

Rationalized aging

Creative destruction and the subdivision of US eldercare

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Abstract

There are approximately 4.4 million direct-care workers in the United States. Comprising the labor of nurses, home health aides, certified nursing assistants, personal attendants, and companions to the elderly, direct-care work constitutes one of the fastest-growing labor niches in the United States. Within the commodified caregiving sector, cost-cutting imperatives to subdivide care labor introduce insalubrious complications for patients by cleaving – or attempting to do so – their physical needs from their emotional and relational needs, a process that I label ‘rationalized aging’. In this essay, I reflect on my experiences as a paid elder companion in New York City to argue that this process of subdivision combines earlier nineteenth-century rationalization strategies with neoliberal regimes of flexible accumulation and to highlight the consequences of subdivision in this sector both for care workers and for the patients in their care.

Keywords

aging, care, work, rationalization, capitalism

Nancy¹ is an eighty-four-year-old woman with dementia. She resides in an assisted living facility, which I call Sunny Care, on Manhattan's Upper East Side. As Nancy's paid companion, I visit her on Sunny Care's eighth floor every afternoon and escort her to a nearby diner. This afternoon, I watch Nancy sip her decaffeinated latte, occasionally encouraging her to eat the tuna salad sandwich that I divided into smaller, more manageable, crust-less squares for her. Today, she responds to the prodding enthusiastically, unlike some of the other afternoons when I watch helplessly as she grows impatient and irritated at my suggestion that she eat. Relieved that she has eaten one sufficient meal for the day, I ask about her years living abroad, as both her daughter and caseworker have instructed me to do, and as I do every afternoon we spend together. I nudge the remaining bites of her sandwich toward her before inquiring about her toilet needs. 'We should get up now and walk to the bathroom, right there', I suggest, pointing toward the nearly empty diner's entrance, which also houses the restrooms. Newly attuned to Nancy's incontinence, I hope to pre-empt both Nancy's discomfort and my coworkers' frustrations with me.

Just earlier that day, Gene, the sole certified nursing assistant (CNA) on Nancy's floor, had chastised me. 'You bring her back wet', she chided, as I gathered Nancy's belongings. I panicked, realizing that Nancy, like all of her fellow patients on the eighth floor, wore adult diapers. When I accepted the role as her elder companion, however, neither her adult daughter nor my employment agency contact mentioned her incontinence. Having hired me to act as Nancy's companion, her daughter and my agency contact simply did not expect me to address her bodily needs. In the two weeks I had been accompanying Nancy, they had never mentioned it in discussing my duties and their concerns. They assumed that was another person's job. But, as Gene's remonstrations made clear, elderly patients are harmed when their physical needs are separated from their relational needs, as it jeopardizes their comfort and care.

In the United States, trained CNAs care for the physical needs of elderly and infirm adults in long-term living facilities. In Nancy's facility, one CNA cares for dozens of patients, providing intricate bathing, feeding, toileting, and ambulatory assistance. This intensive workload means that CNAs rarely have the opportunity to rest during their twelve-hour shifts. It also means that patients often receive perfunctory care. Thus, patients and families who can afford to supplement institutional care do so by privately hiring companions to the elderly; this is a relatively new caring position that, unlike CNAs or home health aides, requires no formal training or credentialing. Elder companions provide company and stimulation that CNAs are unable to offer, given their demanding workloads. As I argue,

1 I have changed all names and identifying information in this essay.

Nancy's family and caseworker's omissions regarding her toileting needs – and, in fact, my presence in Nancy's life as her companion – reveal a process of subdivision in the caring fields that combines earlier nineteenth-century scientific labor management strategies with neoliberal regimes of 'flexible accumulation' (Harvey 1990).

In this essay, I reflect on my experiences as a paid elder companion in New York City to trace the changing contours of low-waged care work in the United States and to highlight the consequences of subdivision in this sector, both for care workers and the patients in their care who, I argue, are subject to a novel process of rationalized aging. In my experiences as a companion to the elderly, I found that cost-cutting imperatives to subdivide care labor introduced insalubrious complications for patients by cleaving – or attempting to do so – their physical needs from their emotional and relational needs (Diamond 1992; Foner 1995). This subdivision of caring labor, I argue, threatens to redefine the aging process itself.

Methods

This essay draws on my experiences working as a companion to the elderly throughout graduate school between 2009 and 2012. Like many women in the United States and elsewhere, by the time I entered graduate school, I had acquired decades of experience caring for aging and ill family members and working as a babysitter for neighbors (Grigoryeva 2017). As several of my female family members work as CNAs and as elder companions in New York, I was quite familiar with this type of work even prior to beginning my graduate studies. My research on New York City care workers' legislative activism for improved working conditions and expanded patient protections provided the analytic lens with which I began to interpret my own paid care work background. The specific narrative I recount here only came into analytical focus after I conducted several months of fieldwork among care work activists. Since this paid experience was outside of my formal research activities, I ground my narrative description in personal memories and perceptions. Working in eldercare and childcare not only allowed me to supplement my research stipends with necessary income but also facilitated a firsthand, embodied understanding of care work that, in turn, shaped the research questions I asked.

Yet, as a white woman researcher, I was also aware of how my care work experiences differed from the majority of women working in the contemporary US caregiving field. Women of color account for more than half of US CNAs, home health-care workers, and personal attendants, which are also the health-care sector's least regulated and most poorly paid positions (Campbell 2017; Fox 2017). My presence in Nancy's facility thus drew curious glances from other caregivers as well as from strangers, who often assumed I was a relative caring for elderly kin. While using personal narrative in this manner prevents me from fully

addressing the function of ‘racial capital’ in structuring this racially segmented, low-waged labor niche or attending to women caregivers of color’s lived experiences of discrimination on the job (Robinson 1983), I nevertheless offer a firsthand perspective on the effects of capitalist restructuring on elderly patients as well as those who care for them.

Rationalization in the caring fields

The emergence and organization of care work in the United States, as well as in countries across the globe, is a crucial concern that joins health care, migration, and labor policy, with significant consequences for elderly Americans and low-waged workers, mostly women, alike. By 2050, the number of Americans over the age of sixty-five will nearly double, increasing the demand for skilled care work (Campbell 2017). Care work positions, including nurses, home health aides, CNAs, personal attendants, and companions to the elderly, account for a projected one-third of total employment growth between 2012 and 2022 (Glenn 2011; Paquette 2017). All of these care positions share a recent genesis in the field of nursing.

The formation of professional nursing care thus provides context for the current proliferation of care work positions in the United States. Professional nursing in the United States emerged slowly, moving from a period of informal, at-home, practical nursing to a hospital-based model by mid-century, when nursing schools consolidated education requirements and institutional care became customary (Melosh 1982). Throughout the latter part of the twentieth century, nursing ‘integrated technical, relational, and even “menial” tasks into a single intertwined labor process’ (Duffy 2011, 87). The reliable daily care that nurses provided to their individual patients augmented medical procedures, built rapport, and provided comfort. Nonmedical tasks were thus perceived as integral to proper nursing care throughout the latter part of the last century.

During the past three decades, across the United States, and consistent with neoliberal regimes of flexible accumulation that are responsive to profit imperatives, hospital cost-containment measures have all but eliminated the relational elements of nursing care in acute care facilities. Minimum-staffing standards and euphemistically labeled ‘family-based care’ initiatives aim to reduce labor costs and limit overhead by excluding relational work from care workers’ pay, making it difficult if not impossible for them to continue providing this necessary care to their patients (Heinemann 2015; Lopez 2014; Pine 2011). For nurses, policies designed to promote ‘rationalization’ and ‘efficiency’ in hospital management and

care provision entail irregular shifts, understaffing, reduced patient acuity,² limited patient contact, and curtailed authority (Pine 2011). As a nurse recently explained to me during an annual professional meeting, ‘providing bed baths let me assess my patients through direct skin-to-skin contact. No more’. Rather, as sociologist Mignon Duffy (2011, 88) observes, ‘tasks like drawing blood and making beds, once considered useful for getting close to the patients and knowing their needs, are now assigned to Certified Nursing Assistants and orderlies’. Reassigning tasks once carried out by registered nurses to lower-paid employees, like CNAs, is a cost-cutting measure. In the United States, CNAs typically earn about US\$10 per hour or US\$20,000 annually, while registered nurses earn an average of US\$32 per hour or US\$75,000 per year (Campbell 2017).

Subdividing holistic nursing practices and redistributing job tasks saves hospitals and other health-care facilities money; discrete tasks can be assigned to different workers, and the simpler ones can be purchased at a lower cost from underpaid staff like CNAs. Labor process theorist Harry Braverman (1974, 82) describes subdivision as the ‘most common mode of cheapening labor power ... break[ing] it up into its simplest elements’. Sundering holistic work into discrete tasks is a hallmark of Frederick Winslow Taylor’s nineteenth-century scientific management tactics, referred to as ‘rationalization’ or simply ‘Taylorism’ (Braverman 1974, 59). Often accompanied by mechanization in the manufacturing industry, rationalization entails the parsing (and subsequent enforced standardization) of job elements into the smallest possible units, resulting in the iconic image of an alienated factory worker whose only responsibility is to turn a lever or push a button. Rationalization thus maximizes efficiency through control of workers’ labor processes (Braverman 1974).

Over a century after their inception, Taylor’s subdivision and standardization approaches have found fertile ground in care work. Acute care hospitals began implementing rationalization as a cost-cutting mechanism in the early 1990s (Duffy 2013; Estes 2014; Pine 2011). Since that time, ‘hospitals have participated in every major industrial management trend of the past century including Taylorism’ (Pine 2011, 264). As medical anthropologist Adrienne Pines (2011, 264) notes, ‘all of these models have used the rhetoric of science to justify evolving forms of decentralized worker control’. At the same time, technological innovation has fostered an increased routinization and detailed tracking of specific caregiving activities, adhering to broader trends toward auditing and rationalization in the global and public health sectors (Adams 2016; Diamond 1992; Estes 2001; Strathern 2003). In the

2 ‘Patient acuity’ refers to the level of nursing care required by the patient’s condition. Acute care hospitals justify nurse understaffing by lowering patients’ acuity levels and providing less intensive nursing care (Pine 2011, 267).

current iteration, hospital and health-care management trends have collided with the increasing need to care for America's growing elderly population, leading to a proliferation of underpaid, strenuous caring-sector positions and the fragmentation of holistic nursing practice.

Creative destruction and proliferating care work roles

Processes of capitalist accumulation not only eliminate skills from the repertoire of individual workers; they also engender new occupations. This process of creative destruction – or the ‘enforced destruction of a mass of productive forces’ in Karl Marx and Friedrich Engels’s (Marx and Engels 1888, 42) terms – is generative (see also Schumpeter 1942). In hospital care, these processes have resulted in specialized positions, like X-ray technician and phlebotomist. In large hospitals and health-care systems, lower-paid and less credentialed X-ray technicians typically execute X-ray imaging previously performed by cardiologists, radiologists, and oncologists. Before the highly circumscribed, relatively low-waged phlebotomist position emerged in the early 1990s, nurses and laboratory scientists drew blood in integrated clinical procedures (Lalongo and Bernardini 2016). Similarly, my paid labor as an elder companion illustrates capital’s creative destruction in its subdivision of the nursing labor process and the creation of low-paid positions requiring less education and training.

Responding to the facility’s minimum-staffing policy, Nancy’s family compassionately chose to supplement her care and companionship by paying privately for my labor. Nancy’s facility was one of the nicest in which I had worked, conducted research, or visited. Unlike other nursing homes, which appear institutional through a combination of muted colors, office tile, and built-in hospital cabinets, this facility had a quintessentially grandmotherly design sensibility. Rose-colored carpet and floral wallpaper gave the lobby and main floor recreational rooms an old-fashioned atmosphere. The floor plan and décor on the main level mimicked a middle-class home, with an entryway leading into a formal den or sitting room with glass candy dishes and figurines, evoking notions of personal taste. As this suggests, Nancy and her family had the means both to ensure that she lived in a comfortable facility and to supplement the care she received there.

On Nancy’s floor, however, the odor of cleaning solvents, urine, and hospital food starkly indicated that this was a medical institution, not a home. This discrepancy between common areas and residential quarters is common in many long-term living facilities in the United States (Lopez 2014). In his fieldwork inside a midwestern assisted living facility, sociologist Steven H. Lopez (2014, 438) found that, for example, ‘practices aimed at “person-centered care”’ occurred ‘only in the activities department, where the work of a few staff is highly

visible to visitors and friends'. Since Sunny Care's entrance and common areas are only accessible to residents who are accompanied by a chaperone, I concluded that they are, likewise, designed for family members' and visitors' comfort, rather than for the comfort of patients themselves. On Nancy's floor, there were ten double-occupancy rooms, arranged in a semicircle around a large multipurpose area that joined a small kitchenette to the dining room. At capacity, the floor housed twenty residents, each with dementia or a cognitive impairment resulting from disease or injury. Residents required assistance with meals, dressing, and toileting, as well as supervision to prevent conflicts and manage emotional reactivity. Some were wheelchair-bound; others were mobile (and antsy). The stairwell and elevator required an access code, preventing residents from leaving their floor, accidentally or intentionally.

One CNA staffed the floor during each twelve-hour shift, a minimal level of staffing designed to limit overhead. In the evenings, I worked alongside Gene. Sunny Care's daily rhythms became evident to me, as I often assisted Gene with other patients in addition to my designated role as Nancy's companion. Each day the CNA on duty woke the patients between six and seven in the morning, washed and dressed them for the day, and sat them at their assigned table for breakfast. The instruction not to allow residents to sleep between breakfast and dinner dogged Gene, as it was nearly impossible for one person to engage and entertain twenty cognitively impaired adults. She arranged them around the television, encouraged their participation in activities organized by the nursing home, and tacitly accepted a room full of residents dozing in wheelchairs and on couches. Four times per day the medical technician rolled a cart onto the floor to administer prescribed medication, vitamins, and stool softeners. Three times per day another aide delivered meals, distributing them with help from Gene, who would prepare patients for mealtime by positioning them at their tables up to an hour in advance of the food delivery.

Rationalized aging: Physical and relational labor at Sunny Care

When I began my job, Nancy's daughter met me at the facility. She showed me photos of Nancy in her youth. As in other elder companion positions I had held, she insisted that I not divulge my paid position to Nancy; I was to pretend to simply be a regular visitor. She expected me to entertain and talk with her mother, to accompany her on walks, and to introduce structure into her week, keeping her mind as agile as possible. Each of these directives reflected the parameters of my companion position: I was to behave as an untrained friend or family member, not as medical staff. Nancy's family did not expect me to engage with her physical or medical needs but only to provide company and stimulation.

My role was to provide ‘emotional labor’, in Arlie Hochschild’s (2012) terms, and nothing more (see also Foner 1995). Hochschild (2012) describes emotional labor as the professional requirement to produce, suppress, or shape emotions suitable for a specific job. Direct care workers, like teachers and service sector employees, typically must marshal or manage their own emotions in response to on-the-job requirements (Duffy 2013; Ibarra 2002, 2016; Stacey 2011). Scholars have also referred to emotional attunement on the part of the caregiver as well as reciprocal emotional connections between caregivers and those for whom they work as ‘relational labor’, to signify the mutual constitution of care and engagement (Buch 2013; Duffy 2015; Twigg 2000). Typically, in other positions that entail relational labor – like those held by nurses and CNAs as well as teachers and waitresses – the relational aspects of the position are obscured or downplayed as nonessential (Buch 2013; Ibarra 2002). But in my experience as an elder companion, relational work was the entirety of my official job description. Nancy’s family hired me to interact with her in the manner that Gene and other CNAs simply did not have time for.

Subdividing interpersonal elements from nursing’s bodily and medical aspects is a profit-maximizing strategy, designed to optimize CNAs’ efficiency and reduce the number of personnel necessary (Lopez 2014, 448; see also Foner 1995; Pine 2011). It invariably creates the demand for relational labor. Patients require social care beyond the physical maintenance of feeding, toileting, bathing, and repositioning. Yet Gene simply could not provide companionship and stimulation to Nancy or to the other floor residents; providing intensive physical care to dozens of patients occupied her entire twelve-hour shift. Families often attempt to fill this gap by visiting regularly or, as Nancy’s family did, by hiring an elder companion to attend to a patient’s emotional needs. For many, however, privately supplementing care labor is financially burdensome. Many patients’ emotional and relational needs remain mostly unmet. In this regard, Nancy was fortunate that her family could afford to hire a companion.

While it is possible to standardize some caretaking tasks, like bathing or toileting, it is not possible to sever elderly patients’ embodied needs from their emotional and interpersonal needs. The need for company and stimulation remains, even if cost-cutting measures and efficiency standards prevent CNAs from adequately providing it. And Nancy’s physical need for a diaper change remained, despite the fact that my circumscribed role as elder companion did not include assisting with Nancy’s toileting. In my paid work experience, subdivision resulted in neglect. I failed to provide Nancy’s necessary diaper change until one of my coworkers corrected my oversight and instructed me in the proper toileting and changing procedures. Thus, cost-cutting pressures not only strain care workers but degrade the care that patients receive.

For elder companions like myself, the notion that one can provide relational labor apart from physical and medical attention presents an ethical impossibility. Patients express their relational needs through their bodies. For example, Nancy was frequently physically combative toward me. All the caregivers I encountered, likewise, reported being physically struck, punched, pushed, bitten, and pinched by patients with dementia. I knew that something I said or did could incite Nancy to hit or pinch me, but I simultaneously perceived her fragility. When assisting her to walk, I remained constantly vigilant, concerned she might fall. When cutting her food, I fretted over the size of each bite, and I obsessively watched her chew and swallow to ensure she would not choke. I attentively read her body and face for indications that she would consent to eat another bite. I repeatedly tried to wake her when she inevitably dozed off during our long afternoons together, following her daughter's and caseworker's admonishment that she not fall asleep until 8 p.m.

Similarly, CNAs are expected to feed, bathe, toilet, and reposition the elderly patients in their care with callous efficiency, but still must somehow manage the relational and emotional needs that patients express. In assisted living facilities, efficiency and cost-cutting measures require CNAs to complete the intricate routines of dressing, bathing, toileting, feeding, and repositioning as quickly as possible (Diamond 1992; Foner 1995; Lopez 2014; Pine 2011). Lopez (2014, 445) notes this constraint means that caregivers' 'social relationship with [nursing home] residents is centered wholly on this narrow feces-related bodily task'.

In other fields, rationalization aims to maximize the laboring body's efficiency. Anthropologist Aihwa Ong (1991, 290) contends, for example, that '[rationalization] specifies exact bodily posture and requires tedious repetition of the same finger, eye, and limb movements, often for hours on end at the assembly line'. It thus constitutes a 'form of body discipline' to which workers must submit (Ong 1991, 290). In the caring fields, care workers' bodies are likewise disciplined to execute physical care for dozens of patients as quickly as possible (Lopez 2014).

Given that care work entails caring for another person, rationalization in this field also disciplines the elderly bodies for whom CNAs care, a process I have come to call 'rationalized aging'. Rationalized aging is a consequence of capital's profit imperative in long-term care provision. Like its influence on the laboring body, it splinters elderly patients' holistic experiences of aging. In reflecting on the incident which I described at the beginning of this essay, when Gene reprimanded me for failing to attend to Nancy's toileting needs, I realized that my role as a companion existed to shore up the gaps in Nancy's relational care generated by the subdivision of holistic nursing care. Additionally, I realized that Nancy's caseworker, and even her family, regarded her physical and emotional aspects as fundamentally divisible and disconnected. This assumption that Nancy's emotional needs

could be attended to apart from her physical body – that, essentially, her family could purchase emotional comfort for her a la carte – reflects how capitalist processes of rationality and efficiency insinuate themselves into collective conceptions not only of laboring bodies but of aging bodies as well.

Yet, the rationalization of aging presents a persistent tension. Patients' holistic needs, particularly in long-term living facilities where needs shift daily, simply do not conform to capitalist logics. And, like manufacturing workers who fight against rationalization's disciplining logic on the factory floor (Ong 1991), caregivers often resist the splintering of elderly patients' physical and relational needs, at least to the extent that they can. When I returned to Sunny Care that afternoon, the process of assisting Gene with Nancy's toileting demonstrated to me the critical inextricability of Nancy's physical and relational needs. Having failed to convince Nancy to use the bathroom at the diner that day, I meekly asked Gene for assistance when we returned. Gene authoritatively and smoothly maneuvered Nancy's body, directing her into the bathroom, holding her in place over the commode. She quickly removed Nancy's pants and disposed of the soiled diaper, while with her other hand, she reached for a fresh, folded diaper from the sink's basin. She grabbed a wet wipe from the counter, wiped Nancy, disposed of it, plucked a new one, and repeated this three times, ensuring that Nancy was clean. Throughout, Gene offered consoling verbal reassurances of how quickly the necessary and uncomfortable interaction would be completed. Yet, Nancy struggled to flee the encounter, loudly protesting with screams and grunts. Gene's guttural 'okay, now' and 'yes, mommy' punctuated by Nancy's shrieks in opposition to her diaper change created a visceral unease in me. This discordant combination of linguistic and corporeal interventions constitutes a central and ethically ambiguous element of care provision. And it dramatically demonstrates the inextricability of patients' holistic bodily and relational needs, despite managerial processes of subdivision.

Despite pressures to subdivide and rationalize care of aging patients, CNAs develop dexterity in delivering intimate and occasionally invasive bodily care while deploying distinctively soothing verbal cues. I, too, eventually performed body management tasks that exceeded what Nancy's daughter and caseworker expected of me, evidencing the impossibility of ethically separating relational and physical labor. Attempts to achieve this separation in either direction, by dividing relational from embodied needs and tasks, has deleterious effects on patient comfort and care.

It is, unfortunately, entirely possible to ignore patients' relational needs or to neglect their physical care and maintenance – at least temporarily – practices that are more common in for-profit facilities than in community-based or nonprofit settings (Spanko 2018). Eighty

percent of US nursing homes are designated as for-profit enterprises³ (Mathews 2016; Span 2018).

Conclusion

US manufacturing decline and the service sector's concomitant rise have generated productive theorizing on twenty-first-century labor. From expanding applications of Hochschild's (2012) concept of emotional labor to emergent studies on affective, intimate, and immaterial labor, scholars have captured the changing contours of work under late neoliberal capitalism. And, in theorizing capitalist dynamics in health care, scholars have long acknowledged that profit incentives place patients at risk for neglect (Diamond 1992). My work as an elder companion suggests that these broader political-economic shifts also influence our very understandings of aging in the United States.

Subdivision and standardization in the caring fields interrupt the complex interplay between caregivers' relational labor and corporeal skill, thereby compartmentalizing elderly patients' holistic needs. Rationalization encourages an understanding of elderly patients' needs as 'standard, rationally administrable units' (Aronson and Neysmith 1996, 423). Despite attempts to streamline caring labor, this field differs from other – even more aggressively regimented – industries because another person's health, autonomy, and quality of life are at issue. Of necessity, caregivers are skillful judges of the ethical complexity and interpersonal ambiguity of medical provision, particularly as they may have to execute necessary tasks against patients' ostensible wishes. These negotiations are not straightforward. Nancy's discomfort with toileting and diaper change entailed shrieks and flailing arms. To ignore her bathroom needs, however, could have caused rashes, sores, urinary tract infections, and other complications.

Given the growing US elderly population and increasing commodification of the caring sector, rationalized aging will likely be the norm for many elderly Americans. The proliferation of caregiving positions – including specialized roles like companions to the elderly (for those who can afford it) – is a critical aspect of care provision today. Yet, in my experience, the proliferation of such roles illustrates the potentially insalubrious cleaving of elderly patients' holistic needs.

3 US nursing homes and long-term assisted living facilities reported a 20 percent profit margin in 2016, though the Center for Medicare & Medicaid Services notes that for-profit firms obscure profits through the use of clever cost categories such as management fees and leasing terms (Lieberman 2016).

The profit-maximizing practices of hospitals and long-term living facilities harm both patients and care providers. Labor unions and workers' organizations have established successful collaborations with patients' advocacy organizations, family members, and the public in their continued struggles for better wages and working conditions. I have worked with and for a number of these organizations and have seen how useful anthropological perspectives can be in articulating the goals of labor organizing and patient advocacy. Anthropologists are especially well suited to attend to caregiving as a form of labor and to question the market-based organization of medical provision, as our cross-cultural and historically specific understandings of health and well-being offer depth and vision to counter reductive policy prescriptions. And, like many of us, I have spent numerous hours in hospitals and hospices at the beds of family members. Thus, the dual concerns of protecting patients and supporting care workers stem from both personal and political convictions. Anthropologists can support caregivers' efforts to improve the conditions facing aging Americans as they simultaneously fight to improve their own working conditions through classroom engagement, solidarity on the picket lines, legislative advocacy, and academic analyses that center these concerns.

About the author

Alana Lee Glaser is Assistant Professor in the Sociology & Anthropology Department of St. John's University. Her broader ethnographic project chronicled the impact of labor law implementation (the 2010 New York Domestic Worker Bill of Rights) on the multicultural, immigrant-led organizations responsible for its passage as well as its unexpected sequelae in the daily lives of individual West Indian Caribbean and West African women working as caregivers in New York City. Her current research examines how racially diverse women care workers marshal their professional capital through international solidarity organizations to challenge the retrenchment of welfare state protections.

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