Plate 4 Institutionalized care work: the commodification of women's 'natural' skills. Photo © Don Smetzer/Getty Images.

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Bodies in Sickness and in Health: Care Work and Beauty Work

'Ah', sighed Mrs Gamp ... 'what a blessed thing it is to make sick people happy in their beds, and never mind one's self as long as one can do a service.'

Charles Dickens, *The Life and Times of Martin Chuzzlewit*, 1844

In our culture, not one part of a woman's body is left untouched. No feature or extremity is spared the art or pain of improvement.

Andrea Dworkin, *Woman-Hating*, 1974

One of the main features of bodies is their contradictory tendency. On the one hand, bodies age, decay, wither and ail, but on the other hand they are also open to improvement through exercise, diet and forms of physical manipulation, actions that may delay the effects of ageing. The search for improvement is often driven by an idealized notion of a body beautiful: a notion that is historically and geographically specific, as well as gender specific and sometimes varying by social class. In both sets of processes, close and personal interactive body work, by specialists and by the individual 'owner' of the body in question, is a key part of daily and generational bodily maintenance. A range of jobs and professions is involved in the care for sick and/or elderly bodies and in the maintenance and improvement of healthy bodies, many of which are constructed as particularly appropriate occupations for women, associated with those typically female attributes of love, care and empathy that are widely seen as natural feminine attributes. As I argued earlier in the discussions of domestic and sex work, feminine skills in relational work are too often taken for granted. In this chapter, as I shall show, nursing (at least until recently), care work and work in salons and beauty parlours are all feminized occupations that are correspondingly poorly paid. But not all body maintenance work is feminized or low paid. The distinction between doctors and nurses is a key example of the lack of association between body work and femininity (Pringle 1998). Through the social construction of medicine as a technical and scientific occupation, it is

disassociated from direct work on the bodies of others and, with its links to elite male workers, is constructed as a high-status, well-paid occupation. Other types of body work lower in the social-status hierarchy – personal trainers and sports coaches, for example – are as likely, if not more so, to be undertaken by men rather than women. The association of masculinity with strength, power and fitness enables men to construct these types of work as congruent with their sense of themselves as masculine.

In this chapter I first address the connections between embodiment, high-touch body work, femininity and social status in caring occupations through the examples of nursing and care work, exploring the associations with femininity and the paradoxes that result for men in these occupations. Here, the bodies of the clients/customers/patients typically are unwell and/or ageing and the relations of power often, although not always, privilege the care providers. I then turn to the healthy body, looking at professions that are concerned with bodily improvement and with adornment, beautification and display: traits that are often associated with female vanity.

Bodies, Emotions, Care and Femininity

In chapter 4 the ways in which stereotypical attributes of femininity are mapped onto occupations, constructing the skills developed in undertaking domestic tasks and childcare as 'natural' attributes of women and so not 'real skills', were outlined. The nature of this work and the limited potential to increase its productivity was explored as an additional reason for the typically low levels of financial recompense for workers employed in the domestic sphere. In caring work in the public arena – in hospitals, hospices and elder care homes – the same sets of associations and the need for a high staff-patient/client ratio to establish and maintain interpersonal relationships are also a significant part of the social construction of nursing and care work as feminized, although there is a significant status differentiation between them. Nursing is what was once termed a semi-profession (Etzioni 1969): the condescension in the label 'semi' associated with the dominance of women in occupations so categorized (Hearn 1982). Librarianship and social work, for example, are also included under this rubric. Clearly, these are demanding professions, based on sets of specialist skills and are usually graduate-only entry, but their reliance on a predominantly female labour force reduces their status. Nursing has also moved towards graduate entry in the last decades and its status has increased to some extent, although it is still poorly paid. Care work remains a 'high-touch', low-status job, including within its ranks large numbers of unskilled workers without relevant credentials who undertake the 'dirty work' end of bodily care. Increasingly, however, migrant workers with nursing qualifications take jobs within care homes, as entry into health and health-related professional jobs is often closed to them.

The Social Construction of Nursing: The Lady with the Lamp

One of the paradoxes of nursing is the way in which, as it moved from the home to the hospital, what is often a hard, dirty job involving heavy lifting, bodily fluids, smells and intimate care became constructed as a job suitable for middle-class women. In part, this is because of the associations between care, love and emotions which permit the care of the sick to be constructed as an act of charity and compassion, as much as an occupation or profession. Since the time of Florence Nightingale whose work in the Crimea has entered popular myths about nursing, the concept of caring has been central to the construction and representation of nursing. Care for others is associated with women's 'natural' talents of empathy and sympathy, able and willing to perform tasks of social reproduction and bodily care that are often associated not only with the body but with the private, the personal and the intimate realms of embodiment where, of course, the relationships between the cared-for and the caregiver are based on love and the ties of affection, rather than on a monetary exchange (Novarra 1980; England and Folbre 1999).

When caring is provided in the public arena – whether by the state on the basis of a system of rationing and entitlement or in the market on the basis of ability to pay – the association between caring and affection leads to a paradox. Commodified caring labour is both highly valorized (as more than a job, as a vocation) and devalued and correspondingly poorly remunerated. As Julia Twigg (2000a) noted, there is a direct parallel between this paradox in commodified caring labour and the social construction of women's unpaid caring work in the home. In each case, the social roles and labouring that are involved are at the same time both 'sidelined, lowly regarded and unsupported' and represented as being of 'supreme value' (p. 407). Twigg identifies what she terms a 'halo effect' (from Nightingale's lamp perhaps?) which obscures the hard physical labour undertaken, illuminating only the tender provision of care, and so skewing the debate about the nature of the work involved. Workers are often represented as having a 'special vocation' involving innate skills and quasi-religious devotion (think of the parallels between old-fashioned nursing uniforms and those of women in religious orders), contributing to the low status and poor pay of this work (England 2005).

In an interesting case study of the caring labour involved in looking after dying patients in a hospice, Nicky James (1992) argued that caring in the public arena comprises three components:

- organization
- physical work
- emotional work

The organization – in the sense both of the institutional setting and the ways in which tasks are organized – sets the framework within which care is carried out, perhaps in a quasi-familial setting in a hospice, but more typically in a bureaucratic setting in a hospital. Nursing, like the domestic work, combines physical and emotional labour. Numerous case studies of caring occupations, including nursing and elder care, have shown that carers themselves adopt this binary distinction when talking about their work. Nurses tend to refer to the different tasks that they perform as either 'work' or 'care': the latter involves emotions and feelings of attachment to those for whom they care; the former encompasses physical labour. Thus, as James (1992: 497) suggests, 'the framework of physical labour ... became the justification and explanation of paid work. Having been sitting talking to a patient a nurse would say "I must go and do some work now," meaning physical tasks.' This distinction was used by staff to construct boundaries, allowing them to complain or to take industrial action, to withdraw their labour without feeling they were letting their patients down, but it was also part of the maintenance of the assumptions which devalue their labour through its associations with 'love' and affection.

As I argued in chapter 4, the boundary between physical and emotional work is not always easy to draw as the tasks overlap. A range of emotions are involved in doing the dirty work, including the management of their own emotions by carers and nurses – the distaste or disgust that certain tasks, material or odours arouse. A typical way of coping with these emotions is the development of distancing mechanisms to separate workers from their work. This displacement mirrors the tactics used by sex workers discussed in chapter 5. Before exploring these distancing mechanisms in a case study of domiciliary care workers, I explore the organization of care work and the stress involved in performing emotional labour in this example of embodied interactive employment.

Empathy and Stress in Customer-Oriented Bureaucracies

Doing emotional labour is an important part of all sorts of interactive service work (Hochschild 1983; Krumal and Geddes 2000; Williams 2003; Hampson and Junor 2005). Face-to-face encounters between workers and consumers/clients require workers to produce a 'display, deployment, and management of emotions' (Hughes 2005: 604) as part of their day-to-day work. Like other forms of consumer service employment, nursing involves a three-way interrelationship – with superiors, with colleagues and with patients (Wolkowitz 2002). Hospitals are a good example of a 'customer orientated bureaucracy': a term that captures the ways in which workers are governed not only through

the standardizing disciplining of a bureaucratic organization, but also by the demands of customers (patients) who are physically present (Korczynski 2001; Kerfoot and Korczynski 2005). The embodied attributes and gendered performances of workers are particularly important in customer-orientated bureaucracies, as workers become responsible for resolving the intrinsic tensions between the rational organization of their work and the more unpredictable demands of patients. 'Empathetic' women workers have a particular role in easing customers (and patients) through the standardized service exchange (Forseth 2005). In the next chapter, I look at the ways in which the same sort of relationship between gender, tension and empathy works in relationships with guests in hotels; as the previous chapter illustrated, albeit in a different type of setting, door staff also have to resolve tensions between customers and between customers and employees. In the healthcare sector, women workers are essential in the resolution of some of the tensions inherent in circumstances where the 'customers' are anxious, sick, perhaps elderly and sometimes confused (Halford 2003; Bolton 2005). Interactions between the patients, their relatives and the workers take place in the context of gendered understandings of care in which nurses are considered to provide care and empathy, as well as bodily maintenance, whereas doctors provide scientific or rational information and so are not relied on for emotional support in the same way as nurses are.

As I have already argued, the emotional demands of this part of caring labour tend to be unrecognized as a skill, and so financially poorly rewarded (Smith 1992; Payne 2006), despite the evident importance of emotional labour in the satisfactory delivery of care. This is not a new claim, however, nor is nursing and careworking a new form of work. Its significance has grown, however, in an economy where women are increasingly involved in waged labour and so less available to care for their dependents outside institutional provision and because of the needs for care of an ageing population. Half a century ago, Isobel Menzies Lyth (1959), a psychoanalyst, wrote a controversial paper that was largely ignored until it was republished in 1988, in which she prefigured recent arguments about emotional labour, as well as the significance of hospitals' organizational practices. Based on research in an English teaching hospital in the 1950s, she showed how the organization of nursing and the intimate relationship it demanded with patients impacts on the organization of care, leaving those closest to patients – junior nurses and nursing assistants – exposed to emotional pressures that more senior staff and managers were protected from. She discovered extremely high levels of distress and anxiety among junior nurses. As Menzies Lyth argued, this stress is a product of the fact that the work of nursing is itself exceptionally anxiety producing. Nurses work with people who are ill or dying in circumstances where incorrect actions might have devastating consequences. Nurses must respond both to the distress of patients themselves and to the distressed family of the patient. Furthermore, many of the tasks involved in

nursing the sick are distasteful or repulsive and so place emotional demands on the workers carrying them out.

Menzies Lyth documented the ways work in hospitals in the 1950s was organized to contain and modify nurses' anxiety. There was a dominant belief that if the relationships between nurse and patient were (too) close, the nurse would experience more distress when the patient was discharged or died and so work practices were developed that would encourage distance. Nurses were required to perform a few specialized tasks with a large number of people, rather than providing continuous care for a smaller number of patients, in a manner more reminiscent of a Fordist form of organization than the niche production of specialist care for the 'whole' body. Calling patients by their condition – the tumour in bed 19 for example – rather than by their given name was also common. Similarly, the weight of responsibility for making a final decision was mitigated in a number of ways. Even inconsequential decisions were checked and rechecked and simple tasks were passed up the hierarchy of command. There were no mechanisms in place to support nurses who became distressed. The administration did not, for example, acknowledge that a patient's death affected nurses or provide support to deal with this and other forms of emotional distress. Instead, the rationale developed that a 'good nurse' was 'detached'. There is an interesting echo here of the advice that used to be given to social researchers.

Menzies Lyth found, however, that although these distancing mechanisms protected nurses from some anxieties, they also created new ones. In interviews, nurses expressed guilt about many of the bureaucratic procedures. Even though they might have carried out their instructions exactly, they still believed that they had practised bad nursing, arguing that they were caring for the system's rather than for patients' needs. Menzies Lyth's arguments pre-date by many years the insistence by James and others (Kang 2003; Seymour and Sandiford 2005) on the importance of the context under which caring occurs, but remain absolutely relevant. The same sorts of distancing mechanisms are evident in, for example, the long training and professional ethics central to medicine and specialist nursing which provide ways for middle- and high-end workers to deal more easily with their own emotions and the emotional interactions with patients. Other mechanisms such as exposing only part of the body and hiding the rest of the patient under a sheet or a screen are also used to reduce the intimacy of interactions. Such resources and mechanisms are not generally available to more junior nurses, to healthcare assistants or, especially, to the unskilled carers in institutions such as care homes for the elderly, where the careful manipulation of emotions is an essential way of reducing the degradation of certain intimate procedures.

It has been recognized that auxiliaries, healthcare assistants and even hospital cleaners, whose work would seem to fall centrally on to the physical

labour side of James' distinction, also undertake a great deal of emotional labour during the course of their daily tasks (James 1992; Sass 2000). This might involve taking time to talk to someone as they bathe them, serve their meals or clean their room. These jobs, although they are defined as unskilled and menial, often require skill and the exercise of judgement and, as Glenn (1992) noted, involve the transfer of domestic or maternal skills into the sphere of waged work. Turner and Stets (2006) have argued that the demands of emotional labour may be particularly stressful for recent migrants, who are a key part of the workforce in caring occupations in many British towns and cities (May et al. 2007). Non-British born migrants working in low-status and poorly paid jobs in the service sector often find that they must perform both emotional labour and physical care across a cultural divide, undertaking tasks that they do not regard as appropriate or acceptable parts of the job, or providing emotional support for, say, elderly people, more usually undertaken by family members in their countries of origin (Dyer, McDowell and Batnizky 2008).

Caring as Body Work/Dirty Work

The provision of care is also hard physical labour that often involves close and intimate work on the bodies of others. The human body, particularly when ill, old or diseased, unsettles the modern western emphasis on an individual's rational autonomy and the supposedly bounded nature of the body. Although there are exceptions, such as psychoanalysis and counselling, most caring work takes the customer's body as its immediate site of labour. In a culture which esteems the cerebral over the physical, the autonomous above the dependent, and the disciplined over the uncontrolled/able, 'body work' in the caring professions is marked by the intimate and often messy contacts that are part of the interactions between labourer and embodied client (Gubrium 1975). Work is not only performed on the bodies of others, but it is often undertaken using the bodies of the workers as a primary vehicle (Jervis 2001). Patients have to be lifted and moved, turned, washed, walked and massaged, typically by the lowest-status workers. And as nurses are promoted 'they move away from the basic bodywork of bedpans and sponge baths towards high-tech, skilled interventions; progressing from dirty work on bodies to clean work on machines' (Twigg 2000a: 390), neatly encapsulating Brush's distinction between high-touch and high-tech work discussed in chapter 2. It is the lower-status nurses and nursing assistants who are left 'to deal with what is rejected, left over, spills out and pollutes' (Wolkowitz 2002: 501), often hiding this dirty work away behind screens (Lawler 1991). For the lowest-status care workers, body work often involves caring for elderly and/or diseased bodies, regarded as

loathsome or feared bodies in contemporary western societies that valorize young, slim and unmarked bodies (Young 1990; Lawler 1997; Jervis 2001). Not for nothing is geriatric care termed the Cinderella service in the British health service.

Undertaking the 'dirty work' of interactive body work represents a challenge to workers beyond their low pay, as the symbolic associations that contribute to the structuring of body work as being of low worth become attached to the workers themselves. Thus, those involved in this type of work may become identified as 'dirty workers', as their waged work poses a challenge to their sense of identity and self-worth (Bates 2005; McGregor 2007), although workers are able to adopt a number of strategies to attempt to mitigate their labelling and the distasteful or intimate parts of their jobs, through, for example, the use of humour, by forming strong collective identities and by emphasizing the dignity of earning a wage (Bolton 2005; Stacey 2005; Kreiner, Ashforth and Sluss 2006). Body work is, perhaps above all, 'ambivalent work' (Twigg 2000b: 391), as the distinction between emotional and physical work indicates. It involves pleasure and emotional intimacy, but also evokes disgust, the necessity of dealing with human waste, or touches on taboo areas around sexuality and ageing. The extent to which emotional work brings stress or satisfaction has been the subject of a long debate (Hochschild 1983; Steinberg and Figart 1999; Erickson and Ritter 2001; Williams 2003; Bolton and Houlihan 2005; Forseth 2005; Zapf and Holz 2006).

In the next sections, I draw first on Julia Twigg's (2000a, 2000b) study of peripatetic care workers to show how they manage this ambivalence and what sources of satisfaction are found in this work. I then turn to the position of men in nursing, looking at the ways in which masculinity may advantage men in the profession, despite the associations between caring and femininity, ensuring their rapid movement from the dirty parts of body work into management. I end this part of the chapter with a discussion of Tim Diamond's (1992) study of a residential care home in Chicago to explore wider questions about the relationships between class, gender and race in the construction and segmentation of a caring labour force.

Providing Care in the Community

Like nursing, care work undertaken in the community – that is, outside the specialized settings of hospitals or hospices – is gendered work, typically, although not always, undertaken by women. It is also low-status, hard, heavy physical work that, nevertheless, also involves the emotions. In her book about the employment world of community care workers, Julia Twigg (2000b) opens one chapter with a quote from Bates (1993: 14) that so nicely captures the different aspects of care work that I have reproduced it here:

> To the outsider, the 'caring' world may have appeared as one of pink overalls, cleanliness, jangling keys, 'come along Annie', wheelchairs, walks around the grounds, trolleys, laundry, the ubiquitous institutional smell, dozing residents in television lounges. This was the re-presented, more acceptable face of the occupation, which in effect in terms of contemporary cultural constructs, was a 'heavy', 'dirty' job, steeped in taboo subject matter, such as the body, age, 'shit shovelling' and death. These social responsibilities were transported form the wider society to a sub-society, staffed largely by women. Within this sub-society, a partial and truncated version of 'caring' was enacted, involving constant tension between caring for and processing people.

This description is of a community home for elderly people, but commodified 'community' care is also provided in people's own homes. Here care work involves not only caring for the bodies of clients, who usually are older or disabled people, in the holistic sense of making them comfortable, providing some human contact and sympathy, but also managing the tasks involved in the daily maintenance of clients and their bodies. Thus, it is a type of work that involves transgressing the boundaries of normal social life, especially when the work takes place in clients' private homes. In this sense, this case study also fits into the material discussed in chapter 4. I have included it here, however, as the workers are peripatetic; they are not restricted to a single home as nannies are and because their work is more akin to nursing in that they care for declining or sickening bodies rather than for children. One of the most complicated challenges of this type of care work is how to manage the relationship between the emotional aspects of caring and the disgust that is associated with some of the essential parts of the job, especially when they are carried out in spaces that are not specially equipped to facilitate the efficient provision of the care and maintenance of human bodies. Care in the home thus touches on, even encroaches on, some of the most significant issues in people's lives – their feelings about their body, the meaning of home (Blunt and Dowling 2006) and the maintenance of dignity in ageing and dying (Lawton 2000).

Doing care work in the community: location, class and ethnicity

Who takes a job as a care worker in part depends on the structure of the local labour market and the range of other opportunities for people – mainly women – with few skills or educational credentials. It is also related to the nature and structure of the migrant population, both within local labour markets and in the UK as a whole. Care workers typically are middle-aged,

Table 7.1 Non-UK born care workers 2006

	UK	*Non-UK*	*% Non-UK*
Care assistants and home carers	535,000	105,000	16
House-parents and residential wardens	35,000	2,000	5
Nursery nurses	151,000	7,000	5
Nursing auxiliaries and assistants	197,000	23,000	10

Source: Office of National Statistics 2006

working-class women, although their numbers are often swollen, especially, although not only, in London, by migrant workers. These include both people of colour and a group of more casual and transient workers: young, often white, women from countries such as Australia, New Zealand and South Africa who fund their travels in Europe by doing care work on a temporary basis. Since 2004, growing numbers of A8 migrants have also taken jobs as domiciliary or residential care workers. Care work is also racialized – in London and Birmingham, for example, a significant proportion of the labour force is Black; in other cities older white women from Ireland are also in the labour force, reflecting the history of migration into the UK in the postwar period. Table 7.1 shows numbers and the proportion of workers undertaking different aspects of care who are non-UK born.

The highest percentage of the non-UK born social care workforce (which does not include state registered nurses) is from Zimbabwe (12 per cent), followed by the Philippines (10 per cent), Ghana (7 per cent), Poland (6 per cent), Germany (6 per cent), Nigeria (6 per cent), India (5 per cent), Jamaica (3 per cent) and the Irish republic (3 per cent). Most of these workers have joined the labour force in the last ten years. The impact of the new accession countries is visible in data from the Workers Registration Scheme (WRS) with which newcomers from the accession states are obliged to register when they take employment. Between accession in May 2004 and June 2006, 12,610 people registered as care assistants and home carers, of whom the majority (62 per cent) were from Poland. In London, where non-UK born workers are a third of the total labour force, their share of care work is significantly higher – 68 per cent of all care workers in London are foreign-born. Care work is low-status work and often the last option for those with the most limited choices in the labour market. As Bates (1993) and Skeggs (1997) have argued in their work on young school leavers, caring courses are the least well regarded of all training options open to young women with few qualifications. Accepting a place is usually a response to poor/low labour market options rather than a positive decision. The young women on these courses tend to keep quiet about the nature of their work,

before and after training, and, as Bartoldus, Gillery and Stuges (1989: 207) noted in a US study of caring, workers believe the general public sees them 'as "unskilled maids" who did society's "dirty work"'.

What is unusual about domiciliary care work – the example that Twigg analyses – is that it is almost entirely unsupervised on a daily basis. This is atypical among low-skilled interactive jobs in the health service, although it is common in some of the other forms of 'home-based' work discussed earlier. Domiciliary care workers have a greater degree of independence than, for example, auxiliary workers and cleaners in hospitals and perhaps as a consequence greater prospects of job satisfaction. They are often able to arrange their hours around the time demands of their own daily lives, fitting in shopping or picking up children from school, for example, between visits. The work involves a variety of tasks, not all of them unpleasant (as the quote from Bates indicates), but it also often involves fragmented tasks and visits and so may be difficult to organize so that time is used most efficiently. Split shifts are common, for example, and so work expands across or beyond a conventional working day. And as I noted earlier, because the work takes place in people's own homes, it is often carried out in cramped or unsuitable conditions and spaces: in people's private bathrooms, for example, where lifting aids and other equipment often do not fit into the space available. Like the basic tasks of nursing, domiciliary care work thus also places demands on the workers' own bodies as heavy lifting or bodily manipulation in awkward spaces create stresses and strains.

The dirty work of keeping clean

One of the main parts of domiciliary care work involves keeping the bodies of clients clean. This is the focus of Twigg's (2000a, 2000b) analysis of the dual aspect of care work as dirty work and emotional labour. Her study was based on interviews with 30 older and disabled people, 24 care workers and 11 front-line managers, living and working in an affluent area of inner London and in a more deprived coastal town. The clients included men and the workers were mainly women: 31 compared to just 3 men, a ratio that reinforces the associations between femininity and care. All the participants were interviewed – some alone, others in small groups (Twigg 2000a: 394–5) – but none of the interviews took place during the interaction between the carer and the cared-for. Clearly, in this type of research, issues about privacy preclude a close and intimate engagement of researchers in the labour process, unless, of course, the researcher is also a care worker. In the second case study of bodily care for elderly people that I discuss below, this was the case, as Tim Diamond (1992) took a job in a nursing home in Chicago. His study raises different questions about the research process than does Twigg's work, but together they provide a moving insight into the labour and love involved in caring.

In her study, Twigg explored in detail two key aspects of the bodily interactions involved in care work: first, dealing with dirt and emotions of disgust, and secondly, dealing with the naked bodies of others. Care work, as Twigg (2000a: 389) argues, 'is about dealing with human wastes: shit, pee, vomit, sputum': all products of the body that usually are evacuated in private, although there are cultural differences between societies. Spitting in the street, for example, is commonplace and acceptable in some Chinese and Portuguese cities, but is frowned on elsewhere. In all societies there are social systems and accepted norms for dealing with waste. Disgust enters the equation only when these are breached. As Mary Douglas (1966) noted more than forty years ago, 'dirt is matter out of place'. In a clean bathroom where waste is neatly deposited and flushed away, its 'dirtiness' is not an issue. For elderly incontinent clients, unable to reach the WC, it is, and dirtiness is associated with shame.

Dealing with excrement was the part of the job that evoked the greatest sense of disgust, in part because of the smell:

> Someone in a mucky bed, you know, you just – you can put all the protective clothing on, gloves, your plastic apron and everything, but you sometimes feel unclean. (Susan in Twigg 2000a: 396)
>
> The smell just stays with you. (Vicky in Twigg 2000a: 396)

Smell, Twigg argues, is so significant as 'it extends the patient's corporality in such a way that intrudes and seeps into others' spaces. Odours by their very nature cannot be easily contained; they escape and cross boundaries' (p. 397).

Workers also disliked other aspects of bodily maintenance work: some disliked dirty teeth, others flaking skin, people being sick, or the sound of expectoration:

> What gets to me is when they're coughing up phlegm and put it in a bowl. (Tracey in Twigg 2000a: 394)

As Lawton (1998) noted in her work in a hospice, these patients' bodies have become unbounded by virtue of their inability to control their waste products. This challenges western notions of the singular, separate, inalienable body of each individual. In hospitals, hospices and in the home, carers struggle to combat dirt and odours in an attempt to reassert dominant 'ideas about living, personhood and the hygienic, sanitized, somatically bounded body' (Lawler 1991: 123). As I argued in the introduction, this idealized separate body is closer to a masculinized version of the body. Women's bodies have long been represented as unbounded, messy, leaky and fecund (Grosz 1994). Menstruation, pregnancy and lactation all challenge this idealized singular,

bounded and separate body. Iris Young's (2005) discussion of her own pregnancy includes an example of the unbounded body. She noted that academic colleagues felt free to touch her and the 'bump' in ways they would not have dreamed of when she was not pregnant. And, as I also noted earlier, the efforts to deodorize and/or re-perfume the female body is the basis of a huge industry, selling a vast variety of deodorants and fragrances not only to women but increasingly to men. In the second part of this chapter, I explore the work of beauty therapists who play a key role in the beautification of bodies.

The second arena of visceral emotion and disgust explored by Twigg concerns the feelings generated by the sight and the washing of elderly bodies. The hegemonic idealized body that dominates not only advertising but the labour market is a slim, fit, young – and usually white – body (Bordo 1993). Western culture provides few – and even fewer positive – images of ageing bodies and almost never of ageing naked bodies. Twigg reports that her respondents found the initial sight of older people without clothes surprising and often shocking:

> I just had to stop myself staring at people, because I hadn't really seen ... because you don't really see people naked. (Sophie in Twigg 2000a: 397)

Sophie was also surprised at the variation between older people's bodies. Other workers emphasized the differences between their own, still young bodies, which led them to reflect on the inevitable loss of strength and vitality associated with ageing, and, more specifically, on the implications of the loss of sexual attractiveness. The nakedness of older people thus 'offered a glimpse into a personal future that was discouraging and unwelcome' (Twigg 2000a: 398).

One of the most challenging aspects of domiciliary care work was the need to touch older people's bodies. Intimate care work inevitably involves skin-to-skin contacts, although many care workers wore gloves for at least some of the tasks. Here is Sophie reflecting on the touch of older people's skins:

> It was really weird when you feel the skin ... actually to feel someone's skin it's quite different than having the glove over your hand. It's *much* more intimate. (Twigg 2000a: 294; original emphasis)

The use of gloves while bathing clients was a common way of avoiding too much skin contact and intimacy. They acted to construct 'a barrier of professionalism between the client and the worker' (p. 404). Sophie, also suggested that the use of gloves was a way to avoid the associations between skin contact and sexual pleasure:

> I appreciate wearing them [gloves] ... you know they [male clients] might get into it having a nice girl rubbing their back with bare hands ... having the gloves,

> it's kind of like wearing a badge saying: I am here for a reason, this is what I am doing. I am not just here with you naked, washing you. (Twigg 2000a: 404)

In some cases, however, the wearing of gloves was constructed by clients as somehow demeaning or dehumanizing, 'evoking a sense that the person being handled is contaminated or subhuman' (p. 404) and the association with how police and other officials handle people who are suspected of being HIV-positive increases this sense of being demeaned.

Dealing with both dirt and naked intimacy are more often associated with relational ties of affection – between mothers and children, for example, or between lovers – than being part of a commodified exchange, and so both carers and their clients need to find ways to cover or get beyond embarrassment and to distance themselves from the intimate body working that is taking place. A number of strategies were adopted by the workers whom Twigg interviewed. Some care workers attempted to put themselves in the position of the recipient of care and to use empathy to overcome their embarrassment. Avoiding direct language was common, as well as chatting or joking while dealing with difficult parts of the job. Some of the women care workers dismissed the notion that such work was necessarily embarrassing, seeing dealing with dirty bodies as a natural extension of women's lives as mothers. Twigg also noted that most care workers did not wear uniforms and so presented a somewhat ordinary, even homely, appearance in contrast to nurses: a fact that was valued by many clients.

The type of body work carried out by these care workers is low-paid, low-status and, to a large extent, demeaning work for both the worker and the client. As I suggested earlier, the associations of dirt are often assumed to transfer to the bodies of the workers themselves. In response, workers emphasize the more pleasant 'emotional labour' that is a large part of their jobs. The care workers interviewed by Twigg, for example, made a distinction between emotional closeness and intimate touching work. They told her that they often developed an emotional attachment to their clients and were warm and tactile in interaction, but they emphasized 'the social touch of cuddles and kisses, rather than the intimacy of bathing, as a route to emotional closeness' (Twigg 2000a: 399). And it was the emotional closeness rather than the 'dirty work' that workers emphasized in discussions about their working lives with friends and relatives. Developing close ties and providing comfort to clients was seen as one of the advantages of the work. As Barry, one of the three male care workers whom Twigg interviewed, told her:

> I get enjoyment, I have to admit, that I get enjoyment out of it and pleasure ... seeing the pleasure on somebody's face when you walk through the door first thing in the morning.... The pleasure of seeing the client's face and knowing that, when you leave, they're happy. (Twigg 2000b: 164–5)

Although Twigg does not comment, I wonder whether the sense of reluctance to admit to pleasure in caring in Barry's comment is a reflection of the more typical association with these tasks with women and femininity. As Twigg (2000a: 408) notes, women's association with body work derives from 'the greater freedom that women are accorded in their access to bodies compared with men', at least if the men are not professionally qualified as doctors. Hegemonic notions of sexuality construct men as predatory and women as passive, so necessitating greater restrictions on men's access to bodies. Typically in the UK, domiciliary male care workers are restricted to dealing with men's bodies, whereas women look after both sexes.

The emphasis on the satisfactions of emotional labour and the felt need to hide the dirty body work involved in caring labour means that this latter part of the job is undervalued. Further, the establishment of emotional ties with clients, while bringing job satisfaction, is also a problematic aspect of care work. Becoming (too) attached to clients is an occupational hazard and some care workers interviewed by Twigg found it hard to bear the unhappiness of their clients and their growing dependence on them. They also had to learn to deal with death, often unexpected and in the home, rather than in a specialized or sequestered location, such as a hospice. Workers talked about having to learn to switch their emotions off when they leave work and to accept that care work, as a job, cannot be unbounded and unlimited. As Twigg (2000b: 170) noted, 'their jobs and the incentives in relation to them, are structured by economic rationality.... The work thus does have clear limits in the sense that care workers are only allocated and paid for specific periods of time and often only for specific tasks.' All care workers have to negotiate the tension between 'the ethic of care' based on love and ties of affection and the economic rationality of waged labour in order to avoid becoming the 'prisoner of love': a dilemma identified by Folbre and Nelson (2000).

In the next section I explore the ways in which male nurses are able to negotiate this tension and construct their work as appropriately masculine when working in a profession saturated with images of femininity. I then return to care work, although in an institution, to explore how the associations between care and femininity construct male workers as out of place in a nursing home in Chicago.

What About Male Nurses?

As I have argued earlier in this chapter, caring is constructed as an essential female attribute and so an ideal of feminine caring is mapped onto nursing and care work as a natural talent embodied by women rather than a skill constructed through training. Indeed, a key theme of the book, as is now abundantly clear, is the way in which the attributes of masculinity and

femininity are mapped onto jobs and occupations to include one gender and exclude the other. As we have seen, women are 'naturally fitted' for certain types of work and not for others, while women who find themselves in masculinized occupations often suffer from being the 'token' woman, marginalized, subject to exclusionary or hostile behaviour and sometimes sexual harassment, and so suffer career disadvantages (Kanter 1977; Collinson and Collinson 1996; McDowell 1997; Simpson 1997). But what of men who enter female-dominated occupations? Do they suffer from being a 'token' man? Are they similarly marginalized and harassed or is their visibility in the workplace an advantage? Although there is not an enormous literature about men in non-traditional occupations, there does seem to be evidence that they benefit from their position through assumptions about career development and leadership potential associated with stereotypical views about men's attitudes to and aptitudes for waged work. Men in primary school teaching, for example, may find they have advantages in the recruitment and promotion process and they often ascend the career ladder more quickly than their women colleagues, but their advantage may alienate them from female staff (Williams 1993). Male nurses, too, are often promoted more rapidly than women (Bradley 1993).

In a profession such as nursing which is so heavily imbued with notions about emotional labour, men might be expected to be at a disadvantage as the oppositional construction of rationality and emotions which maps onto a male/female divide seems to construct them as out of place. Men – currently 10 per cent of nurses and 14 per cent of primary school teachers in the UK – may, for example, find their competence challenged if they rely on versions of traditional masculinity at work or alternatively find their identity and/or their sexuality challenged if they adopt what are constructed as feminine attitudes and behaviours at work, whether in the classroom or the hospital ward (Heikes 1992; Isaacs and Poole 1996; Evans 1997; Alvesson 1998). Lupton (2009) has argued that men in female-dominated jobs and workplaces fear feminization and stigmatization, not necessarily or only in the workplace but also among their peers and in their social networks. As Kimmel (1994) has argued, men scrutinize each other for signs of femininity and homosexuality. For most men, constructing a satisfactory hegemonic masculinity demands continual self-scrutiny and hard work. Manhood is always insecure, uncertain and incomplete (Connell 2000) and in feminized occupations men's anxiety about their masculine identity is exacerbated.

In an interesting study based on 40 in-depth interviews with men working as primary school teachers, cabin crew (one of Arlie Hochschild's (1983) examples in her classic work on emotional labour), librarians and nurses, Ruth Simpson (2004) found that men in these jobs adopted a range of strategies to maintain and reproduce behaviours that were congruent with their sense of themselves as masculine. These included re-labelling, status enhancement and distancing themselves from the feminine. I draw on her interviews with 15 nurses in 10 different hospitals in the southeast of England, who responded to an advertisement the author placed in a professional nursing journal. Five of the men worked in general nursing, five in mental health, four in accident and emergency and one in palliative care, and the site and type of work also affected social relations and the construction of appropriately masculine identities in the workplace. Masculine authority and so an absence of emotions was easier to assert and more of an advantage in the Accident and Emergency department than in the other arenas of the hospital. Male nurses there emphasized that the work was exciting, fast, stressful and hard to handle compared to general nursing, whereas male mental health nurses emphasized the links with the custodialism of the job, which was represented as a symbol of masculine authority (Simpson 2004: 360).

The nurses whom Simpson interviewed recognized that their minority status gave them advantages. Four key themes emerged from the interviews that she labelled:

- the career effect
- the assumed authority effect
- the special consideration effect
- the zone of comfort effect

Many of the nurses believed that they had greater opportunities to move up the hierarchy and eventually into management (where as I noted earlier the ability to perform emotional labour becomes less significant). This career effect often operated through the special consideration effect when men were given opportunities to acquire skills and expertise that were not open to women nurses. Simpson (2004: 356) included a comment from one man that during his training:

> I always got first crack at 'does anyone want to go to the theatre to see this?', 'would someone like to accompany the doctors to do that?'

But others among her respondents argued that the assumptions that men would prefer to move rapidly into management were not necessarily helpful. This man was uncomfortable with assumptions by his (female) colleagues that he wanted quick promotion. He reports staff nurses saying to him:

> 'Oh, you won't stay at D [the lowest grade] for long, they never do, the men.' And I am thinking what's wrong with just being a normal nurse? Why should a man have to go up to management level? (Simpson 2004: 356)

The men who talked to Simpson also told her that they seemed subject to different and more relaxed rules and expectations, often able to get away

with mistakes or behaviour that would have earned a woman a reprimand. The assumed authority effect was also both an advantage and disadvantage. Men were assumed to be more senior but also more assertive and sometimes expected to speak out on behalf of their colleagues and patients in ways that women were not, or take on tasks that may be outside their expertise. Here's a newly qualified general nurse talking about this:

> They all seem to come to me rather than Tracy [a more experienced female colleague] and even Tracy will come to me and ask for advice when she is more than capable of knowing herself. But sometimes you are frightened that you're going to say the wrong thing all the time because I don't have the knowledge base. (Simpson 2004: 358)

Few of the men Simpson talked to reported feeling isolated or uncomfortable at work, even though they were greatly outnumbered by their female colleagues. Indeed, most of the male nurses reported feeling relaxed and at ease working with women. They appreciated their support and valued their assimilation into the 'realm of women' (p. 358). Simpson captures this in her concept of the 'comfort zone'. However, when men were asked to reflect on the popular images associated with their job, on how it fitted with their own identity and with dominant notions of masculinity, many of them reported strategies to try to overcome the sometimes evident incongruity between their own self-image and the feminized image of their job, including re-labelling the job in discussions with friends, recasting its main characteristics to emphasize more masculine components and distancing themselves from 'the female' and from women in the workplace. As Leidner (1993) found in her study of insurance agents, similar processes of emphasis allowed men to construct their work as congruent with their sense of masculinity. Thus a nurse who had worked with drug addicts, for example, emphasized the danger of the work that took place in 'a sort of rough and ready area ... around quite tough issues', as well as his own masculine appearance: 'I'm tall and big and unshaven and got a big scar on my face' (p. 359).

Several nurses reported anxiety generated in discussions with friends and acquaintances about their work:

> Men ... they laugh and say 'oh, you're a man for goodness sake, why have you chosen to do nursing? Why can't you be a doctor?' (Simpson 2004: 361)

But not all men want to enter traditionally masculine-coded occupations, nor as Simpson concludes did all the men that she interviewed working in female-dominated occupations want to adopt conventional masculine attributes and career aspirations. What emerged from her work are the sets of contradictions and paradoxes that faced these men as well as the variations

between them. While some of them valued the opportunities to get ahead, others preferred to resist the associations between masculinity, authority and ambition. Nevertheless, it seems clear that for men there is greater freedom and more opportunities in non-traditional occupations than there is for women in a similar position in male-dominated jobs. As Simpson (2004: 363) notes, 'the positive cultural evaluation given to male attributes in society [is] reflected in the rewards that accordingly accrue' to men in non-traditional work.

Gender, Ethnicity and Race in a Care Home

A more personal and in-depth study of the position of a man in a female-dominated occupation is found in a moving study of an elder care home in Chicago by Tim Diamond (1992). His book *Making Gray Gold* is based on 18 months he spent training and then working as a nursing assistant. It is not only revealing about the ways in which gender identities are constructed through work, but also on the interconnections between gender and ethnicity in intimate and caring work in a private 'home' in Chicago.

Diamond is a sociologist who in the 1980s, as he was teaching and writing about medical sociology and the expansion of employment in the care sector, realized how little he knew about what life and work in care homes actually involved. After taking a part-time course, he worked for between three and four months at three different nursing homes. Committed to the methodology of participant observation, Diamond became an employee, doing exactly the same work as the other nursing assistants. As he started his research, he also read feminist literatures, especially about methodologies, believing that 'as a white man who wanted to work in this field, it might be valuable for me to experience some of the work that is done largely by women' (p. 6). His key theoretical influence was the US sociologist Dorothy Smith (1987, 1990, 1991), who argued powerfully for a method of practical research based on a focus on everyday work-tasks in the labour market as a way to build insights into how organizations and the wider society work. Diamond, after Smith, defines his work as an institutional ethnography which focuses on the actual daily social relations between individuals, rather than analysing the framework of texts, regulations and instructions within which care assistants must perform their work. As he notes, 'this standpoint is rendered invisible by the way most administrative and professional documents and texts are constructed' (Diamond 1992: 6). His aim was to make the invisible visible, showing the disjunctures that exist between teaching texts and training manuals and the nature of the work that care assistants undertake. Through his participation in the daily work in the institutions, he showed how what were defined as straightforward, routine

manual tasks involved a great deal of caring emotional work by the low-paid and low-status workers, as well as the development of strong bonds between workers and the people they looked after.

While Diamond's approach is certainly ethnographic, because he is a white, middle-class man working in a position typically filled in Chicago by working-class women of colour, his study cannot be classified as an analytical auto-ethnography as defined by Anderson (2006). Diamond's outsider status – his skin colour, class and gender – meant that he could never become a complete member of the group that he was studying. Indeed, suspicion about his motives brought one job interview to an abrupt end with the question: 'Now why would a white guy want to work for these kinds of wages?' (Diamond 1992: 9), as Diamond was shown to the door. Right from the start, Diamond's gender was an issue – he was one of only two men on the training course, and because he was so out of place he was never able to benefit from the beneficial effects that Simpson (2004) identified for male nurses. Unlike nursing, being a nursing assistant in a care home was not constructed as a career and there was little opportunity for promotion, unless care workers trained as registered nurses. The work itself was also constructed as depending on essentialized feminine traits, despite the emphasis on acquiring specialist knowledge in the initial training course. As one of Diamond's co-students noted, 'What this work is going to take is a lot of mother's wit' (Diamond 1992: 17), by which she meant maternal feelings and skills. One of the class instructors defined it as 'a certain kind of just being there' (p. 18). But, as became clear to Diamond, just being there depended on maternal experience: an advantage that he just did not have. Here, Erma Douglas, a nursing assistant, is advising Diamond on washing people:

> I never wash the head when it's cold, and most times don't put soap on the face at all – it always gets in their eyes or mouth. She stared at me after this instruction, surprised that I did not already know this. 'You ain't had no babies, have you?' (Diamond 1992: 19)

Race, ethnicity and skin colour was a constant issue in the nursing homes where Diamond worked. The staff members were mostly people of colour, the residents in the main white. As Diamond explains:

> During the course of the research I worked with women, and a few men, from Haiti, the West Indies, Jamaica, Ghana, Nigeria, Mexico, Puerto Rico, India, South Korea, China and many from the Philippines. Never before, or since, have I been so acutely self-conscious of being a white American man. (Diamond 1992: 39)

In the early stages of his work, Diamond felt uneasy. The residents stared at him and often commented on his maleness, saying they reminded him of a

nephew or a son, sometimes a doctor, but as time passed he realized that it was because he was atypical and so stood out as different: 'except for the few male residents and the occasional visitor, I was the only white man many would see from one end of the month to the next' (p. 39).

Some of the elderly residents, on occasion, exhibited racist attitudes. During the training, students were warned that 'patients have to be one size and one colour. Even if they tell you they want a white nurse instead of a black one, you have to swallow your pride and keep going' (p. 24). The course instructors were professional nurses and were predominantly white; the students non-white and despite the veneer of professionalism that overlay the teaching, it was clear to the trainees that they 'were not being trained to be professional nurses; we were being prepared for a different and lower stratum, in which most of our colleagues were non-white' (p. 28) – that sub-society identified by Bates (1993). A question about the function of the skin gave rise to a difficult moment in Diamond's group during the training period. When the correct answer emerged – to protect the body – the murmurings ceased but as Diamond noted, its role in constructing divisions of labour in the healthcare industry might have been addressed too (Diamond 1992: 30). And interestingly, and sadly, Diamond also noted that caring – as an emotional experience – was never mentioned either. The course was based on issues of germs and disease – the mind-body divide was at its centre and the body work part of caring, rather than emotional work, was the focus.

Nursing assistants made up three-quarters of the workforce at the homes were Diamond worked. Their work was hard, hours were long, their status and pay rates low. Many women had to meet rents that were up to half their take-home pay, and for women supporting dependent children, their wages typically fell below the official poverty line even though they were in full-time employment. Some of them did double shifts, or took a second caring job, often in a private home, to make ends meet, as Diamond discovered through casual talk at work:

> A Filipino man remarked as we passed out trays together that this place had more hustle than the other place where he worked, on the evening shift. And then he turned to me to inquire 'where else do you work?'...
>
> Two days later I was having lunch with Solange Ferier from Haiti. 'You know, I have done this job for six years in my country. There's one thing I learned when I came to the United States. Here you can't make it on just one job.' She tilted her head, looked at me curiously, then asked, 'You know, Tim, there's just one thing I don't understand about you. How do you make it on just one job?'
>
> 'Oh, ah ... I ... ah ... do a little teaching and tutoring when I get the chance' was my fumbling response. (Diamond 1992: 47)

The stories that Diamond tells in his book are moving and provide an extremely insightful account of the working conditions in nursing homes.

Yet, as I read the book, an underlying current of anxiety troubled me. Did he/should he tell his co-workers that he was an academic doing research for a book? Is it ethical to do covert research? The question clearly troubled Diamond himself and he directly addresses it in the introduction (p. 8). But even here his answer is not clear, as he reports that he told some people – his co-trainees for example and some of his co-workers, even a number of residents – but he also notes that 'as the study proceeded it was forced increasingly to become a piece of undercover research' (p. 8). The relationship between him and his co-workers and patients would have become different and presumably more problematic if they had not believed that he actually was, and so responded to him as, a care worker.

One of the key themes in Diamond's study is the contradiction between the ways in which care work is organized as a discrete series of tasks and the needs of the residents for more holistic caring that meets their emotional as well as physical requirements. The work is typically divided into a series of timed tasks – waking people, making beds, serving breakfast whether or not the residents wanted it then – leaving little room for personalized care. The timed daily schedules of tasks also excluded the less easily quantifiable parts of caring work, as Diamond explains here:

> The official tasks were difficult, sometime unpleasant and took some skill. But there was also a host of unspoken, unnamed demands before, during and after the tasks that presented problems, both physical and emotional. If the orders from the rational plan had parcelled out the tasks into a time-motion calculus that made sense in the abstract, carrying out the orders continually came up against the unplanned, fluid and contingent nature of everyday caring. (Diamond 1992: 143)

Meeting unplanned needs took experience and Diamond found that when the nursing assistants with whom he worked described the nature of their jobs it was often in terms of gaining experience or skills in getting to know people, in anticipating their needs and desires and seldom in terms of acquiring technical skills. The assistants spoke with pride and dignity about meeting the needs of the elderly people in their care, but also were aware of the necessity of maintaining the balance of 'getting close enough but not too close' (p. 148). As one colleague told Diamond, 'When you walk out of the room, you've got to leave them there and move on to someone else. You have got to practise hallway amnesia' (p. 159). The training and the timed daily work schedules made Diamond realize that 'formally the nursing assistant's job had nothing to do with talking' to patients (p. 159): instead, the work was constructed as and measured through a series of specific tasks. 'The social and emotional work was distilled into measures of productivity, and a responsive job was made over into a prescribed set of tasks' (p. 166).

In Diamond's and Twigg's case studies, as well as in Menzies Lyth's earlier work, the contradictions between rational, bureaucratic forms of organization and the provision of care are clear. These contradictions have grown. In the new millennium, there is an increasing emphasis in care work in all its settings – whether in the home, in elder care facilities or nursing homes and hospitals – on a rational model of timed tasks. The consequent work speed-up has increased pressure on workers. In British hospitals, for example, the stress involved in nursing increased significantly in the last years of the twentieth century and into the new millennium. Ackroyd and Bolton (1999) looked at the workload in the provision of gynaecological services in an NHS hospital in the 1990s and showed that although control and surveillance of the nurses had not increased, the numbers of staff had declined as the inflow and outflow of patients increased. Thus, while nurses still had a degree of autonomy, their workloads and work effort had increased significantly. As most nurses – like the care workers Twigg and Diamond worked with – have a commitment to their patients' welfare, there was little resistance to the increased effort needed, but growing dissatisfaction with a perceived inability to provide a good service as nurses felt they had to rush through their allocated workload. Rationalization and reorganization might seem to increase efficiency in public hospitals and increase profits in private facilities, but often at a cost which is borne by nurses and other care workers as their commitment to the emotional work of caring is a key part of their ethical stance. And yet, because of the associations between emotions, love and caring, these forms of work are poorly paid and often low status. Care work is, in the main, undertaken by women, and in the USA, but increasingly in the UK, by a migrant workforce. As Diamond comments on the expanding workforce in nursing homes in the US:

> The labour foundation of this developing institution is made up of workers drawn not just from within the society. The Filipino nursing labour force, as the primary example, has become central to the infrastructure of health services. The United States depends upon the Philippines not just for military bases in the Pacific but for its health care personnel as well. (Diamond 1992: 187)

A Filipino nursing force is also a significant part of provision in Canada (Kelly and Moya 2006) and the UK, where they are joined by a diverse set of workers from a growing number of nations. Among nurses in the UK, Smith and MacKintosh (2007) have identified an emerging ethnic hierarchy in which women of colour are found in the lower ranks of the profession and in less prestigious areas of work. As in the less credentialized areas of care work discussed above, the construction of the qualified nursing labour force

in the UK is also dependent on foreign-born and/or foreign trained nurses. In the UK as a whole in 2003 about 3 per cent of all nurses were foreign trained, rising to 13 per cent in London (Ball and Pike 2004). In a survey of three inner London health trusts, the proportion of foreign-born nurses was found to be higher: 12–25 per cent (Buchan, Jobanputra and Gough 2004), drawn in order of significance from the Philippines, Australasia, India, Ghana and Nigeria. The nurses were concentrated in the basic levels – in grades D and E – and so had a lower average earning capacity than British-born nurses. These findings of an ethnic division of labour support the arguments in chapter 3 where I drew on Butler, Foucault, Ong and Bourdieu to show theoretically how hierarchies are constructed in the labour market on the basis of skin colour, ethnicity, class and gender. The embodied characteristics of potential workers, in combination with stereotypes about the suitability of differently endowed bodies held by employers, co-workers and the wider public, systematically disadvantage all those 'Others' who do not conform to hegemonic assumptions about the suitability of workers for embodied labour and care work.

Maintaining the Perfect Body

In the second part of this chapter, the focus shifts from elderly and sick bodies to an exploration of some of the jobs and occupations that are associated with bodily improvement, bodily adornment and beautification, including therapeutic massage, beauty parlours and hair salons and workers in gyms or as personal trainers. As Bryan Turner argued, the body is perhaps the last frontier in society over which the individual has (relative) control and so is a particular source of both anxiety and modification. One of the most significant ways in which bodies are modified is through surgery, where the change is permanent and often not reversible. I have chosen not to discuss cosmetic surgery here (there are several good discussions available, including Morgan 1994; Davis 1995, 2002; Gimlin 2002), but rather to focus on less radical forms of bodily modification, including diet, exercise and beautification. These modifications are based on active forms of self-modification in which individuals strive to conform to the regulatory norms that define the ideal body. This notion of a regulatory norm or ideal body parallels Judith Butler's arguments about compulsory heterosexuality introduced in chapter 3. Further, the bodily modifications desired are a clear example of Foucault's notion of disciplinary practices based on regulatory norms and capillary power. Foucault's analysis of disciplinary practices and forms of body power, what he termed the 'technologies of the self', is provocative and useful in analysing the different forms of self-disciplining body work. Many scholars have drawn on reinterpretations of Foucault's arguments

(see, for example, Bartky 1993; Bordo 1993; Monaghan 2002) to help think through the meaning of body work. Through self-discipline, then, individuals strive to produce a modified self. In many cases, as these modifications typically demand considerable will power, the disciplinary practices are mediated or overseen by a specialist – a therapist, a dietician or a trainer, whether in a gym or other specialist space or in the client's home.

The focus of the last part of this chapter is on these mediated relationships, as it is here that interactive body work is located. The client purchases the support, the example and the services of another to aid in the desired bodily transformation. Exercise in the specialist spaces of the gym is perhaps one of the clearest examples of such body work, as here both customers and clients engage in body work on *themselves*. The desired transformations are thus a product of the *joint work* of the service purchaser and the service provider. In a study of why people work out in gyms and health clubs, Nick Crossley (2006) draws on both Foucault and Bourdieu to provide a framework for thinking about body work to achieve self-improvement. However, he did not consider the labour process but only the views of clients. Bourdieu (1977, 1984) himself did not devote much attention to body work, although he briefly suggested that subjects, especially middle-aged women, 'invest' in their bodies, perform work with and on them, in the expectation of returns to their investment in, for example, improved career prospects and in the relationship 'market'. The more recent emphasis on health and fitness and on fighting the effects of ageing might be added, as well as expanding the analysis beyond middle-aged women.

In comparison to 'working out', in other forms of transformative body work, the transformation is not only less permanent but also less active as the body of the client is passive – in the hair salon or beauty parlour, for example. Here intimate work on the body involving touching, cleansing, plucking and pummelling occurs, but the body of the client is typically supine or passive and not actively involved in the body work. This second type of transformative body work is perhaps closer to the patient being operated on in a hospital or the dead body in the funeral parlour being prepared to be viewed after death. In all cases the same sorts of issues about bodily boundaries, intimacy, privacy, touch and sexuality, odours, smells, disgust and visceral emotions that were explored in the earlier part of the chapter are also part of the social construction of the work of adornment and bodily modification and part of the interactive exchange between workers and clients.

The case study that completes this chapter is an example of passive body work: the working practices of beauty therapists. Here, men are out of place, especially if these workplaces are compared to working in gyms. Beauty therapy is yet another example of a feminized occupation. Not all self-improvement work, of course, is so feminized. Working as a trainer in a gym, for example, is a less gendered occupation and is open to interpretation as a gender-congruent

form of work by both men and women. Think back to the work of Waquant that was introduced in chapter 6 and the masculinity of heavy, sweaty training as part of 'body-building' in a gym is clear, whereas a different set of associations with the female body, with supple and slender femininity produced by a 'work-out' in a health club, with aesthetics, as much as fitness, also allows the construction of this work as feminized. But in the close, confined and perfumed spaces of beauty parlours, as I explore below, men are redundant.

Working in Beauty Parlours: Physical and Emotional Work

There is a wide range of work under the general heading of beauty 'therapy', from hairdressing through massage to alternative or complementary treatments with parallels to medicine, where a degree of professionalization and regulation is now becoming more common. Osteopaths and chiropractors have official recognition in the UK and so are regulated; homeopaths, reflexologists, acupuncturists and herbalists are not, but draw on a professional rhetoric, whereas beauty therapists merge into the more purely decorative end of beauty treatments. Here I draw on the work of Paula Black and Ursula Sharma (2001), who interviewed eight beauty therapists employed by a department of a local college in a northern city and seven experienced therapists and salon owners in this and another city in the same part of the UK. They also visited a limited number of salons as clients.

When Sharma and Black (2001) undertook their empirical work in the late 1990s, the beauty industry was expanding. At the time there were over 7,000 outlets providing beauty therapies, employing 10,440 therapists (Beauty Industry Survey 1999). The workers were almost all women and their clientele was also predominantly female. Not unexpectedly, the rates of pay are generally low, just above the national minimum wage. Most salons were small and had only a few employees, but increasingly they are located within other spaces – department stores, hotels and health clubs, for example. There is also a movement to provide beauty treatments within hospitals to boost the spirits of long-term patients as well as to advise patients with disfiguring conditions.

The range of 'treatments' offered straddles the impermanent to the more permanent, involving varying degrees of technical competence. Sharma and Black (2001) list, for example, makeup and nail extensions as impermanent and eyebrow shaping/tinting, hair removal by electrolysis or waxing and slimming treatments as more permanent procedures. Therapists also increasingly practise what they term 'healing modalities such as aromatherapy, reflexology, massage of various kinds and occasionally Reiki (complementary therapies which claim to increase well-being and relieve stress rather than cure particular ailments)' (Sharma and Black 2001: 915). In this sense then, their work is more than merely cosmetic. Rather, it overlaps with the medical profession. As a respondent explained:

> I would say that it does offer a very high therapeutic angle to it; it boosts people's confidence and self-esteem ... if somebody said years ago 'I am going to a beauty therapist's', you instantly thought beauty and vanity, the two go together. But these days there's more to salons, there's more emphasis on stress-related problems and that. (Black and Sharma 2001: 106)

In the interviews, the therapists talked about their work as playing a key part in making women feel better about themselves:

> You give them [a] feeling of well-being. I think they get that attention for that period of time which perhaps they don't get in other areas of their lives. (Sharma and Black 2001: 918)

Indeed, they emphasized this emotional part of their labours rather than the physical work of improving women's looks. They defined beauty therapy as work involved with feelings as well as with the body and insisted it was more than decoration. In part this emphasis was to counter the general public's view of beauty therapy as trivial or as akin to sex work:

> We all have to deal with the 'oh, they just paint nails and do massage – nudge, nudge, wink, wink!' Men tend to regard it smuttily and women ... tend to think we are all brainless bimbos. (Sharma and Black 2001: 917)

One of the ways to counter these stereotypes is to emphasize the associations with medical treatments by, for example, presenting a clinical appearance through wearing clean white overalls which de-emphasizes the worker's sexuality and emphasizes her professionalism. Therapists also explained that they took care when taking on male clients, especially for treatments such as waxing body hair. The growing male market for such treatments has made the need to de-sexualize therapists' appearance and persona even more significant.

The therapists defined the work they did as pampering, treating and grooming, but also emphasized that all three sets of tasks demanded an emotional involvement and relationship with each client as an individual. The therapist uses her personality and style to build up an individualized relationship with each of her clients. As one women explained, 'you get clients who are sort of *your* clients' (Sharm and Black 2001: 919). Therapists build these connections by gauging the mood of their clients, whether they want to talk during a treatment, for example. They must also learn to manage their own

emotions and to steer clear of controversial topics. One therapist explained the informal set of rules that operated in her salon:

> We have, like, these rules. You don't talk about religion, you don't talk about sex, you don't talk about politics; you have got to know your key things you do not discuss. But then you have still got to be quite relaxed with that client ... you've got to show you're a human being as well, and if they want to talk about anything then, you know, you are there to listen. (Sharma and Black 2001: 920)

Beauty therapists, like the nurses and care workers already discussed, also have to deal with intimate contact with clients' bodies. They have to negotiate a contested relationship in which the clients may feel awkward and embarrassed that they do not match the norms of feminine beauty promoted in the salon and more widely. Workers, too, have to cope with their own feelings of distaste or revulsion. They may have to disguise feelings of boredom or distaste as well as ensure they do not burden clients with their own emotional issues, but the performance of emotional labour is not necessarily a sham. Their professionalism 'may demand self-control and deference to a client's mood and wishes' (p. 921), but a degree of reciprocity is developed with some clients. The close, personal and repeated interaction enables a different sort of relationship to be established than, for example, the more ephemeral relationships that occur between the workers in fast food outlets and their customers that are the subject of chapter 8. In this way, the work of beauty therapists is more similar to that of the care workers, as both groups find pleasure and job satisfaction in establishing emotional ties with their clients. Sharma and Black emphasized this sense of satisfaction reported by many therapists, contrasting their attitude with those of the airline workers interviewed by Hochschild (1983). She found high levels of dissatisfaction among these workers, in part explained by close monitoring of their bodily performance. Both the domiciliary care workers and the beauty therapists, especially those working in small salons, had a greater degree of independence in their workplaces.

Beauty therapy is an exceptionally gendered occupation that takes place in a set of spaces also associated with women. It not only relies on feminine attributes such as tact, sensitivity and compassion, but it also works on the female body and its adornment. Although as I have noted, workers present a non-sexualized appearance, they must also conform to acceptable versions of heterosexual attractiveness, wearing visible make up, for example, and having a neat but flattering hairstyle. They must continually work on their own bodies, as well as those of their clients, to meet these expectations. Men's entry to this predominantly female world raises similar questions about how to fit into or challenge the sets of associations between this type

of work and femininity, as in the case of nursing explored earlier. While there is scope for men to redefine various aspects of the therapeutic role as congruent with masculinity, through links with psychoanalysis or other branches of medicine, for example, it is less obvious how they might reconstruct some of the more intimate body work tasks like plucking and dyeing bodily hair unless, like male care workers, they are restricted to practising body work on other men. The classic example is the barber's shop, where men cut other men's hair in an atmosphere and space that is typically more redolent of utilitarianism than pampering. For some years, my own partner had his hair cut at a barber's that advertised itself as 'Mick's: no waiting'. This seems to me to sum up the difference between (most) men and (most) women's attitudes towards bodily adornment. Whenever I visit 'health clubs' in hotels, I look, usually in vain, for male beauty therapists but see only men as personal trainers, men working in the gym, men as life guards by pools and men as bar staff in the leisure spaces.

Men are out of place in the perfumed worlds of pampering, treatment and grooming described by Black and Sharma, just as Diamond was in the predominantly female worlds of Chicago nursing homes. Beauty parlours are an even more extreme example of a feminized world than care homes, in which the joint endeavours of the female worker and female customers reproduce as near as is possible an idealized image of hegemonic femininity.

In the next chapter, I continue this theme of men as out of place in an exploration of the ways in which young working-class men's sense of themselves as masculine disadvantages them in other types of low tech consumer service sector occupations: in hospitality and retail jobs that are often the only types of work easily available to young men with few skills and credentials. In these jobs the interactive aspects of service work are more significant than the body work analysed here, although workers' own embodied performances are once again a key part of the employment contract and the service exchange.

Plate 5 Learning to mop: the acquisition of 'feminine' skills in a diner. Photo © Plush Studios/Getty Images.

8

Warm Bodies: Doing Deference in Routine Interactive Work

It is humbling, this business of applying for low-wage jobs, consisting as it does of offering yourself – your energy, your smile, your real or faked lifetime experience – to a series of people for whom this is just not a very interesting package.

Barbara Ehrenreich, *Nickel and Dimed*, 2001

Most of the forms of body work discussed so far have included the intimate touching of the bodies of others, involving pleasure and pain, as well as various acts of caring for the bodies of others. While not necessarily including touch, interactive service exchanges with physically present clients are also an expanding part of the consumer economy. Here the physical production of a particular appearance and the deferential performance of an often-scripted exchange are an essential part of embodied social relations and the construction of identity in the workplace. In retail sales, in leisure industries and in hospitality, both employers and customers have expectations of appropriate forms of servicing their needs by bodies that are present during the exchange. A range of expectations of and attitudes about 'good service' by appropriately embodied workers thus affects recruitment and employment practices. Customers' expectations and evaluations of the service provision influence their propensity to return and repurchase the service and so materially affect profit levels. As these types of services typically are used up in the exchange, there is an almost infinite possibility for reprovision if the service is deemed acceptable.

In many forms of interactive service exchanges, the heterosexual matrix, defined by Butler, operates to associate deference, servility and an appropriate degree of 'invisibility' (that is, servicing without being noticed) with differently raced, classed and gendered bodies. As I explore here, masculinity is often, if not inevitably, a disadvantage in interactive service employment at the bottom end of the labour market. Hegemonic versions of masculinity typically are associated with dominance and action, 'in your face' presence, rather than