moved in with me and brought her children. But it did not work because I was too prissy, I wanted all the things in place. So I divided the place up with her; each one with her things, each one cooking their own food.

geriatric medicine. They are used to assess the degree of independence of individuals. Completing the tables is very simple, just a yes or no answer is required. Positive answers receive one point and the total points obtained define the individual’s degree of independence/autonomy.

16 Only three residents stated that opted for geriatric institution. They are all men and independents, they don’t receive visits because they haven’t relatives. Only 12 people are frequently visited by children or family members, among them only one man.

One day, in a discussion, she told me to go out, out of her home because I had given it to her, and now it was hers!

The transition from a world of individual freedom to one of institutionalization is linked to aging, the appearance of diseases of varying degrees of seriousness, and family and social conditions. Adaptation to the new way of life is related to the capacity to accept aging and its vulnerabilities, but also and especially to preserving family ties. For those who are accustomed to family reciprocity and solidarity, the absence of the family at this stage of life may be perceived as abandonment, and tends to be felt much more severely than by those who always lived alone. For the latter, institutionalization tends only to be felt when they lose contact with the outside world. Studies on forced institutionalization have shown that old people suffer in silence, and perceive this act as a rejection and a violence that is reflected in the increase of infections, falls, depression, and more severely, mortality (Mallon 2004; Van Rompaey 2003; Plamondon 2000).

The institutionalization, thus, is the result of multiple factors, of which a significant part of which have little to do with the motivations of each one. While some enter into an institution to maintain their independence and autonomy that could be threatened by their children, others were interned by their families, often against their wishes.

Living Conditions at the Hotel-Lar

Located on a busy avenue of a wealthy district of the city, the *Hotel-Lar* looks like a pleasant place from the outside. It is formed by two residential houses –which I shall designate as wings I and II. There is just a single, narrow entrance, which leads directly to the reception and the director's consultation room: this is spacious with a washbasin and soberly decorated in green and white, with a well-kept winter garden at the rear. The location of the consultation room on the ground floor of wing I is strategic: the residents cannot see it. This facilitates the interviews with the relatives (and the payments) without necessarily having to enter into direct contact with the residents. For example, children and grandchildren come and go without being seen by their resident parent or grandparent.

One of the wings with individual rooms is reserved for wealthier residents. At the time of the research, only seven people lived in these rooms, which are very small (1.8m x2m) and simply furnished. Some have a small

refrigerator. The rooms are separated by thin wooden dividing walls that do not block noises from passing between them. There is no electric bell, night light or alarm in the rooms, meaning that the residents have to shout to the nurses when they require assistance with using the bathroom, taking their medicines and so on. Sometimes, when the residents insist, they receive rude replies or yells of 'shut up'! The beds have no protective barriers, which leads to frequent falls during sleep. João, for example, sleeps the whole time tied to his bed so that he does not fall out.

The less wealthy residents occupy rooms for three or four people, which are poorly lit and are fitted with old furniture. These collective rooms are a little wider to accommodate more beds. The distribution of the residents by room does not follow any medical criteria to accommodate them according to health conditions and/or according to ADL and IADL scales, with no separation between the most independent or autonomous and the most dependent and infirm. Hence, residents with serious infirmities share a room with others with less severe or no physical or mental deficiency. As a result, some people with Alzheimer's disease moan and shout in the day and night and disturb their room companions. In other words, the preliminary entrance examinations conducted by the doctor-owner have no medical criteria to ensure a better quality of life for the residents.

The corridors are very narrow, hindering access to trolleys and wheelchairs. A narrow ramp with a sweeping curve and no rooftop covering links the two wings; crossing this area becomes treacherous on rainy days. At the end of the corridor leading to these rooms in wing I is the bathroom used by the residents of this wing and, on its right, the staff bathroom. In fact, the *Hotel-Lar* has just two bathrooms for the 43 residents, one in each wing. The third bathroom is exclusively for staff use. The bathrooms are not gender specific, they are unsanitary and smell badly. Each bathroom contains one toilet. The bathroom in wing I is small and windowless. Decorated with brown tiles, it is dark and stuffy, and lacks any kind of safety adaptation for elderly people. Furthermore, the narrow door prevents access by wheelchairs. The solitary toilet is positioned between a high, old sink and an enormous waste bin (mixing every day waste and medical waste), brooms and floor cloths.

Wing II has two floors with seven collective and three individual rooms on the ground floor and one double and four individual rooms on the second floor. Wing II is even more rundown than Wing I. The access stairway is very

narrow and poorly maintained with a small, badly lit hall decorated with old furniture: a cupboard with a door falling off its hinges and one chair with a broken back. The bathroom has no lock on the door, which causes embarrassment for the women, and again is inadequately cleaned. Lourdes (63 years old) declares that she has to purchase toilet paper because the director says she 'shits a lot', and the *Hotel-Lar* cannot afford the extra expense. She suffers frequently from diarrhoea for which she receives no medication.

The canteen is equipped with enormous tables and flimsy plastic chairs. Four meals are served every day. The residents complain intensely about the food and the repetitive menu and Antônio complains that it is 'always badly cooked rice, pasta, minced meat and a cabbage salad'. Dessert is rarely served and no fruit, yoghurt nor biscuits are offered as snacks between meals. In addition, there are no alternative menu options: if the person dislikes a particular food, their only choice is to eat nothing. Ilda, for example, dislikes pea soup. Therefore, on the day the soup is served she goes hungry. Antônio says,

Life here is rubbish! We pay a fortune and get nothing in return. Breakfast, as you can see, is the same thing every day: milky coffee, bread and butter.

There is no specific room exists for recreational activities, which, when they occur, have to take place on the veranda or in the canteen. The veranda is large with a garden, caged birds and railings onto the street. This is where the residents prefer to spend most of their time.

Relations between Residents and Staff... (Lack of) Staff Care

The ratio of staff to residents is small if we take into account all the activities needed to run a geriatric house with approximately 43 residents: there are a total of twenty-one employees (just five men) divided into two shifts. Only ten employees per shift are available for the 43 elderly people. Of this total, three are cooks and the rest are nursing assistants whose duties range from providing baths and food, giving injections and medicines, and cleaning the establishment.

All the employees thus perform a multitude of activities, many of which go beyond their specific duties. For instance, the men act as nursing assistants and are responsible for transporting dependent residents (in their arms or on wheelchairs), and are also responsible for maintaining the building

(painting, small repair jobs), washing the rooms and cleaning the yard. Similarly, the female nursing assistants are responsible for washing clothes and cleaning the bathrooms. These employees thus have no time to give more attention to the residents. One resident, Alice falls frequently: she fell twice in one week, yet the staff considered this 'normal.' In her last fall, she broke her arms, felt pain, cried and complained, but nobody took her seriously. She was only given medicine two days later when, unable to stand the pain any longer, the director examined her and discovered the fracture.

The *Hotel-Lar* has just one doctor, the psychiatrist-owner, no paramedic and only one nurse who works during the morning shift. The director's son is a physiotherapist and organizes a weekly activity for the residents. The lack of a medical team is the residents' biggest concern and source of anguish. As Antônio said:

If you want a doctor, you have to pay. I myself had stomach ache the other day: I asked for medicine but nobody gave me anything. I told them to buy the medicine and put it on my monthly bill, but they said they could not. We pay a lot of money here but if you want a physiotherapist, a doctor, you have to pay extra. I could be living at home with money, spending it, but no, I have to pay a little over R\$ 900, ooevery month here. There are people here who have nothing and pretend that they have. Her there (Miriam) has nothing and her son makes a deal with the director pretending that she needs to stay here. I've already told her to run away.

The lack of attention and adequate treatment for each person's infirmities are the biggest source of complaint. Dora, for example, says that the staff 'are impatient and rude'. The residents are often labeled by the staff as 'grumblers' and 'complainers' and frequently called 'pig', 'filthy', and 'crazy'. The residents feel neglected and state that the nursing assistants or the institution's administration do not take their aches and pains seriously. Antônio asked us one day, 'Can you hear those cries?[of two old women with Alzheimer's].They cry like that all day and nobody does anything. It's always the same thing'.

Various residents complain of intestinal problems (constipation or diarrhea) but are not given medication. In other example, Liliana, whose room is on the second floor of wing II, further away and without easy access to the administration, told how she had fallen in her room and waited six hours to

be treated: 'The staff here are really bad; they leave us suffering from pain'. The same applies to Flora, who moans with pain all day. Her room companion says:

I don't know what's wrong with her. She was taken to the hospital, and when she arrived back she spent more than half an hour in the wheelchair with her head thrown back, there in the corridor. Stuck there, waiting.

Amélia, who has difficulty speaking, is another resident who cries for help all day without receiving attention.

But José's experiences is one of the most serious cases of neglect, verging on total social abandonment. He eats the plants from the garden, the rubbish from the bathroom, and licks the toilet. José dislikes bathing and therefore does not wash every day. Nor is he convinced of the need to do so to avoid infections. We observed that this prompts discrimination and stigmatization not only by the other residents, but also especially by the staff who call him 'disgusting' and 'pig'.

The Institutionalization of Old Age and Living Conditions

Many studies have been made of care institutions, beginning with the classic works of Foucault (1975) and Goffman (1961). These scholars stimulated countless studies of the institutionalization of old age all over the world. In Brazil, while the institutionalization of children, mental patients and criminals has received considerable attention from our social sciences researchers, Institutionalized old age is yet to be widely investigated. The works of Groisman (1999, 1999a, 2002) are probably the most widely referenced in studies of institutional aging.

I do not intend to summarize the history of geriatric houses in Brazil, Groisman and others have already done this, nor analyze Long-Stay Institutions for the Elderly (ILPIs) in the Brazilian context. I highlight the living and care conditions in the *Hotel-Lar* and compare them with the categories used to classify mistreatment of old people proposed by Health Surveillance Agency (Agência Nacional de Vigilância Sanitária/ANVISA) for running this kind of establishment. They reveal that the institutionalization of elderly people remains invisible to the wider public.

Since 1999, the National Plan for the Health of the Aged (PNSI) has set out rules for the operation of geriatric institutions and similar

establishments, as well as geriatric hospital services, delegating responsibility for assessing their compliance with regulations to the states and municipalities. However, the regulations are only effective when accompanied by public policies for the health of the aged and careful monitoring of public and private establishments.

Based on PNSI, ANVISA established specifications for the operation of long-stay institutions, specifically with regards to space. I present a comparison with the conditions observed in the *Hotel-Lar*. The regulations state that:

There must be at least two external entrances, one to be used exclusively by services. [the *Hotel-Lar* has just one entrance used by people, deliveries and waste].

Stairs and ramps must be at least 1.2m wide to allow trolleys and wheelchairs to pass. [in the *Hotel-Lar* the access stairway to the first floor of wing II is very narrow and the steps smooth and slippery, while the ramp is less than 1.2m wide making the use of trolleys and wheelchairs difficult].

Dormitories must hold four people at most and have a minimum area of 5.50m² per bed, should not be mixed and must be equipped with a bathroom, night light and alarm bell.

[in the *Hotel-Lar* the rooms are separated by gender but lack private bathrooms and the residents are forced to use the shared bathroom. None of the dormitories has a night-light or alarm bell].

Individual sleeping quarters must have a minimum area of 7.50m², including space for a wardrobe and the resident's belongings.

[in the *Hotel-Lar* the individual rooms are approximately 4m² in size].

Shared bathrooms must be separated by gender and have toilet closets wide enough to allow front and side access by a wheelchair user.

[the *Hotel-Lar* has just two bathrooms for residents, without separation by gender and lacking any support or safety equipment (bars and alarm). The bathrooms contain cleaning materials and a large waste bin for every kind of rubbish (quotidian and medical)].

Should have rooms for collective activities with a minimum area of one square meter per person.

- [the *Hotel-Lar* does not have an activities room, so the residents have to use the veranda or the canteen].
- Should have its own transport service for residents.

- [the home lacks its own transport; in emergencies residents are transported in the institution director's car. At night, this means waiting for the director to drive from her home to the *Hotel-Lar*].
- Laundry: personal clothing and institutional laundry (bed linen, towels, etc.) should be washed separately in washing machines, and specially dried.
- [the *Hotel-Lar* laundry is not separated in any way, and there are no washing machines or tumble driers. Everything is washed in cement basins and dried on clothes lines].

An individual's basic needs can be defined as the set of bio-psychosocial requirements that allow him or her to live healthily and maintain his or her identity (tastes, culture, behaviors...) in a communal space provided with security and healthcare or well-being (Malo 2000). Life in an institution is a microcosm apart, which modifies social rules and distorts the relations between people, restricting the freedom of residents and their capacity to choose and attain their wishes. Institutional rules thus appear to have the force of law (Mallon 2004).

The human and physical facilities provided by a care institution cannot ignore the risks of mistreatment. Rundown facilities and poor quality care are institutional forms of violence. If the institutions are to avoid banalizing everyday violence they must value the human dimension, offering comfort and respecting the individual's pace of life or, at the very least, introducing less rigid schedules of daily activities. It is not the case of *Hotel-Lar* where the few staff members have to perform many different tasks, and respect individual rhythms is almost impossible.

The description of the physical and psychological living conditions in the *Hotel-Lar* already indicates the highly vulnerable – and unlawful – state in which the 43 residents live. The total absence of control and inspection by public authorities allows this private establishment to operate. The state's inertia led to the scandal of Santa Genoveva Clinic, a case analyzed by Groisman (1999), where the death of 99 elders shocked Brazilian society by revealing abuse, lack of hygiene and illicit enrichment. This attests to the need for systematic supervision to curb the forms of violence that can take root within geriatric institutions: it is imperative to break the silence as it results in mistreatment.

To finish

In recent decades, laws have called for respect of the ethical principles related to vulnerable elderly people, both in terms of recognizing their rights and of regulating their domestic and institutional protection. To implement these policies, social programs were created to disseminate the idea of good treatment as an individual and collective responsibility. For instance, France created a new regulation for institutionalized people: the *bienveillance* (well-treated) instead of *maltraitance* (abuse). The National Committee for Preventing the Mistreatment of Elderly, created in 2002, has the objective of making the population aware: ‘the fight against the mistreatment of elderly people is a responsibility of everyone, given that in everyday life anyone may come across situations and/or risks of mistreatment in the family or professional setting’¹⁷. To turn *maltraitance* into *bienveillance*, the same Committee issued a guide¹⁸ designed to develop *bienveillance* and to reinforce the policy of preventing mistreatment in medical-hospital and geriatric institutions. The plan’s aim is to question the taboo surrounding mistreatment, informing the public and training professionals, denouncing those responsible for the abuses and protecting the victims. Hence ‘to combat mistreatment it is necessary above all to change the way in which elderly people are seen, recognizing their role in society and considering them as individuals with rights and responsibilities, but also needs and expectations: being recognized, heard and understood’. That same year, a new national plan was created for ‘Aging Well’ and ‘Treating well and combating mistreatment’. (Bilé& Martz 2010).

The Brazilian legislation recommends that the family has the principal responsibility for the care of their elders. Only in the absence or failure of the relatives, the State is responsible¹⁹. The notion of the *bienveillance* was regulated with the creation of the Statute of the Elderly (Estatuto do Idoso, 2003) considered to provide better protection for people over the age of 60, regulating their rights and responsibilities and, principally, assigning the responsibilities of the state and the family in the care of old people. The

17 Gouvernement of France, ‘Prévenir et lutter contre la maltraitance des personnes âgées’, Comité National de Vigilance contre la Maltraitance des Personnes Agées, Ministère de la Santé et de la Protection Sociale, 2002.

18 Gestion des risques de maltraitance en établissement. France, Ministère de la Santé et de la Protection Sociale, 2007.

19 Constitution of 1998, art. 230. The responsibility for the elderly are from “the family, the society and the state have a duty to assist the elderly, ensuring their participation in the community, defending their dignity and well-being, guaranteeing them the right to life”.

new statute established the framework for creating a “senior helpline” and “senior citizen’s” offices in almost all Brazil’s states, as well as numerous social programs targeted at this age group. Two years later, in 2005, a plan for combating violence against elderly people was created, and the outcome of a joint endeavor by the National Council for the Rights of the Elderly/CNDI (Conselho Nacional dos Direitos do Idoso), of the Federal government, and social movements. Its objective is to establish systematic action strategies based on the planning, organization, coordination, control, monitoring and evaluation of all the stages of execution of the actions for preventing and confronting violence against the elderly.

The State, however, lacks adequate inspection and supervision to curb the growth in family and institutional violence against the elderly, as revealed by statistics compiled by Brazilian institutes and researchers (Minayo 2003; Faleiros 2007; Camarano 2010; Peixoto 2011). These sociological and anthropological studies have also pointed to an increase in accusations of domestic violence against the elderly, and all show that the aggressor is always a family member. However, if for acts of domestic violence against the aged, there are specific channels for complaints and monitoring (see above), in the case of institutional violence, there is only the Health Surveillance Agency (ANVISA). But, as this agency is also responsible for the regulation, control and monitoring the relations of production and consumption of all goods and services related to health (food, drugs, cosmetics, labs, clinics and hospitals, ports, airports, and other more), it can hardly be expected to be diligent in monitoring geriatric institutions as well.

The analysis of living conditions in a private geriatric institution, which has never been surveyed by any Committees nor ANVISA, reveals that the welfare of the elderly is in theory guaranteed by Brazilian law, it still has a long way to break the wall of silence and indifference to the mistreatment of elderly people. In other words, it is necessary to create specific instances for the control and supervision of the basic needs and daily life of people who live in these institutions and, consequently, to the care at the end of life.

My research, of a qualitative nature, involved studying five geriatric houses; two of them publics and two privates, one philanthropic. The objective was to compare the living conditions of the older institutionalized. Although this article presents an analysis of only one private institution, the studies of Groisman on geriatric institutions (e.g. Santa Genoveva), and what

we observed in the others private institutions, questions the idea that private geriatric institutions give more and better attention to their residents than public. This is, perhaps, largely due to the neglect of government agencies that are supposed to control and supervise these institutions. Without such control the situation there is little chance that change will occur.

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