LEARNING TO BE:
THE TRAINING AND EDUCATION INDUSTRY FOR ALLIED HEALTH CARE WORKERS IN NEW YORK CITY

by

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Abstract

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by

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In this dissertation, I examine the significance of a multimillion-dollar training and education industry for allied health care workers, which emerged in New York City during the mid-1990s. Based on an analysis of in-depth interviews and fieldwork with health care workers and trainers, I argue that the industry's reach and tenacity cannot be solely, or even largely, attributed to its production of appropriately qualified workers, whether in terms of skills, credentials, or attitudes and ideology. In fact, the industry is indifferent, in important ways, to such instrumental outcomes, and I show its most salient feature is its participation in an affective register, a register of engagement and emotional energy that is distinct from skills, ideology, and specific emotions. This finding is the basis for a discussion of how affect articulates with extant notions of economy and value in sociology and its importance for understanding emergent forms of work, education and inequality. Major features of this training and education industry that I analyze include: the role of state and federal financing; the importance of joint labor-management training initiatives and the promise of mobility to contemporary labor unions (in this case 1199

SEIU); the problematic emphasis on "soft skills" and customer service training; and the impact of training opportunities on the career "choices" of health care workers and their patterns of engagement with education. I have documented an industry in which education is largely a benefit of paid employment, not a social right, and conclude by discussing how the training and education industry for allied health care workers may be indicative of larger trends, as learning becomes a lifelong, privatized endeavor.

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I have been fortunate to study and work with three faculty members for whom I feel both intellectual and personal respect. Patricia Clough, professor and director of the Center for the Study of Women and Society, has influenced me in not very subtle ways: she has shared with me her writing and reading, coached me through bureaucratic hurdles, and encouraged me to think faster and freer. Many of the concepts in this dissertation have been worked over and discussed by a group of graduate students at the City University of New York inspired by Patricia. She has created for many of us a powerful space for experimentation and creativity.

Stanley Aronowitz, distinguished professor and director of the Center for the Study of Culture, Technology, and Work, hired me as a research fellow my first year of graduate school and made it possible for me to pay for food and shelter while doing research and intellectual work—indeed, he has given me the most important gift, that of time. He is the reason I attended the Graduate Center, an institution at which I have met the most extraordinary, gifted, committed, and politically engaged people.

After taking one of her courses, Barbara Katz Rothman, professor, asked me to write an overview of the ethical perspectives for a report on reproductive technologies to the Ford Foundation. Since then she has been a mentor and is now a friend. I deeply admire the way she has positioned herself in the academy and in life, offering a clear, canny and compassionate presence in an overwrought profession. To her I owe a good deal of my sanity.

I am also indebted to the late Robert Alford, who embodied, in his classes and in his written responses to the work of students, unbounded generosity. Thank you to Michelle Fine and Colette Daiute, the co-PIs of the Spencer Foundation Social Justice and Social Development in Education Studies Training Grant at the Graduate Center, of which I was a recipient. Thanks are also due to Elin Waring, who was an informal advisor when I was a teaching fellow and writing fellow at Lehman College.

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I was exposed to the ethnographic eye early in my life, from my father, Michael, an innate sociologist and incessant observer of the world. My sisters Aimee Ducey and Jeni Houser, mother Emily Osborn, and second father, David Houser, have always given me advice and encouragement, even when I was too stubborn to listen. Finally, I am fortunate to have had the support and love of my husband, Ty Eggenberger, during the long haul of graduate school. Together we explored New York City on the subway and the Hudson Valley on our motorcycles; he is my connection to honesty and absurdity, and a second pair of eyes. Without his flawless intuition, I would not have Rita in my life, who enabled me to finish.

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CHAPTER 1: INTRODUCTION

It is almost impossible to overstate the importance of the health care industry to the local and regional economies of New York City. In 2002, approximately 12% of New York City's workforce was employed in health care, or nearly one out of every 8 workers (Center for Health Workforce Studies 2002, pg. v). According to a Fiscal Policy Institute analysis (2002), in 2000 the health care industry employed approximately 375,000 people, making it the city's number one sector in terms of employment and the number one sector in all boroughs except Manhattan (Bronx, Queens, Brooklyn, and Staten Island). Business services briefly surpassed health care in employment numbers in 2000, but downsizing and instability in that sector revealed health care to be the long-term anchor of the city's economy. Employment in the health care industry grew by 14.1% from 1990 to 2000 and is projected to continue to grow, making it a buffer against more volatile industries. In fact, the Northeast corridor stretching from Baltimore to Boston has become the "nation's health epicenter," adding 50,000 jobs between 2000 and 2002, while all other industries combined shed 220,0000 (Leonhardt 2002).

More importantly, this industry provides jobs and stability to a sector of the labor force that is normally most vulnerable to the vicissitudes of the economy and employers. According to 1998 data, 128,000 of the 375,00 health care jobs in New York City are open to people with an associate's degrees or less. These workers are members of the sub-baccalaureate labor market—"individuals who have at least a high school diploma but not a baccalaureate degree, individuals who may or may not have some college

education" (Grubb 1996, pg. 2). In 1996, just over 27% of the labor force had more than a high school diploma but less than a baccalaureate degree and just over 32% had a high school diploma (Grubb 2002)—nearly three-fifths of all workers in the United States are in the sub-baccalaureate labor market. One of the largest—perhaps the largest—employers of sub-baccalaureate workers in New York City is health care. Data collected by the Fiscal Policy Institute shows that black females are the single largest segment of employees (at 28% of the workforce), followed by white females (25%), in health organizations employing over 100 workers.

The health care sector in New York City is also one of the major strongholds of unionism in the United States. 1199 Service Employees International Union (SEIU) represents over 237,000 health care workers in New York State, primarily allied health care workers in the city's voluntary hospital sector. District Council 37—affiliated with the American Federation of State, County and Municipal Employees (AFSCME)—represents over 10,000 allied health care workers in the city's public hospital system, the Health and Hospitals Corporation (HHC). Many smaller unions represent pockets of health care workers in the nursing home and growing home care sectors, some of which have merged with 1199 SEIU in recent years. Unionism has guaranteed wage levels above the national average in an industry—it is not be a stretch to say—that supports the core of immigrant and minority workers, and their families, in New York City.

This dissertation documents the lives of a segment of these workers. It describes how these workers get into health care and how they navigate the complex labor market of allied health care occupations. But above all, it analyzes one particular industry at the intersection of health care and education: the training and education industry for allied

health care workers. This industry knits together health care organizations, unions, educational institutions, and the state. The core of this dissertation describes how health care workers—largely women of color and immigrants—access and negotiate educational opportunities; how trainers and educators conduct and legitimize their work; and the kinds of skills that are valued and taught in this industry. I argue that this industry specializes in, and creates a demand for, products like motivation and affect—products for which need may never be satiated. This industry is not necessarily an instrumental or rational education system devoted to preparation for work. In fact, it is frequently indifferent to distinctions between education and training, skills and attitude, or technical work and emotional labor.

♦

This plan of this dissertation does not conform to a traditional mold (though it is far from experimental). I have for instance, opted not to write a single, sustained literature review, and have integrated my perspective on the work of other scholars in the chapters where it seemed most germane to the evidence. This dissertation draws upon quite diverse strands of sociology—including the sociology of work and occupations, labor, education, emotions and emotional labor, as well as economic sociology, science and technology studies, political economy, and contemporary Marxist social theory. It is anchored by a case, an industry, which could be analyzed with any number of theories and concepts; I have selected those concepts which seemed both to elicit something

important from the evidence and to draw new connections to and from an increasingly fragmented and specialized discipline.

Most of the evidence in the dissertation is drawn from in-depth, face-to-face interviews. I conducted 44 in-depth interviews, 23 with allied health care workers who were enrolled in training and education programs, and 21 with educators, trainers, and workforce planners. I also observed on-the-job training seminars in soft skills in several settings (see Chapter 7). This dissertation is informed by my prior fieldwork in health care facilities, principally carried out as a researcher on two projects funded by the 1199/League Training and Upgrading Fund (TUF)—indeed, it was my conversations with health care workers in the field that first drew my attention to the prevalence and complexity of training and education in health care, and its particular importance in New York City. The conversations convinced me that in-depth interviews would be necessary to capture the full range of "learning experiences" that an allied health care worker might encounter.

By "allied" health care workers, I am referring to people in the "sub-baccalaureate" labor market—that is health care workers whose jobs require at least a high school degree and probably some sort of postsecondary training, credential or degree, but not a baccalaureate degree. At least one-third of those working in health care in New York City are employed at this level. In general this is a segment of the labor market for which there isn't enough quantitative data—on the training and educational institutions or the students. Some of the occupations that the people I interviewed held or were in training for included: nuclear medicine technologists, licensed practical nurses, certified nursing assistants, respiratory therapists, and registrars or unit clerks (see Tables

I and II in the appendix). Most of the workers I interviewed were women, about half were black or Hispanic and many were immigrants. This reflects the demographics of workers in allied health care in New York City.

The trainers and administrators I interviewed were part of a network of power brokers in this industry, and they represented a variety of important institutional actors: hospitals, unions, universities or colleges, and proprietary and for-profit training entities (see Table III in the appendix). I recruited the trainers and administrators through existing contacts and referrals to one another—this is a true network of people, most of whom have known each other for a long time and some of whom have held positions at several organizations central to the training and education industry. While I by no means interviewed everyone in this network, I tried to interview people in a variety of positions and organizations. I also interviewed some people off-the-record and informally, especially during the exploratory phases of the research.

I recruited the health care worker respondents in several ways. I started by sending out a letter and postage-paid response card to a random sample of participants in the 1199 TUF "professional training programs." This resulted in only a handful of respondents. I also recruited respondents through training programs, referrals by other health care workers, and through my contacts at several hospitals who distributed flyers on my research. I make no claims to having interviewed a representative "sample." I did, however, attempt to interview workers in a variety of occupations and from varying backgrounds. The participants mostly work in hospitals, though many began their health care careers in other settings. Their participation was voluntary and confidential. The interviews lasted from one to two hours, and though I did not pay the respondents for

participating I usually tried to buy or bring them coffee or lunch (they invariably refused—one fellow even bought *me* coffee).

The identities of the health care workers interviewed for this study have been disguised in two ways—I refer to each worker by a first-name pseudonym and in sections of the dissertation where I describe specific workers' occupations and educational backgrounds, I have used a pseudonym for the hospital or health care facility at which they worked. These hospital pseudonyms are used consistently, so the reader can tell, for example, that some workers I interviewed are employed by the same hospital. In Chapter 2, where I present background on the politics and financing of the industry, I use the actual names of hospitals and health care organizations. Throughout the dissertation I use the actual names of schools and educational entities, even when describing the health care workers, because I believe so many students pass through these schools that the identity of workers I interviewed will not be compromised, and because I believe naming these institutions is important for future researchers who may want to extend or draw upon this research.

I do not refer to the trainers and administrators I have interviewed by name, and I have in some cases slightly altered their job titles to obscure their identity, but I do at times refer to the organizations for which they work by name. Many industry insiders will therefore be able to identify themselves and their colleagues in this study. I decided it was not necessary to identify the trainers and administrators by name because—as I will argue in sociological fashion—this industry as a whole exhibits tendencies and has effects which are more and other than the aggregation of individual decisions. These effects are sometimes even just beyond articulation and even beyond measurement.

Therefore, though I rely on in-depth interviews, this is not a story of individual people or powerful agents—it is the story of an industry and its tendencies and patterns.

I have, in general, integrated questions of method into my analysis. For instance, I have commented at several points on limitations to my analyses due to how I recruited respondents. But above all, I have reflected upon and tried to build into my analysis an awareness of the methodological implications of conducting in-depth interviews. I constructed my interview guide so as to avoid leading questions as much as possible and to ensure consistency across the interviews, but the interviews were conversations more than they were surveys. I have tried to treat the interviews not as statements of fact, but as "vocabularies of motive"[1]—situation-specific and culturally-embedded conversations in which the respondent and I co-produced narrative and understanding.

The interviews served several purposes: to document the occupational and educational histories of workers and trainers, explore how they understood and felt about their experiences, and discuss the history and workings of the training and education industry for allied health care workers. There is some continuity between the two groups I interviewed: at least seven of trainers and administrators started their careers as health care providers and they were able to reflect on their own experiences building a career in the health industry and their personal experiences with various kinds of training and education. I coded the interviews using an old-fashioned, but effective, paper-based system of reading the interviews, marking sections according to themes, and then clipping and sorting those themes (see Lofland and Lofland 1984). I also regularly re-

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[1] The phrase is C. Wright Mills' (1940). It has been frequently invoked in qualitative research, but Anita Garey's (1999) fine book, based on in-depth interviews with a group of women health care workers on the dynamics of work and mothering, embodies the idea particularly well.

read entire interviews during the coding and writing phases, in order to better place particular quotes in the context of the entire set of interviews as well as within the particular history of the person being quoted.

This dissertation is about an industry and about a tendency and about tracing theory (not testing it)—more than it is about specific people. I have done this in part as an attempt to break with the strong sociological tendency to write about working class people and people of color in a way that exoticizes "them" or reaffirms arbitrary boundaries of who "they" are—even in cases where the sociologist is oriented toward social action and social justice. These are workers and respondents who can and do speak for themselves—they do not need me to do so. I believe my analysis reflects my still evolving efforts to assimilate what has been called a "relational" approach to sociology, which "sees relations between terms or units as preeminently dynamic in nature, as unfolding, ongoing processes rather than as static ties among inert substances" (Emirbayer 1997, pg. 289). The intellectual roots of such an approach are beyond the scope of this introduction; applying such an approach in my analysis has been, in any case, a more effective way of embodying it than just describing it. As the sign on the desk of one of the trainers I interviewed read: "tell me, I will forget; show me, I may remember; involve me, and I will understand."

♦

In Chapter 2, I describe how training and education for health care workers in New York City has exploded into a multi-million dollar industry since the mid-1990s. I also describe the types of training (multiskilling, upgrading, on the job training,

education) and "vendors" that are encompassed by this industry and explain why I have chosen to focus my analysis on the industry as a whole. Chapters 3 though 7 are substantive chapters in which I present and analyze my interviews with participants in the training and education industry.

In Chapter 3 I argue that the growth and tenacity of this training industry cannot be wholly attributed to its supposed production of appropriately qualified workers. Though trainers and educators frequently "pitch" their training programs in instrumental terms—as a response to business "needs" and a "skills gap"—much evidence calls into question the existence of skills gaps; in truth such a pitch for training is only partially related to what is actually happening in training and in worksites. The discourse of commodification in both health care and education shows the extent to which a market for training and education has to be created; the question is, for what is it a market?

The patterns in which health care workers engage with training and education, described in Chapter 4, support the thesis that training and education industry has drifted away from traditional ends like skills, knowledge, and credentials; several trainers and educators I interviewed talk about how training is a vehicle for nurturance, coping, and—not least—keeping people in their jobs for a longer period of time. In this chapter, I propose that the value of training may lie in its modulation of affect—the will to act and to engage. I also describe in preliminary form how affect is different than emotions and emotional labor.

In Chapter 5, I address the question of why training for health care workers might focus on engagement when health care work and caregiving work are so often understood as inherently rewarding and meaningful. This chapter discusses why and how the health

care workers I interviewed got into health care, and whether there was any correspondence between an articulated desire to care for others and their occupational history. I argue that warnings about either a "loss of meaning" or a reduction in amounts and quality of care too readily make "marketization" the scapegoat or fail to address basic problems in how health care work and the health care system are organized (if organized is the best word).

Chapter 6 is the first place I analyze the interviews for markers of what I call an affective register—moments when respondents talked about satisfaction, engagement, growth, meaning, learning, transformation; a compulsion to move forward, to transform and expand. These are the "rewards of small change" experienced by both trainers and students/workers. I suggest that the compulsion to move forward is immanent to the training and education industry; health care workers may not so much choose to engage as step into the circuits of an affect economy. The question this chapter opens, however, is whether this training and education industry is "functional"—whether it is an advanced system of control and maintaining social order, a manufacturer of the motivation to work.

By examining "soft skills" training in chapter 7, I conclude that there is a certain indifference in this training to consistent ideological messages; messages which would otherwise be evidence of the industry's role as a mechanism of control. Indeed, because this training is indifferent to individual emotions and subjectivity, it introduces an element of arbitrariness and unpredictability that may not prove to be functional (to capital, to employers). As I conceive of it, this training intervenes at a different ontological register than subjectivity, emotions, and ideology.

Chapter 8 is a largely theoretical window into how affect, and the training and education industry's intervention at the level of affect, articulates with extant notions of economy and value in both contemporary economic sociology and influential strands of contemporary Marxist political economy. I pay particular attention to the work of Randall Collins, who I believe models a theoretical space in which the logic of capitalism can be questioned *and* the economics of affect made intelligible to conventional economics and sociology. This chapter suggests a way of answering, if not an answer, to two crucial questions: who benefits from this training? What are its political and normative implications?

Chapter 9 is a postscript. I return to the history of 1199 SEIU, and unionization in the health care sector, to discuss how training and education simultaneously sustain the promise of mobility while it more firmly entrenches occupational hierarchy, mystifies skills, and portrays workers as perpetually inadequate. I have documented an industry in which education is largely a benefit of paid employment, not a social right, and it may therefore be an indicator of things to come—as learning becomes a lifelong, privatized endeavor. What does it mean to engage in lifelong learning in an era of vanishing mobility?

The concept of affect, which animates this dissertation and opens up new ways of thinking about education and training, has of course a long but subordinate history in sociology. Recently, the concept has been pulled forward—pulled forward by what Patricia Clough would call thought's future (2000), by the necessity to rethink the disciplinary boundaries, hegemonic concepts, and calcified methods which do not allow

us to grasp all that is going wrong.[2] As I sat in a communication training skills seminar at a hospital in New York City several years ago, I thought—could it be that this is a good use of millions of dollars? Why this training, why there, why then? I have sympathy and respect for the health care workers and trainers I interviewed and observed for this dissertation—we are all carried along on whatever ride this is—but surely communication skills training was not the remedy the health care system required. A few months later, a Manhattan hospital employee suggested I put my recent hospital stay—for which I had no insurance—on a credit card at a low interest rate (14%), which they could provide. My reaction was something like "over my dead body" (it seemed to really capture what was at stake). I wonder how many people charged their hospital bills to a credit card after speaking with that nice woman from the billing department; I wonder if customer service training—which has been a major focus of this training industry—came in handy during those conversations.

[2] Patricia Clough (2000; 2002) first brought the concept of affect to my attention, along with an intellectual conversation and an introduction to many of the theorists I cite in this research. "Ideas that have any importance, any impact, do, after all, come in company, not as isolates, and the essayist is mostly a transcriber of ideas abroad in his networks" (Harrison White, quoted in Emirbayer 1997, pg. 282). While this may be a statement only a well-known, ivy-league, (and male), sociologist and not a doctoral candidate can afford to make, it sounds right to me.

CHAPTER 2: FINANCING AN INDUSTRY

> "We went from being a bodega to being Wal-Mart practically overnight."
>
> *— an 1199 Training and Upgrading Fund official on the recent flood of funds for training health care workers.*

Since 1996, 1199 SEIU has been a pivotal agent in the solicitation of hundreds of millions of dollars from state and federal government to finance the training of health care workers and subsidize the health care industry. These funds have created a veritable cottage industry in New York City of health care workforce specialists, with independent trainers and consultants, education institutions of all types, unions, and health care organizations all looking to benefit from the cash surplus. How did this come about?

The simplest explanation for the recent levels of investment in training for health care workers in New York State is one of political machinations. One 1199 official joked to me that archeologists had still not discovered the secret pipeline Robert Moses built from 1199 to Albany, New York's capital. Indeed, much of the journalistic coverage, liberal and conservative, of recent health care policy and legislation has criticized the determining role of closed-door, last-minute deals brokered by 1199 President Dennis Rivera and Governor George Pataki.

Rivera has been instrumental in wresting funds from the state and federal government to subsidize New York's health care industry (particularly New York City), including the wages of health care workers. Such funds underwrite the collective bargaining process between 1199 and health care facilities and have obviated the need

for militancy in contract negotiations since the mid-90s. 1199 was able to obtain a 13% pay raise for workers in a new contract with the League of Voluntary Hospitals in January 2002—a contract for which negotiations had been stalled since before September 11th, 2001—after Pataki and Rivera convinced the State legislature to dedicate 95% of the proceeds from the Empire Blue Cross conversion into a for-profit insurer to New York's state health care spending, including "worker retention" (Robbins 2002) . The conversion created nearly $1 billion in revenue, and Rivera consequently endorsed the Republican Pataki in his 2002 campaign for a third term in office. This deal angered critics: in most states where Blues plans had converted to for-profit status, proceeds had been used to form permanent foundations aimed at expanding health care coverage.

While securing subsidies for the health care sector and workers' wages, Rivera has also been able to earmark portions of various grants specifically for training and upgrading. In 1997, New York State received a waiver from the Health Care Financing Administration (then the federal administrators of Medicare and Medicaid, now known as the Centers for Medicare and Medicaid Services) to begin mandatory enrollment of 2.4 million Medicaid recipients into managed care plans (referred to as the "federal waiver"). In 1999, the state began to move approximately 1.2 million New York City Medicaid recipients into managed care plans. It was anticipated that "Medicaid Managed Care" would lead to a significant reorganization of the delivery of health care services in New York City, where costly emergency rooms and acute care services, particularly in public hospitals, had historically been the *de facto* site of primary care for Medicaid recipients

and the indigent and uninsured.[3] It was hoped that when applied to Medicaid recipients, managed care would reduce the use of expensive emergency services and necessitate the development and use of ambulatory clinics and other non-acute preventive health care services.

Working under the theory that this move would generate huge savings for the Medicaid program (a program funded jointly by the federal government and New York State), Dennis Rivera and Kenneth Raske, President of the Greater New York Hospital Association (GNYHA), convinced the federal government to allot $1.25 billion in aid over five years to New York hospitals to reorganize their operations in response to the influence of managed care (Berliner, Gibson, and Devine-Perez 2001; Pallarito 1997). This aid became known as the Community Health Care Conversion Demonstration Project (CHCCDP). 1199 lobbied for this money to go entirely to voluntary hospitals, but after facing considerable criticism, CHCCDP funds were also made available to the city's public hospital system, the Health and Hospitals Corporation (HHC) (Commission on the Public's Health System 2003). According to final terms of the deal, hospitals would be eligible for the aid only if 20% or more of their annual admissions were Medicaid, self-pay (uninsured) or indigent patients; the amount of aid was to be prorated according to the percent of admissions from these patients.

The funding formula meant that the majority of the money went to New York City, and not New York State, hospitals. In the first cycle of $250 million in grants, ninety-one hospitals in downstate counties were slated to receive grants and 5 hospitals,

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[3] Managed care is a form of health care financing and delivery which in principle emphasizes the use of preventive services and primary care physicians, and pays providers on a flat-fee basis rather than according to actual costs of treatment. See Starr (1982).

all in New York City, were slated to receive over $10 million apiece: public hospitals Bellevue, City Hospital at Elmhurst, Kings County Hospital, Lincoln Medical & Mental Health Center, and the voluntary hospital Bronx Lebanon (New York State 1999). The 11 HHC hospitals all received among the largest amounts—because they serve the greatest number of Medicaid, self-pay, and indigent patients. Among the 33 voluntary city hospitals receiving the largest amounts of funding were Interfaith Medical Center, the Brooklyn Hospital Center, Wyckoff Heights Medical Center, Beth Israel, New York Presbyterian, and St. Luke's Roosevelt.

In a city-wide agreement, Rivera was also able to ensure that 25% of the federal waiver grant money, about $300 million, would be used specifically for health care workforce training. The remaining 75% was to fund "infrastructure": the expansion of primary care services and managed care readiness. A hospital like Bronx Lebanon was therefore slated to receive about $2.6 million in the first funding cycle for training alone. In the case of voluntary hospitals, the training money was administered by 1199's Training and Upgrading Fund (TUF), a joint labor-management fund, which was then able to retain a portion of the grant monies for its administrative costs (Commission on the Public's Health System 2003, pg. 45). HHC centrally administered its training grant money, and unions representing public hospital workers, such as DC37, were among grant recipients.

The first cycle of CHCCDP money (originally meant to be the first year) was dispersed and spent over a period of two and a half years, so that in 2003, hospitals were just beginning to receive funds for cycles 2 and 3 (combined into one payment). Part of the delay was caused by the fact that hospitals could not spend the training dollars

quickly enough, though they rapidly spent the infrastructure funds. In late 2003, when at least a quarter of the total $1.25 billion had been drawn down, health care advocates asserted that there was too little oversight in the spending of this money and a lack of information about the impact of CHCCDP-funded programs. Groups like the Commission on the Public's Health System (CPHS) showed, based on limited data obtained from the state Department of Health under threat of a lawsuit, that a great deal of the infrastructure money was spent on information systems; advocates said it was unclear whether such systems improved primary care services (Commission on the Public's Health System 2003). HHC was more forthcoming with reports of how it used funding than 1199, perhaps because HHC had to fight to obtain a portion of the funds and, as a public system, has more established accountability standards.

At the time of this writing, hospitals have not submitted final reports from the first cycle which would indicate whether funded training programs met their goals and how their effectiveness was assessed. The funds appear to have had no associated evaluation requirements. The data obtained by CPHS showed that the greatest number of reported "training encounters" funded by CHCCDP were for customer-service related training. The first page of a 2003 internal 1199 Training and Upgrading Fund report indicated that the top program, in terms of number of institutions offering the program, was customer service (19 institutions). In chapter 7, I will discuss the nature of some of this customer service training based on observations and interviews. My own experience evaluating a communication skills training program (Aronowitz, Ducey, Gautney, and Wetzel 2001) would suggest that the impact of such training on the quality of primary care services and the readiness for managed care is minimal. Part of this research is to therefore examine

why customer service training would be so popular and how it relates to the nature of contemporary work and education.

As significant as the federal waiver/CHCCDP funds are, they are just the tip of the training iceberg in New York State. Under the State's 1996 Health Care Reform Act, $100 million was set aside for retraining health care workers. Dubbed the Health Workforce Retraining Initiative (HWRI), the program was publicly justified by the argument that increased competition in health care posed significant risks of lay-offs and restructuring, for which health care workers needed to be prepared (Benson 1997). It was expected that many hospitals would merge to increase their bargaining power with insurers, downsizing their workforce in the process. Most of the first installment of $22 million in HWRI grants went to New York City. The 1199 "Hospital Training Fund"—that is, 1199 TUF—received $7.3 million, the Consortium for Worker Education (CWE) received $2.2 million, and Health and Hospitals Corporation (HHC) received $3.6 million. All other grants were to individual health care facilities for amounts well under $100,000. An even greater proportion of the $28.1 million in grants made under HCRA 2000 went to 1199. The 1199 Planning and Placement Fund[4] received the lion's share at $12.6 million, while HHC received about $2 million, and CWE received $1.5 million.

[4] The Planning and Placement Fund and the Training and Upgrading Fund (TUF) are two of eight funds encompassed by the 1199 SEIU/League Employment, Training, and Job Security Program (ETJSP). ("League" refers to the League of Voluntary Hospitals, since it is a joint labor-management program.) Other funds in ETJSP include a training and job security program for 1199-represented registered nurses, and separate funds for workers in sectors whose unions recently merged with 1199—such as Local 144, which represented nursing home workers. Any of these funds might use money allotted to them for training programs, though in practice much of the training is coordinated by a small group of staff in the TUF. I refer throughout this dissertation to the 1199 TUF to denote my focus on ETJSP's training programs.

There have also been several other types of grants made available to health care workforce training programs. In 2001, the state provided $80 million dollars in health care workforce training grants to target individuals receiving Temporary Assistance to Needy Families (TANF), New York's welfare program. The 1199 Education, Training and Job Security Program (ETJSP)—which includes the Training and Upgrading Fund—received over $32 million of those grants (New York State 2001) and routed at least some of it to its fund for workers in home care where, among other initiatives, it started a program to assist immigrant workers who had been nurses in their home countries obtain their American nursing license.

In sum, then, the political process surrounding health care workforce training funds in New York State has meant those funds are largely, and to some illegitimately, used to subsidize New York City voluntary hospitals and 1199. CPHS was from the beginning vocally critical that CHCCDP funds were allotted only to hospitals and not clinics or community health agencies, particularly given the emphasis on primary care in managed care and the lack of such services in the many underserved communities of New York City. CPHS also argued that though HHC hospitals received significant funding in CHCCDP, these allocations were disproportionately small to the percentage of uninsured that public hospitals serve and did not reflect their true burden of caring for needy New Yorkers. This is particularly galling to public health advocates like CPHS since funds that other states have routinely used to increase health care coverage or public health programs are instead used in New York to subsidize hospitals. It has been reported that the governor has received permission from the federal government to allot another $350 million in CHCCDP (which will be cycles 6 and 7) funds to worker retraining and

"retention," as well as Graduate Medical Education (Commission on the Public's Health System 2003).

In the next section I will examine in greater detail the kinds of training that these funds have supported as well as the network of educational institutions, consultants, and workforce specialists that has thrived because of these funds. The criticisms of groups like CPHS as well as evidence in this dissertation about the fleeting quality of so much training make it tempting to indict 1199, Governor Pataki, or what I call the training and education industry, for their ultimate indifference or silence towards the problems of health care as a whole. This is, after all, a nation where over 40 million Americans under age 65 were reported uninsured in 2000.

Though the capitulation by major political brokers on the issue of health care reform since the Clinton administration debacle of 1994 is disheartening, the politicized fight in New York (which 1199 is often likely to win) over health care funding cannot, ultimately, be blamed for foreclosing larger and more visionary health care reform. Such a view takes scarcity for granted, suggesting that money that should have gone to community clinics or to altering health care as a whole has instead propped up inefficient hospitals, subsidized unrealistic wages, and supported a job training charade.[5] The operations of hospitals should not be pitted against issues of health care coverage and access. Nor should hospitals and unions have to rely on such creative and backhanded, and ultimately temporary, political bargains for funding. Similarly, it is untenable to argue that health care workers should not receive wage increases. In 2001, the median hourly wage of a nursing assistant in New York City (in all types of organizations) was

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[5] The title of Gordon Lafer's C. Wright Mills Award-winning book (2002).

$13.06; in the United States as a whole, it was $9.27—the difference can be explained by the impact of unionization. (See Table IV in the Appendix for wage data of selected occupations.) Most nursing assistants I interviewed, who worked in hospitals, were making about $14.00 an hour. This does not seem to be the segment of the labor force for which the merit of 13% raises should be called into question. And though I am quite critical of some aspects of the training and education industry, not all of the training and education funded in recent years has been frivolously used, and we will see in this dissertation examples of workers who have substantially changed their lives through the educational opportunities available to them.

Types of Training

Although the 1199 Training and Upgrading Fund likes to present itself as a vehicle for the upward mobility of its members, in fact the hundreds of millions of training dollars it directly or indirectly controls fund an array of training and education encounters, not all of which provide a basis for such mobility. In fact the most common program funded by the influx of training monies has been customer service. The array of training or educational experiences available to allied health care workers generally falls into one of four categories: occupational multiskilling or upgrading, individual upgrading (via "career ladders"), on the job training, and non-vocational college education. Below I will describe each of these types of educational experience and the types of educational vendors that provide these experiences—i.e., the substance of the "training and education industry." These kinds of training and education experiences should be considered separately in so far as they have very different objectives. Furthermore the

economic rationale behind each of these types of training, and consequently who pays for them and the conditions under which they are made available, are distinct.

But, ultimately, my aim is to consider how this array of training and education programs is functionally and experientially blurred, from the perspective of the "industry" and health care workers alike. In later chapters I describe occasions of indifference among those planning education and training programs to the nature of training itself, as well as the lack of distinction participants sometimes make between different types of education and training. This indifference and blurring does not always occur, but it is symptomatic of a level or plane of operation which is shared by these quite diverse aspects of training and education: any learning is good, any education gets me somewhere. That said, to understand the blurring it is necessary to understand the distinctions.

Occupational Multiskilling and Upgrading

The influx of training funds has had a multitude of effects—most of which remain unknown since little emphasis was placed on the systematic coordination of these funds or the evaluation of their use. But one industry-wide trend which emerged early was an emphasis on cross-training and "multiskilling." 1199 supported multiskilling as a preventative measure: expectations of an expanded role for managed care in the City and strict new reimbursement mechanisms[6] lead to dire predictions of hospital lay-offs.

Most experts hoped that the influence of managed care in New York City would encourage workforce planning based on business principles of flexibility and

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[6] Particularly those entailed by the draconian Balanced Budget Act of 1997 (Steinhauer 2000).

adaptability, or at least on a more rational assessment of staffing needs. Traditionally, workforce "planning" in New York City was the outcome of professional and labor-union turf battles as well as political favoritism (Center for an Urban Future 2002). This, combined with the influence of gargantuan, bureaucratic teaching hospitals employing thousands of people, made the region a fertile testing ground for just how finely the division of labor could be drawn in health care settings. Given this history, hospitals also supported the idea of multiskilling and cross-training, hoping it would restore to them more control over and flexibility in arranging the division of labor—as well as the potential maneuvering room for laying off staff or manipulating personnel costs.

The biggest multiskilling initiative, by far, has been the wholesale eradication of the nursing assistant job title in hospitals and its conversion into various "technician" titles. In almost all New York City voluntary hospitals, nursing assistants (nursing aides) are now known by the newly-created title of patient care technician (PCT). PCTs continue, in most hospitals, to do the work of nursing assistants, whose primary responsibilities are cleaning and caring for patients: helping them to eat, dressing them, changing linens, helping them become ambulatory. But PCTs have also been trained to do electrocardiogram tests (EKGs) and phlebotomy (draw blood). Most hospitals have consequently reduced the numbers of specialized EKG technicians or phlebotomists that they employ. In addition, the PCT "upgrade" entailed becoming a certified nursing assistant (CNA)—a qualification that has long been required for nursing assistants in nursing homes (because of their complex regulatory environment), but not hospitals. The reaction among PCTs to this change has been mixed: it was seen simultaneously as an increase in their workload and as a welcome opportunity to learn more technical and

transferable skills. The union also ensured that PCTs received a nominal wage increase as part of the upgrade. In public hospitals (the Health and Hospitals Corporation), nursing assistants are likewise becoming psychiatric technicians, "med-surg" technicians, or pediatric technicians, depending on the unit where they are employed. These are nursing assistants trained in EKG and phlebotomy as well as particular skills relevant to the kind of patients for whom they care. These titles are thus both multiskilled and specialized.

In another case of multiskilling, in one academic medical center in the Bronx, a patient care associate (PCA) title has been created by combining tasks that used to be separated between housekeeping, dietary, and nursing departments. Unlike the more traditional housekeepers or dietary aides, PCAs remain on a single unit all day; they serve food and help patients eat but also clean their rooms, beds, and bathrooms in-between meals. Multiskilling experiments have also occurred in non-nursing, or non-direct care occupations. In some hospitals, unit clerks and registrars were made into "business associates" and trained in a wider array of office and clerical skills.

It is arguable whether these forms of upgrading and multiskilling are a response to the "needs" of health care organizations for more highly-trained workers. From the outside, the creation of PCTs exemplifies the incessant march forward of the skills and credentials required by jobs unaccompanied by a change in the nature of those jobs or the work that is done. Was it necessary to the functioning of hospitals for nursing assistants to become certified? While it may be useful to have nursing assistants on the floor who can do EKGs, it is not as if there weren't people who could do EKGs previously. The creation of PCTs did not coincide with any significant change in the technological basis or organization of health care work.

In general, it is difficult to identify organizational or technological innovations specific to the influence of a competitive managed care market (the transition to which both HCRA and the federal waiver grants were intended to ease). New York City hospitals have always been based on a stark division between low- and high-tech: because the industry is dominated by powerful academic medical centers, the investment in sophisticated diagnosis and treatment equipment at these hospitals has been substantial. Though the effects of managed care on technological investment and innovation are not known in the aggregate, in general it has been assumed that managed care controls and limits the investment in clinical technologies while it may invest more in information technologies that expedite administrative functions like patient records, coding, and billing. It is possible that the historical relative immunity of New York's health care sector from managed care and market forces explain why investments in information technology have been slow, particularly in comparison to managed care-dense states like California. Therefore, in the variety of hospitals where I have conducted fieldwork in the last few years, including academic medical centers, the vast majority of staff on the hospital floor have no contact with computers.[7]

Computerization is occurring, but the impact on occupations and the workforce has yet to be documented. In the short run the implementation of computerized records has created a demand for specialized coders and billers and has been the impetus for the

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[7] When staff do encounter the effects of computerization, it may confirm their feelings that patient care and the work of caregivers is devalued. In one hospital where I conducted field work, giant supply cabinets with electronic security devices had been installed on each floor. Nursing assistants had to enter pin numbers to obtain supplies ranging from toothbrushes to bandages and electronically record the amount of supplies used. While these cabinets may have controlled inventory, this initial experience of computerization sent the explicit message that staff were not to be trusted and that the first goal of the hospital was to cut costs by controlling the behavior of the frontline and least well-paid workers.

upgrading of skills among registrars, unit clerks, and other personnel on the floors who handle information, as we will see in the cases of several health care workers interviewed for this project. The overall impact of managed care on New York's health care industry has also been less than what was originally anticipated, particularly in terms of mergers and organizational restructuring (Casey 1998). Many critics of the siphoning off of various state funds to subsidize hospitals and the training of their workforce have pointed to the relative lack of layoffs in recent years to suggest that the training and education monies were unnecessary. They would certainly question the necessity of the PCT occupational title, for instance. Labor unions have argued, on the other hand, that it was their pre-emptive multiskilling programs which prevented those layoffs—without the creation of PCTs and PCAs, hospitals would have been forced to lay off many more workers.

Upgrading via Career Ladders

This study, because it focuses on workers who enter the health care workforce at the bottom, presents the stories of people who try to turn employment in the health care sector into a career ladder. These are women and men for whom the health care sector presents one of the most accessible entry points into stable work and for whom an industry devoted to their training and upgrading provides chances for upward mobility.

These workers represent two modes of encountering education as an adult. First, is the mode of young people who enter the workforce directly upon graduating from high school (or before graduating) in lieu of college. These workers may later return to community colleges or occupational training programs, using them as a "second chance"

system. The experiences of the workers I interviewed, who range in age from 29 to 55, allow for a retrospective and qualitative look at workers encountering education in this mode. But these workers' experiences also encompass another mode: workers of all educational backgrounds who return to school later in life or who are continually exposed to training and educational experiences as a result of transformations in work in a services-driven economy. In 1991 34% of Americans over age 17 participated in adult education activities; by 1999 that number was 46%. In the health industry 70% of technicians and 85% of nurses and pharmacists participated in adult education in 1999, and about half that percentage participated in personal development courses *not* related to their careers. Only post-secondary teachers had higher rates of participation in personal development courses.[8] The experiences of these workers will enrich our understanding of two growing phenomena: the return to college and occupational training programs later in life and the increasing prevalence of educational or learning experiences as a part of working life.

In addition to tinkering with the occupational structure in hospitals as a response to perceived instability and insecurity, the 1199 Training and Upgrading Fund is involved in providing the training and education to create career ladders for individual workers. This is often accomplished by assisting union incumbents to move into shortage areas. To take the most obvious example, as of 2003, the health care industry nation-wide is experiencing a critical shortage of registered nurses (RNs). 1199 TUF is therefore investing much of its resources into helping qualified union members become RNs.

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[8] U.S. Department of Education, National Center for Education Statistics, "Participation in Adult Education," unpublished data.

Sometimes this means encouraging (through career guidance and financial support) a member who is already enrolled in college to accelerate the process and go into nursing. At other times it means helping a union member obtain a high school degree or GED (which is not a requirement for housekeeping or janitorial positions, and until quite recently wasn't a requirement for nursing assistants in hospitals) and then complete a two- or four-year college degree. The home care division of 1199 SEIU used a TANF (New York's welfare program) grant to assist 1199-represented immigrant home care workers who had been nurses in their home countries obtain their American nursing license. This program involved training in the American health care system and practices, college courses if necessary, and preparation for the licensing exam. This is perhaps one of the most dramatic examples of upgrading, since entering registered nurses in New York City facilities routinely start in the range of $50,000 per year while home care workers generally make around $6.00 an hour (and frequently cannot get enough hours to work full-time). This program was also, incidentally, one of the rare cases where job training not only moves individuals off welfare rolls but also moves them into jobs that pay a living wage.

Historically, the 1199 Training and Upgrading Fund's encouragement of occupational mobility among its members was passive: it provided tuition reimbursement for union members enrolled in college, usually two courses a semester, up to its budget limits. These days, however, the TUF is creating more programs that provide paid release time for workers who attend school, sometimes with its own grant monies and at other times in cooperation with hospitals who are willing to allot their training dollars in this way. For instance, a hospital facing a shortage of Operating Room Technicians (OR

Techs, also known as Surgical Technicians) might agree to fund the training of a few of its own employees as long as they agree to work for the hospital upon graduation.

In order to serve union members who are not yet prepared for college or face personal obstacles to attending college, the TUF also offers a variety of courses at its main offices on 42nd street and its training facilities in the boroughs. The TUF specializes in exam preparation courses, GED courses, ESL courses, and other remedial or transitional-type classes. Though one official told me the Training and Upgrading Fund hopes it will eventually become a college in itself, actual college-credit courses are developed in conjunction with a vendor, frequently the City University of New York (CUNY). Thus, 1199 TUF and several CUNY Colleges created the "HC4" program, which provides counseling and tutoring to a cohort of students during their first four college courses.

The availability this kind upgrading would likely be minimal were it not for the union, particularly training which qualifies workers to leave their current occupations and employers. 1199 has been aggressive in securing funds for training its members for more professional occupations. Training and Upgrading Fund officials said that grant monies for which it is the direct recipient (and not the administrator) are typically allotted to upgrading members into new occupations. Many other joint labor-management education programs rely solely on the "penny funds" generated from collective bargaining, whereas for 1199 collective bargaining funds would not even approach the funding levels necessary to sustain the programs now in operation. Without a union and the state funding it secures, it is unlikely health care organizations would invest so heavily in training and educating their workers. Although employers often invest in training the

workforce, they do not prioritize training that could potentially prepare workers for jobs outside their organization, let alone give workers time off from work to pursue this training.

Because much of the evidence presented in this dissertation makes it easy to criticize the training and education industry for health care workers, it is necessary to repeat periodically that the training and education industry for allied health care workers in New York City, anchored by 1199 TUF, presents an unparalleled set of possibilities to a group of workers—women, immigrants, people of color—otherwise systematically marginalized in the American occupational structure. Research has shown that while many sub-baccalaureate certificates and associate degrees provide economic returns greater than those of a high school diploma, those returns vary widely and "some kinds of postsecondary education provide no economic advantage at all" (Grubb 1997, pg. 241). The sub-baccalaureate labor market contains a great deal of uncertainty and many potential pitfalls for those engaged in it. Health-related sub-baccalaureate credentials (certificates or associate degrees), on the other hand, are an important exception: they have been shown to increase economic returns for women[9] at statistically significant levels (Grubb 1997).[10]

Indeed, there is substantial gender segregation the sub-baccalaureate labor market; according to Grubb's analysis of data from the 1984, 1987 and 1990 Survey of Income

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[9] Sample sizes for men in health-related occupations were too small to estimate economic returns.

[10] This return cannot necessarily be credited to the nature or content of the education/training itself; more likely it is an outcome of the fact that for many health care occupations state licensing agencies specify the educational requirements. That is, a sub-baccalaureate credential may be *required* for entry into a health care occupation (Grubb 1996, pg. 39). The implication is that economic returns to *licensed* and *unlicensed* health occupations may be substantially different: licensed (or even certified) occupations may inflate, or entirely account for, the economic returns for women in health-related occupations documented by Grubb.

and Program Participation, "health-related occupations" was the *only* field in which certificates showed statistically significant positive economic returns for women over time; at the associate degree level, only health and business-related fields showed statistically significant positive economic returns for women over time (pg. 236).[11] This makes health care one of the only viable avenues for women to increase their earnings in the sub-baccalaureate labor market and—to put it mildly—raises the stakes of success or failure in this field.

While allied health care occupations at the paraprofessional level are undoubtedly subject to a "care work wage penalty" (England, Budig, and Folbre 2002), and those health care workers in positions that do not require a post-secondary credential (such as home care workers) are paid around minimum wage, workers who are able to obtain some education and pass certain key exams may effect a major change in their standard of living. Thus, according to the Bureau of Labor Statistics, the median hourly wage for a respiratory therapist in the New York City metropolitan area in 2001 was $22.91 and for a registered nurse, $28.20. Both of the fields require only an associate's degree. Health care is also a field in which demand for workers is expected to remain high for the foreseeable future, making it a relatively stable niche in the topsy-turvy world of service occupations.

That said, looking at the experiences over the life course of a health care worker (as we will in remaining chapters), or the actual organization of training and education for health occupations, a more vivid and complex picture of what it means to work as an

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[11] Fields included in the data were business, education, engineering/computers, public service, vocational/technical subjects (for instance, cosmetology), and associate's degrees in academic subjects.

allied health professional emerges. A specialized sub-baccalaureate credential, such as a respiratory therapist degree, carries substantial risks in addition to short-term returns: it doesn't qualify the worker to do anything else, should there cease to be a market for respiratory therapists. Similarly, career ladders leading through the world of allied health occupations to traditional white collar professions tend to lack some rungs. Switching health occupations often requires repeating substantial course work or starting from square one; the various types of schools and institutions that have jumped into the health care training market are poorly articulated with one another; and it is an industry in which promotional opportunities within organizations have always been minimal, because of the specialized nature of health care work and the dominance of professionals. In short, any move in the realm of health care occupations requires external education or training. They experience of health care workers might be considered the quintessential example of "lifelong learning."

On the job training

Although in many industries individual employers are responsible for training their employees, in the case of New York City's health care industry, on-the-job and hospital-based training are more centrally organized. This happens formally and informally. On the formal side, this is because 1199 Training and Upgrading Fund has become a sort of "middle man" between state and federal training funds and voluntary hospitals; it is also, ostensibly, well-situated to identify health care-wide training needs because it is overseen by joint labor-management board of directors. It can advise specific hospital directors of personnel and human resources on the training that has been

conducted at other hospitals and the training which can be funded under grant stipulations. Informally, 1199 can act as the go-between for decisions about which trainers or training consultants to hire; which curriculum to use; and which schools or educational institutions to consider as subcontractors. Therefore, if you are a training vendor hoping to get into the health care market, your status with the 1199 Training and Upgrading Fund essentially determines your level of access. Training in the Health and Hospitals Corporation (the city's public hospital network) is even more centrally determined, with the relevant unions such as DC37 playing a secondary role to HHC's central administration.

Under current conditions, hospitals have received training grants which are not part of their internal budgets or a direct cost to their operations. Though they have access to differing levels of funds depending on the grants in question and they have the authority to determine individually how they will spend the money, in the end there is much isomorphism across the industry in terms of how these grants are spent. The TUF's internal Executive Directors Report[12] on year one of the Federal Waiver grants indicated that 21,239 workers "were served" in 207 programs. The top five programs, in terms of the number of institutions offering the program, were customer service (19), operating room technician training (15), computer education (14), crisis intervention (14) and lab tech cross-training (10). The "most popular vendors" for this training included the Consortium for Worker Education (CWE), CUNY, Pace University, and Long Island University. Some of this training is voluntary and some of it is mandatory.

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[12] 1199 TUF permitted me access to the first page of this internal report.

These kinds of programs are generally based in the hospital and are ostensibly oriented toward the hospital's specific needs, problems, or strengths. They may be run by hospital-based training or human resource directors or organized on a contract basis, with hospitals hiring outside vendors to run the training program and/or develop the curriculum. Such courses do not usually entail college credits and most do not result in a raise, credential, or promotion for participants.

Education

While multiskilling, upgrading, and on-the-job training are ultimately all vocationally-oriented, general education sometimes happens as well. While we will soon see that the distinction between education and training is frequently lost in this industry, it is worth noting the spaces where less vocational and more humanist or traditional forms of education take place. The most obvious space is a corollary of the fact that many health care occupations require a college credential (an associate's or bachelor's degree); so while creating a career ladder out of health care occupations, many health care workers also enroll in liberal arts courses or other general college courses. Also, at the pre-college level, in the basic reading and writing courses that the 1199 Training and Upgrading Fund makes available to its members, teachers have a good deal of discretion in terms of their curriculum. Thus one teacher at the TUF I interviewed views his reading and writing courses as a chance to introduce students to literature and novels, creating an experience that is continuous with more traditional college education.

Other than that, however, under the umbrella of training and education opportunities that are sponsored or coordinated by 1199, there is very little room for the pursuit of college degree as a formally sanctioned end in itself, except through traditional tuition reimbursement mechanisms. Some training grants even restrict the use of funds to vocationally-oriented programs. Certainly students find opportunities to take liberal arts courses while pursuing a health career or credential; other health care workers may pursue or continue their education independently of union-sponsored programs. Indeed, many colleges probably see that as one potential of their contract courses, continuing education departments, or adult non-degree programs: these working adults might become future students.

Education, of course, need not (and does not) take place only under the aegis of formal educational institutions. Labor and the working class have historically recognized education as the vehicle for mobility while they have also regarded formal schooling with skepticism, suspecting that it predominantly reproduces class distinctions rather than extinguishes them. In 1978, 1199 founded the Bread and Roses Cultural Project with a planning grant from the National Endowment of the Arts. This Project has been sponsored numerous cultural and education activities for union members over the years, largely outside the purview of traditional educational institutions. As we will see in the chapter on the significance of training and education programs such as the TUF for unions and labor movements, the Bread and Roses Cultural Project can be seen as the moral and political alter of the Training and Upgrading Fund. The stories of the Training and Upgrading Fund and the Bread and Roses Cultural Project reflect fundamental

tensions in the ideological climate of unions, in philosophies of work and education, and in the priorities and values of American culture.

Training and Education Vendors

In terms of workforce development in New York, "accessing training dollars has been a competitive tussle amongst over 150 nonprofits, community colleges, private universities, unions and for-profit trainers" (Center for an Urban Future 2002, pg. 9). Health care workforce development has been a particularly sought after prize in this tussle, given that health care employs 375,000 people, making it the number one employer in the city. The Center for an Urban Future reports that by late 1990s, "...critics began to charge that training funds were less an engine of economic development for the city than a jobs program for the training industry itself. Often, the data backed them up" (Center for an Urban Future 2002, pg. 5). Indeed, the training industry for health care workers has been an economic engine for a variety of training and education entrepreneurs, described below.

Table 1 lists the names of some the institutions offering allied health care training programs in New York City, which health care workers I interviewed reported attending. I also interviewed representatives of many of these institutions (among others)—typically a dean or administrator in charge of health care programs. Not included in this table are the private and independent consultants who run programs in many health care facilities, typically on-the-job training. Some of these programs make an appearance in the following chapters. Here I want to give a sense of how these various vendors tussle over and ultimately carve up the lucrative market for training health care workers.

Table 1: Examples of Education/Training Institutions in the Allied Health Care Training Market

Private, non-degree schools		Allen School NYU Medical Center Surgical Technology Program (hospital-based)
Two-year colleges	**Public**	CUNY: Bronx Community College Hostos Community College Queensboro Community College Borough of Manhattan Community College Medgar Evars Community College SUNY: Nassau Community College
	Private	Technical Career Institutes (for-profit)
Four-year colleges	**Public**	CUNY: Lehman College City College Baruch College SUNY: Stonybrook
	Private	St. John's University New York University Touro College College of New Rochelle Monroe College (for-profit)
Other		Consortium for Worker Education (CWE) 1199/Hospital League Training and Upgrading Fund (TUF) JFK Jr. Institute for Worker Education at CUNY CUNY on the Concourse DC37 Education Fund

1199 TUF maintains a database of universities, colleges, schools, and consulting firms—called "vendors"—organized according to the area of training in which they

specialize. To be in this database is essential for any entity breaking into the niche market of training health care workers. These vendors and programs can be distinguished from one another on the basis of three key attributes: whether they offer college credit, whether they offer a credential (a certificate or degree), and whether the program is oriented toward a specific job title in the health care sector.

The issue of college credits is contested in the industry. Universities and colleges that can provide credits argue that non-credit training is essentially a waste for health care workers, providing little basis for further mobility. This principled argument goes hand-in-hand with a less principled expectation that the ability to provide credits will provide leverage in the training market. But just because colleges can offer credits doesn't mean they only conduct credited training programs.

The issue of credentials is important because existing studies of the sub-baccalaureate labor market suggest that programs which do not provide credentials (a certificate or associate's degree) are much less likely to result in economic returns (in the form of wages) beyond a high school diploma. That said, not all sub-baccalaureate credentials are equal. Some credentials are recognized requirements for a specific job, such as a nursing license, and are therefore correlated with economic returns. Other credentials do not qualify the recipient for a specific job, such as a certificate in disability studies (discussed in the next chapter), and are not likely to be correlated with economic returns. Office assistants in doctors' offices do not need an associate's degree in health office studies, but colleges that offer such a degree hope the credential will enhance employability of program graduates and become a standard requirement for a yet-to-be job title. The same is also true of the many non-credit certificate programs in the health

care field, such as the certificate in managed care offered by CUNY on the Concourse. Students and training providers hope these certificates will legitimize their programs and establish a new standard in the labor market, but the certificates are not required by employers or licensed/regulated by the state.

Though college credit is argued to be of primary importance in setting apart terminal from non-terminal programs, within the world of allied health care work credit is not always of most importance. In the experience of health care workers, a credit-bearing certificate in disability studies has no value in the labor market when compared to a non-credit, 9-month certificate from a surgical technician program. Surgical technician program graduates can make upwards of $30,000 annually. The disability studies certificate, by contrast, is not a recognized credential for a specific job in the health care industry and does not move the student very close to the most economically meaningful credential, a college degree.

In terms of the kind of training described in the previous section, upgrading and multiskilling programs could be offered by almost any of the vendors listed in Table 1. The PCT upgrade, for instance, was a non-credit program resulting in a certified nursing assistant (CNA) credential. This training has sometimes been conducted by the employing hospital, but more frequently the hospitals hired vendors (places like CWE or other schools which already run CNA programs) to conduct the training.

On-the-job training generally falls under the non-credential and non-credit category and can include job-specific programs, such as training for a new computer system or phlebotomy, or non-job-specific programs like communication skills and customer service. Mandatory programs are generally held during work time, but many

hospitals have been offering voluntary programs held during a worker's free time. Almost all vendors seem to want to offer this kind of training—from four-year colleges to individual consultants. Consultants could be long-established firms who run programs in multiple industries or former health care providers who specialize in health care issues. Private consultants and firms may specialize in courses such as computer skills, customer service, foreign language, or accent reduction. These vendors may offer courses at their own facilities or at the workplace, but the program is typically "customized" to the particular industry or employer.

Credit programs can be offered only by accredited private and public universities and colleges. In New York City, the City University of New York is one of the largest vendors for credit-bearing training. What is notable, however, is the extent to which universities and colleges are moving into the area of non-degree and non-credit programs. Lehman college, a four-year CUNY college in the Bronx, offers a bachelor's degree in nursing, but it has partnered with 1199 to offer non-credit college preparatory courses for 1199 workers, and has a sizeable non-credit continuing education department which health care workers frequently attend to maintain their professional licenses. CUNY on the Concourse, described in the next chapter, offers almost entirely non-credit certificate programs. Colleges and universities are increasingly reaching into the lucrative non-credit contract training market.

The ability of other vendors to participate in the allied health care training market is limited because they cannot offer credit-bearing programs. The Consortium for Worker Education (CWE), one of the major figures in New York City workforce politics, operates a Health Care Institute which responds largely to "job orders" from the union or

employers. For instance, it provided OR Tech training for 1199 members being upgraded to fill shortages in that area and it also contracted with the city's public hospitals to train 35,0000 workers in customer service. The Allen School, a major trainer of certified nursing assistants for the nursing home industry, also offers a 900-hour medical assistant certificate. Medical assistants are typically trained in clinical skills (such as drawing blood) and business skills that will allow them to perform multiple tasks in a private doctor's office.

Because it is a highly regulated industry, for many health care occupations the required educational preparation and credential for entry are well-defined. The paramount example of this is registered nurses, who must be licensed and attend an accredited program (typically a associate's degree program). Licensed practical nurses (LPNs) must likewise be licensed, but as long as the program meets state curricular guidelines, it need not be credited. But there is also a good deal of chaos in the health care sector. Lehman College, for instance, offers a non-credit certificate in health information technology through its adult education program, but Monroe College's health information technology associate's degree program was halted because its students were not finding jobs (leaving college representatives scrambling to redirect the 90 students enrolled in the program). The demand for health information technologists may exist, but because there are several possible levels of certification in the field and little standardization between schools and programs, employers are themselves unsure which level of credential is appropriate for the nature of their information technology processing needs.

On the whole, very little is known quantitatively about training programs not operating under the more regulated system of universities and colleges. Workers looking

to carve a career out of the allied health care industry face an array of training choices from an array of vendors, typically with very little information to make distinctions between them.

CHAPTER 3: TRAINING FOR WHAT?

A comprehensive review of major sociological studies of the relationship between the education and the economy concluded that there is no correspondence between the development of the economy and the development of education and that any relationship between the two varies by time and place (Rubinson and Browne 1994). My study of a local education and training apparatus and the forces which animate it supports this conclusion. The growth and persistence of the training and education industry for allied health care workers cannot be wholly attributed to its production of appropriately qualified workers, whether in terms of skills, credentials, or attitudes and ideology. And yet, this is the most readily available pitch for selling the training and education industry.

Those who participate in the education and training industry often present their work in instrumental or technocratic terms as a response to the needs of employers and the economy. The most acceptable way of justifying training and education is to identify a "skills gap" and say that employers need workers with new and better skills in a rapidly changing economy. According to the Center for an Urban Future, "there is a real need in the business community for high quality training...Vital city industries such as biotechnology, light manufacturing, financial services and aviation require the highest levels of knowledge and innovation to compete in the global market" (pg. 8). An administrator at a non-credit training organization said to me:

> There's always going to be a need for training and upgrading and they'll be other monies available as time goes on because we understand

> that the economic development of the workforce depends on constantly being upgraded in order to have any kind of job security. That's the future, really, of employment in this city and in this country, because things are changing so fast. Technology forces people out of jobs and hopefully unions help to direct employers to retain their employees by upgrading and training them.

This rhetoric is ubiquitous; as she went on to say: "for workers today, learning must be a lifetime pursuit."

This kind of rhetoric led Ivar Berg, in his classic 1970 study of the relationship between education and jobs, to stop interviewing human resources personnel (1970, Ch. 4) in exasperation—preferring instead to look for concrete evidence of expanding skill needs prompted by occupational and technological change (and finding very little). While there are real, local-level shortages and skills gaps for which training is often needed, and there persists a nation-wide shortage of certain health personnel, neither of these facts in themselves justify millions of dollars of investment in on-the-job and soft skills training documented in this study. A major rationale for the hundreds of millions of dollars invested in training health care workers in New York City is that there are substantial skill deficiencies among health care workers which require training in computers, communication, customer service, and other general competencies. Some of this training money has indeed been spent to close identifiable skills gaps or train workers for skills and occupations for which there is a shortage, but as we will see throughout this dissertation, other kinds of training that are heavily funded and the general patterns with which health care workers encounter training and education suggest that this industry is animated by forces far more complex than the mere response to the needs of the "economy."

In so far as the justification for the training and education industry for health care workers partakes of the logic that there are general skill deficiencies among American workers, it deserves scrutiny. At least since the Nixon administration job training has been a favorite political tool—of conservatives and liberals—to show that steps are being made to right a sinking economy, to compensate for the disappearance of manufacturing jobs, to substitute for welfare in the age of a state withdrawal of services, and to help the poor without creating "dependency" on the state (Lafer 2002). The "skills gap" has even been offered as an explanation for expanding wage inequality in the United States and job training as its solution. Education more broadly is of course one of the cornerstones of the socially-stabilizing ideologies of meritocracy and mobility.

Ivar Berg showed that there isn't a substantial disparity between the educational achievements of the American workforce and the educational requirements of jobs—at least not a disparity that can account for the tremendous growth of formal education. This finding was consistent with Randall Collins' (1979) theory that inflation in employers' hiring requirements far outpaces any increases in the level of skills necessary to perform most jobs. Wanda, a licensed practical nurse (LPN) whom I interviewed, felt that her day-to-day work as an LPN was identical to that of a registered nurse (RN), which made the lower pay of LPNs and the higher educational requirements for RNs seem irrational. Credential inflation may not be the only force behind the division of labor in health care, but there can be little doubt that there is an element of arbitrariness in

the educational requirements for occupations in health care, which introduces real barriers to mobility for workers like Wanda.[13]

More recent research continues to dismantle the idea of a skills mismatch between the preparation of American workers and the skills necessary to actually do most jobs and has shown that federal job training programs such as the Job Training Partnership Act made no substantial difference in the living standards of the poor and poorly educated (Grubb 1995; Lafer 2002).[14] The training industry's insistence that it is responding to the needs of business is problematic because it assumes that worker education and training actually have a significant impact on the economic viability of most businesses. Michael Handel wrote in a recent review of the skills mismatch literature that "swings in macroeconomic forces had a far greater effect on the nation's fluctuating fortunes in the 1980s and 1990s than the modest trends in school quality or individual attainment" (2003, pg. 138). In other words, it is impossible to hold a skills mismatch or shortage accountable for economic performance when wide swings in productivity and employment levels occur while the extent of skills and education in the labor force change very little. For example, the boom of the early 1990s occurred without any sizeable change in the stock of national skills. This suggests that employers do not create and destroy high-quality or high-wage jobs based primarily on the skills or education or talent of the labor force—they destroy and create such jobs without regard for the skills and abilities of workers.

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[13] Perhaps the theory that best captures the way in which the division of labor can be unrelated to the requirements of the work itself is Andrew Abbott's work on "jurisdictional conflicts" between the professions (Abbott 1988).

[14] For a description of how federal job training funds created a training industry in New York City, see (Center for an Urban Future 2002).

David Livingstone has posited that there is in fact an "underuse of knowledge and skills in current industrial market economies" on a "massive scale"; that "we are already living in a 'knowledge society' in which the collective learning achievements of adults far outpace the requirements of the economy as paid work is currently organized" (Livingstone 1999). This perspective sheds light on the experience of Marie—a patient care technician of some ability—who told me she was "wasting away" in her current job. So Marie has sought, whenever possible, to return to school, though she was continually stymied by assessment tests and a math phobia—neither of which probably reveal very much about her capacities as a health care provider or her ability to perform more advanced work. Naturally there are frequent local and individual instances of skill shortages, but as we will see with soft skills training (in chapter 7), the goals and outcomes of training are frequently constrained organization problems and economic forces that training is ill-positioned to affect.

In essence, the belief among education and workforce policy makers that there is a stable set of business "needs" and occupational "shortages" which they could fill if only they had better connections to industry—a belief frequently repeated among my interview respondents—is well-worn mantra but an incomplete view of how education relates to the labor market. This view of labor shortages presents occupations and jobs (their work content) as stable and fixed and the ability and competencies of individuals as the only malleable factor. It neglects how jobs change in response to factors not dependent on the kind of labor available. Again, there may be in the local and regional health care market a clear shortage of several dozen OR Techs and several thousand RNs,

for example, and this need is known and can be filled. But this does not justify the extent and nature of training and education now evident in New York City's health care sector.

Much of the rhetoric and even panic about skills shortages in the United States does not refer to cognitive or technical skills at all. Handel writes that "cross-sectional studies often suggest employers are less concerned about cognitive skills deficits than what they consider poor work habits, motivation, demeanor, and attitudes" (2003, pg. 150). This is also a complaint chiefly made about workers without a college education (pg. 157). Moss and Tilly found in their surveys that the majority of employers mention some kind of soft skills as among their most important hiring criteria (Moss and Tilly 2001). The training and education industry for allied health care workers also places a great deal of emphasis (though not exclusive emphasis) on soft skills training in customer service and communication. Although attitude and demeanor could be considered "skills" of which there is a lack, history suggests employer complaints about the poor attitudes of workers are hardly new or indicative of a growing *gap* in skill requirements. Young, immigrant and minority workers in particular have long been exposed to implicit and explicit demands to conform to middle-class behavioral and emotional codes.

Herbert Bowles and Samuel Gintis have consistently argued that education is primarily an indicator to employers that workers have the right attitudes and are accustomed to the types of relations and rules imposed in the workplace (Bowles and Gintis 1976; 1981; 2001). This view has been supported by ethnographic studies of youth and education (MacLeod 1995; Willis 1981). Bowles and Gintis argue that although higher education levels are associated with higher wages, education levels are not measures of cognitive ability nor are wage levels reflections of the skills content or

demands of jobs. This latter point was also Berg's most basic criticism of human capital theory: wages are an indication neither of the skill requirements of jobs nor of the productivity of workers.

Gordon Lafer has convincingly shown that the political benefits of job training compensate for and disguise its failure to have the economic effects that theorists of a technical-capital persuasion (which includes human capital theorists) predict or desire. Many aspects of the training and education industry for allied health care workers in New York City can be explained by the machinations of political bargaining (particularly between Governor Pataki and 1199 President Rivera) and public relations positioning. My emphasis in this dissertation is not so much on the rationale and causes for the tremendous investment in training and education, but on the experiences embedded in this training and education industry and the constellation of values and value in which this industry participates. Ivar Berg noted that even though the economic rationale (in terms of productivity) for higher education in general is weak, there are other "cultural, political, and psychological benefits associated with education" that are often ignored by economists. This is a clever turn of phrase, since "benefits" are not necessarily intended effects; it points away from an overly-neat functional analysis. Even if it is demonstrable that this industry arose as a response to a lack of skills like customer service, in its implementation and effects the industry has shown itself to be something other than a response to the needs of health care organizations or the health care labor process.

A Market for What?

The training and education industry has been pitched in a field of commodification. As my interviews show, training and education for health care workers is a market that must be made. The prevalence of discourse among the trainers I interviewed which suggests that both education and health care are commodities is not surprising. Critical and purportedly mainstream analysts of education and health care have commented upon (or bemoaned, depending on the perspective) the increasingly prevalent view that they are industries like any other.

A recent study of health care in the San Francisco Bay area labeled the period of 1983 to the present "the era of *managerial control and market mechanisms*" (Scott, Ruef, Mendel, and Caronna 2000, pg. 22): "general business ideologies and practices—for example, an emphasis on product lines, cost centers, and strategic planning—which would have seemed out of place if not illegitimate to early participants are now widely accepted as normal ways of thinking about conducting healthcare" (pg. 17). The corollary in education is recent attempts to privatize public school systems and the infiltration of all sorts of consumer products and advertising into the space of school. In the case of health care, of course, numerous histories of physicians, hospitals, and medicine suggest that health care has been informed by concepts of profit, markets, and competition since its beginnings (Larson 1977; Rosner 1982; Starr 1982).

There is an influential strand of thought that argues health care and education cannot function effectively under market conditions because their products are public goods—goods which benefit all of society, not just those who pay for it (on health care see Arrow (1963) and Parsons (1951); on education see Hirschman (1970)). Of course,

little about the American health care and education systems suggests they are working effectively—and they are now subject, at least in part, to market forces. But, sustaining them as markets is not easy because of their status as public goods—as the sometimes strange and always creative discourse of those involved makes clear.

Education

Educational institutions in New York City are thinking strategically about the health care industry and workforce as a stable source of students and revenue. One former social worker who now runs her own training consulting firm called it an "untapped market." An instructor at a private college remarked, "think of what higher education does anyway. Aren't we in a sense the only business that loses our customers on a regular basis?" Given this "loss," a major source of financial stability and continuity is to take part in—and in a sense create and propel—a culture of lifelong learning.

Many aspects of the health care industry and health care work make it a particularly receptive market for creating a culture and pattern of lifelong learning, not least the inclusion of continuing education into licensing requirements for most health occupations and the fact that most occupations in health care require distinct educational credentials. The development of the training and education industry does not simply occur as a response to industry needs or obvious skills gaps among the workforce. In a situation of abundant funds, curriculum is invented and sold.

Perhaps no educational institution included in the fold of this study more neatly fit the profile of commodification than "CUNY on the Concourse." With $3 million in state grants, 1199 and CUNY joined to turn 50,000 square feet of the former Caldor's

department store building on Grand Concourse and Fordham Road into a training facility (New York State 2002). CUNY's half of the space was anointed CUNY on the Concourse, in support of which three CUNY colleges in the Bronx (Lehman College, Hostos Community College, and Bronx Community College) pooled their academic resources. Centrally located in what could be described as "credential concourse," in its first semester of operations in the fall of 2002, CUNY on the Concourse offered a number of non-credit certificate programs, a GED and bridge-to-college program, and a select few credit programs. In addition it advertised itself as a one-stop consulting firm, which could design contract courses for businesses in a number of industries. As one of its officials said:

> In adult education you have to realize...it's like doing shopping. People, they're just walking off the street, they're doing window shopping, they look at what you're offering, they come upstairs, and then they ask questions. That's the way that it works, especially when you offer courses to the community.

In this model of education, the "community" becomes analogous to individual consumers and education a product that can be displayed in shop windows. It is a model in which the consumer has very little input into the design and production of the product except in so far as they periodically participate in marketing surveys and focus groups. Albeit this kind of enterprise has a distinct advantage in terms of marketing: it can count on the near universal respect of accorded education by most Americans and the feeling that education is something we should all probably be doing.

A dean at a CUNY college affiliated with CUNY on the Concourse remarked:

> I'm really trying to do away with the notion of competition and figure out how we can work collaboratively to really corner the health career training market in the Bronx. I honest to God don't think about the

> sense of competition, because we do well and we have good programs and there's more than enough for everybody.

While he doesn't think in terms of competition, he does think about "cornering the market." There is indeed for than enough for everyone—health care organizations can hardly spend the training funds recently made available to them.

CUNY does have competitors in the education marketplace, and they are diverse. Located just half a mile from CUNY on the Concourse, Monroe College targets a slightly different group of "consumers," with its approximate $6,000 tuition per semester and degree-granting programs. The initial higher investment required to attend Monroe means it cannot rely on people in the neighborhood walking by to fill its classrooms. Unlike most of the CUNY offices in which I have been, the office of the director of health sciences at this private, for-profit college was cluttered with college paraphernalia: posters, stickers, mugs, pennants. "I'm a really aggressive marketer, personally," he said.

> I go to high schools, I distribute materials about the program. I do the stress quiz…I just give them a quiz on calculating your stress ratio and give little gifts to the group with the highest stress. Monroe College has, on every bus, newspaper—you've seen the latest ad [pointing to poster in the corner of his office]—it's everywhere.

The college prides itself on a more personal, less bureaucratic approach to its students. He went on:

> It is different here. It is a very customer-service type college and things are just much different here. It's clean, every room is white and washed and painted and vacuumed. It's amazing, it's such a pleasure really.

As part of the more personal (and less bureaucratic) image of the college, the President of the college holds an annual "Pie Day" when he gives a pie to every single

staff member. Monroe is attempting to corner the market in the Bronx for non-clinical allied health care occupations, such as clerical staff in medical offices and health information technicians.

In the wake of federal and state support for the (re)training of the health care workforce, all of the educational vendors I interviewed for this study moved into the business of contract courses. One study has found that over 90% of community colleges in the United States now offer contract training (Dougherty and Bakia 2000). One CUNY dean indicated his college "relies a lot" on contract courses, especially with 1199: "they're programs that have grown." Monroe College had also entered the fray. Said its director:

> One of the things that I started doing about two years ago was continuing education...We felt there was a big market for that. Health care is probably one of those industries that no matter what you do, what level of your education, that continuing education is so important. So what we started doing initially was just biomedical science, maybe a terminology class, maybe an anatomy class.

Though Monroe College could do so, these courses did not offer college credit.

> Then we branched off into coding, into coding and finance classes at hospitals and I guess about 6 months ago we decided we wanted to hit a new market so we looked at the people who are registrars and we wrote a curriculum called Health Care Access, oh goodness, I have to actually tell clients "we can't fit you in for another year."

He went on to explain that the program and the curriculum "turned out to be so good" that 1199 arranged for them to train 400 registrars in one group of medical centers. Indeed, 1199 TUF liked the curriculum so much that they obtained the rights to it from Monroe College. Monroe College, however, had struggled to find its niche in the world of training health care workers. It recently cancelled its health information technology

associate's degree program because graduates were not finding jobs. After what the director described as months of meetings with the 1199 TUF, trying to sell them several credit bearing programs, the college finally succeeded in selling a non-credit medical terminology course and then the registrar curriculum.

This raises the issue of how curriculum is developed for various types of training and education programs. In some cases, 1199 TUF has played the broker between employers and trainers in developing curriculum. In the case of voluntary hospitals, the Training and Upgrading Fund plays a central role in collecting information on available vendors for all sorts of training courses (from communication and customer service and accent reduction to phlebotomy and EKG skills). The pressure for a vendor to have a good reputation with the TUF may influence the vendor's presentation of self and curricula. One independent consultant I interviewed partnered with another independent consultant at the suggestion of 1199 TUF to develop an on-the-job training seminar for nursing home employees.

Frequently private consultants develop curriculum. When the Consortium for Worker Education was hired to train 37,000 city hospital workers in customer service (primarily members of DC 37), they subcontracted to an outside, private consulting firm to develop the curriculum. The Institute for Worker Education, which has developed a series of credited college courses for a certificate in disability studies, made an explicit point of opening up the curriculum development process to workforce experts and colleagues involved in health care practice because they considered university faculty to be out of touch with changes in the health care field. One former hospital-based trainer indicated that the process of selection for vendors to teach their workers was often a

political process. Another hospital representative described to me how a speed-writing course was established when a hospital executive said he wanted his new secretary to learn the skill.

In practice, then, "needs" for training are developed and constructed, not merely identified and filled. Perhaps one of the few examples I found in my research of a clear case of a response to the needs of employers was when a CUNY college installed a dedicated T1 line connecting it to an area medical center so the college could train the center's employees in a newly-installed computer-based information system. An academic administrator at the college said:

> ...what I do is really a supply and demand industry, so I can only offer courses for which there is a demand, so in a sense I am plugged into that, the need for more jobs or less jobs.

He is indeed literally "plugged into" that demand. But such statements gloss over the how the "market" in health care training works; there are many examples of aborted training programs and invented curriculum which exemplify the often murky character of needs and complicated dynamics of "supply and demand."

Education has been described as a marketplace "where knowledge (or skills) brokers barter for the sale of their cost effective, efficient, truncated pedagogical packages" and "the notion of curriculum has been displaced by content-poor, outcomes-oriented 'packages'." Moreover, "educators are (being) replaced by trainers and assessors, most with minimalist pedagogical education" (Butler 2000). This training and education industry has been opened to a host of labor market intermediaries whose impact and roles are largely unknown.

Though universities and colleges are required by accreditation standards to hire faculty with formal credentials, new patterns of organizing academic labor—such as the reliance on part-time and adjunct faculty—undermine the consistency of teachers and curriculum. Consider the variety of the teachers that I interviewed for this dissertation. Daniel, an instructor at a hospital-based OR Tech program, was hired because of his previous experience as an OR Tech and because he had a bachelor's degree. Similarly the director of health sciences at Monroe College was hired because he had experience as a health information technologist, and because he had a bachelor's degree, which was necessary for accreditation purposes. For many education or training jobs, prior health care experience and nominal degree are the formal hiring requirements—not pedagogical experience or formal training in the subjects which they will actually teach.

Several of the trainers and administrators I interviewed started their careers as health care providers, typically as nurses or social workers. This certainly provides a necessary type of knowledge to teach in the health care field, but it does not mean that these trainers end up teaching in areas in which they have formal experience or knowledge nor does it mean that they have pedagogical ability. Health care facility-based human resources personnel could, in particular, be called upon to teach almost anything that was deemed necessary, from technical skills to communication skills. Again, this does not mean the quality of those classes is necessarily poor, but there is unregulated variety in terms of the background of trainers and educators in many organizations.

Most of the sub-baccalaureate certificate programs (e.g., for OR Techs, certified nursing assistants, or home health care training) considered in this study relied on retired nurses or foreign-trained doctors who did not or could not (because of licensing issues)

practice in the United States. While I only have information on their salaries and wages from interview respondents and some programs paid their instructors relatively well, it is difficult to put together a living on what is usually part-time work and it is a situation in which the bargaining position for higher wages is not strong. One teacher at the Consortium for Worker Education asserted that the Consortium's continual efforts to replace full-time teachers with part-timers was "one of the first indications that the goal of this organization really isn't to educate people."

One administrator and former nurse pointed out that a lot of training programs and organizations rely on grants and contracts—which typically do not allow for spending on teacher preparation and education, i.e., faculty development. Moreover, education and training on a contract basis—particularly if it is training that takes workers away from their current jobs—is forced to conform to a grueling and probably self-defeating schedule. Sometimes students have classroom instruction for 7 or 8 hours a day, 5 days a week—making for exhausted instructors and students and little time for the independent digestion and exploration of curriculum.

The diverse backgrounds and positions of trainers in this industry have differing effects on the trainers' ability to make substantial change and realize their goals. One consultant—a former social worker whom I had occasion to observe giving a "pitch" to a nursing home for her geriatrics courses—explained the difference between planning and conducting training as a director of social work versus as an independent consultant:

> The negative about being a consultant and an instructor is you can only give your two cents, you can't be vested in the outcome.

She recognized that training was not, at times, the solution to the problem at hand:

> There are certain facilities that we're dealing with right now where I've already in my own mind established that management is part and parcel of the issue. They're going to offer conflict resolution to the management staff, and I want to say to the management staff you just need to eradicate where the conflict comes from, not manage the conflict.

She may in fact be able to say this to management, but her ability to instigate or oversee any long-term or fundamental change as a consultant is limited. On the other hand, she said developing training programs in conjunction with 1199 was "a dream come true" because she could be involved in change in a number of organizations and at a system-wide level. For other people, the consultant role may seem to offer the opportunity to speak more frankly with management, which may be more receptive to the advice of outside experts.

Nonetheless, the lack of vested interest among subcontracted trainers and education in the larger context of their training programs is a potentially significant problem, as it is a problem for all industries (including education) that have pursued a flexible, post-Fordist model of production. But in education and health care the stakes seem particularly high, or at least particularly human, and the implications of such a model for the quality of education and care are troubling.

They Want to Work

The "needs" of business and employers are often the primary justification for training and education. Of course, another common suggestion is that training programs are a response to the needs and desires of students. It is, after all, impossible to argue with the idea that everyone can be improved by more education and training. My interviews

verify the fact that many health care workers want more education and training and view it, quite rationally, as the only vehicle into better jobs and better lives. During a conversation about CUNY's focus on vocational and terminal degree programs, an official at CUNY on the Concourse said "here in the Bronx...they want to go to work." Said another official at a CUNY senior (4-year) college:

> We're in a borough that is made up of mostly middle and lower-middle class kids who are really anxious about figuring out a way of making more money and getting a better job. ...We're essentially a liberal arts institution and always will be, but we also have a strong connection to professions, what the students demand, what they want.

These trainers suggested that vocational education, rather than being a tool of "cooling out" expectations and channeling aspirations (Clark 1960; Pincus 1986), is actually a manifestation of the desires of the poor and working class. The Center for an Urban Future, assessing the debate within CUNY about the role of vocational training (and calling the debate a "destructive stalemate") presented what it saw as an irrefutable argument: when the problem is considered "from the perspective of its students and the people who employ them," CUNY is obligated to become a "job training engine" and "start doing business" (1999, pg 2).

The Center for an Urban Future views CUNY as "the most important institution in the city for workforce and job development" and criticizes CUNY for not adequately fulfilling its responsibilities. Though CUNY may have the resources to steer the course of workforce development, there is considerable debate over whether it *should* take that role and whether or how that role can be balanced with its more traditional mission of being the most accessible institution of higher education to the city's poor and working class residents. CUNY has moved a long way from its brief experiment with open admissions

and free tuition in the early 1970s (Lavin and Hyllegard 1996), and the notion that CUNY put more effort into vocational and contract training is an attack on those idealists who made truly open access a brief reality. Those who are involved in vocational and contract training at CUNY, on the other hand, respond negatively to the suggestion that contract training is another step in the process of the vocationalization of higher education (see Brint and Karabel 1989). A dean at one CUNY college said the programs he runs are not only academically challenging and sound, but noncredit continuing and contract education is a powerful mechanism for reaching out to those working and minority adults who might otherwise never attend college. Likewise, for the administrator behind the disability studies certificate program, a course such as Introduction to Home Care not only encompasses some of the most sophisticated academic knowledge in psychology, social work, sociology, and other disciplines, but it simultaneously values and legitimizes the hard work that so many direct care givers do.

Doubtless this is so. And it is certain many working class and immigrant students justifiably crave better jobs with better pay to support their families. And for many people work is a valued part of their sense of themselves. But it does not necessarily follow that "they want to go to work." This construction of "they" may be intended as a liberal corrective to the conservative idea that "they" want to stay home and live off welfare, but it nonetheless preemptively confines the imaginative and political potential of redefining "needs." As Paul Willis wrote recently: "the highest ambition inculcated into the working-class student, indeed reflecting their own desperate needs, is for a job, often any job" (Willis 1999, pg. 139). This is a real and immediate need, but not an expression of hopes and dreams. For what should be obvious reasons, "in the critical

thoughts of blacks in the West, social self-creation through labor is not the center-piece of emancipatory hopes" (Gilroy 1993, pg. 40).

Health Care

The notion that health care is a business pervaded my interviews with hospital leaders, human resources directors, and trainers and was the basis for legitimizing much of the "soft skills" training classes I observed. These classes are the subject of Chapter 7, but here I want to describe how general business and market terminologies have become normal ways of thinking about health care.

At a one-day retreat for staff of a medical-surgical floor at a major public hospital, the trainer—also the director of staff development—emphasized that the focus on teamwork was necessary because the hospital "is like any other corporation." Retreat participants were asked to write a commercial for their unit, basing it in particular on how they would sell the qualities of a co-worker they had interviewed as part of an earlier retreat exercise. Then participants read their creations aloud. Whether or not the exercise instilled a belief that their hospital was a corporation, it certainly tapped into the creativity and good humor of the hospital staff. One nursing assistant had to stop reading aloud after the line in her ad "anyone is welcome—good credit, bad credit," because the laughter was so loud. While imitating a common trope in advertising directed at less affluent target groups, the nursing assistant's ad also invoked a real problem with the analogy between hospitals and corporations: as a public hospital it was required to accept any patient who walked through the doors, regardless of their ability to pay.

In this "retreat," the instructor also tried to get around the ever-present issues of resource constraints, poor staffing levels, and supply shortages by arguing that these things were beyond the staff's control. What was in their control, on the other hand, was their attitude and their ability to work together as a team, both of which could potentially improve the hospital's image and "customer" (patient) satisfaction. Another instructor of a communication skills course pushed the same logic a step further and argued that improved customer satisfaction might, in turn, create more business for the hospital and provide the revenue necessary for supplies and greater staffing levels. Discussing this emphasis on customer service training that emerged as part of an industry-wide focus on "re-engineering" in the mid-90s, a former hospital Director of Training (now consultant) said:

> I think that with the competition, there was a real feeling managed care was coming in, that one of the ways that you keep the people and you get more people to come in, is by word of mouth. I think everybody was saying that if one person has a good experience then they'll bring another person in, but if one person has a bad experience it will effect 7 or 8 people. So given what was happening with the competition coming, with managed care coming in, that one of the ways to ensure that you have a patient base is that people are treated nicely.[15]

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[15] Anecdotes in the nursing literature suggest that training in health care-as-a-business is now rampant. One nurse's essay is worth quoting at length:

> ...in an effort to understand how the staffing cutbacks that compromised patient care contributed to our hospital's mission and enhanced our revenues, I attended a hospital-sponsored educational session on reorganization titled, ironically, "Delivering Exceptional Customer Care." I heard the business consultant, who was brought in by the hospital management for a multimillion-dollar initiative, tell a room full of nurses to avoid using the word "cancer." An oncology nurse asked, "What, then, do we say to a newly diagnosed patient?" "Try to say nothing," came this consultant's blunt and sincere reply. "The patient will associate the word with the hospital, and that's bad for repeat business" (Bingham 2002).

As in the quote above, this consultant suggested (perversely) that patients should be recruited for hospitals (as "repeat business"). The idea that it is bad to have words like "cancer" associated with the hospital is also relevant to the idea of branding and affective value discussed in Chapter 8.

Another training consultant, describing her specially-designed courses in gerontology, had developed her own strategy for introducing the health care-as-business principle:

> When we talk about the institution...quite clearly we talk about the fact that the institution has its own goals and mission and it has to continue to thrive, and that's the primary goal. Make money and do resident care. That may seem like a conflict for the staff, or that it's somewhat distasteful to the staff, but we're all involved in that. If they don't make a profit, we don't have a job, so that's reality.

This strategy served to present health care-as-business as an accepted reality and effectively foreclose the incessant complaints of limited resources that can dominate training sessions if left unchecked. "If they don't make a profit, we don't have a job" is the most base position from which to entreat workers to make sure patients are "treated nicely" and to sell their organization, all the while skirting around any the organizational and industry-wide barriers to what is at bottom the most important issue: quality of patient care.

Anyone who has set foot in a hospital, at least a New York City hospital, will probably be skeptical that this discourse emerges from a real shift in orientation in health care facilities toward business ideologies such as "the customer is always right." Although my interviews are littered with a discourse of commodification, they are also littered with examples of just how unruly the markets for health care and for educating allied health care workers are. The nursing assistant's advertisement clearly suggests that the nature of the health care is not fully amenable to the wholesale adoption of managerial or business logics. Veronica, another nursing assistant, talked about how she was taught in an in-service that patients were "clientele" and the hospital was a "hotel."

"I just go along with it," she said. "I know it's a patient, because you go into a room and somebody asks you for a bed pan when you're bringing a meal."

Difficulties putting the logic of business or of markets into practice occur when the logic comes up against entrenched organizational culture and practices. The training sessions in soft skills that I have observed would repeatedly stumble into the problem that the organizational infrastructure did not truly allow for the wholesale adoption of managerial or business logics. There is no better illustration of such organizational issues than the half hour period I spent in the waiting room at CUNY on the Concourse.

Like any retail outlet relying on the allure of its window displays to drawn in customers, CUNY on the Concourse must still provide the kind of products and customer service necessary for locking in the final sale. At the time of my visit, the rectangular waiting room of CUNY on the Concourse was divided length-wise by an imposing, chest-high counter, behind which sat three people, two of whom were receptionists of some sort. Starkly lit and dominated by an institutional gray, the room showed little evidence that its designers were interested in customer service. While sitting in a waiting room chair, I watched a white, middle-aged receptionist try to minimize contact with a Hispanic women and her mother, who had come upstairs to ask about LPN programs, by asserting she didn't know what they were talking about. Only after persistence by the daughter did it finally become apparent that the receptionist knew exactly what they were talking about. The same receptionist told a young black man who wished to pay for a computer course half on debit card and half on credit card that she didn't know how to do that, and couldn't he just "put it all on the debit card?" The question seemed mundanely cruel, as the man awkwardly made it clear he could not charge the entire course to his

bank account. The receptionist then phoned a supervisor who told her how to run the charges separately. The second receptionist, a young Hispanic woman, put a phone call on hold and asked the first receptionist whether they offered discounts for family members, to which she responded "it's not the welfare office."

I suspect these kinds of interactions are common when there is a discrepancy between how an organization presents itself—in this case as a one-stop shopping center for education—and what that organization is really prepared to do. In addition, perhaps the clientele of CUNY on the Concourse are not particularly surprised to be treated shabbily by a representative of a large bureaucracy like City University of New York. And ultimately, since their choices in the market of sub-baccalaureate education are limited, CUNY on the Concourse may not noticeably suffer because of its poor "customer service."

♦

Education and health care are clearly arranged with an eye toward markets and revenue—the training and education industry for health care carves out a specialized niche at the intersection of health care and education. But given that health care and education are in some ways resistant to wholesale commodification, what exactly is being bought and sold in the training and education industry for allied health care workers? What is valued?

I contend that it is *not*, primarily, skills and credentials. Programs in the training and education industry have been subject to virtually no evaluation studies. One voluntary hospital-based training official said she never felt any pressure from the hospital administration to prove that training dollars would reduce costs, increase

productivity, or improve care. This may be largely a result of the fact that hospitals do not have to pay for most current training from their own operating budgets; hospitals don't particularly care about return on investment when they aren't investing. (Most of the funding can be traced back to state and federal governments.) And yet, training and education does have to create some sort of market—identifying or constructing needs, finding people to enroll in classes, and generating a sense of its importance.

To borrow a famous formulation from organizational sociology, it could be said that the training and education industry "is a collection of choices looking for problems, issues and feelings looking for decision situations in which they might be aired, solutions looking for issues to which they might be the answer, and decision makers looking for work" (Cohen, March, and Olsen 1972). When training is a generously-funded solution looking for problems, it's likely to create them.

And at this point, the training and education industry supports a good many decision makers. What is most interesting about the literature review with which I opened this chapter (Rubinson and Browne 1994) is that education and the economy are conceived as autonomous spheres (a reflection of the literature itself). Though it is undefined, "the economy" seems to refer strictly to the world of waged labor typically reflected in statistics on wages, productivity, and gross national product. The problem with such a formulation is, of course, that education, like health care, is itself an industry. Its economic effects do not solely exist indirectly, in the production of workers and skills for "the economy"; education employs large numbers of people, makes some of those people quite wealthy, produces goods to be consumed, perpetuates a need for those goods, accumulates investments, and support numerous ancillary industries (such as

publishing). In this sense training and education for health care workers in New York City is an economic entity rather than an adjunct to the economy.

The training and education industry for allied health care workers does of course also exist in relationship to "the economy" traditionally conceived,[16] but this is not the major focus of my study. The training and education industry for allied health care workers in New York City produces and legitimates new forms of value. This means that education partakes in the economy and can be seen as an innovator of new products. My argument is that one of the most significant forms of value in which this industry participates that of affect. But affect is not, I will show, a product or substance that easily lends itself to be measured or understood by traditional categories of thought in economics or economic sociology. Therefore, though it is useful to think of education as "commodified," such terminology is inadequate in its ability to capture the reverberations of the particular training and education industry considered here and to capture important aspects of the economy and value more generally.

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[16] Various aspects of the training and education industry support quite different theories about how education and the economy are related: training nurses to fill a vast shortage seems consistent with the view that education responds to economic need; upgrading nursing assistants to certified nursing assistants/patient care technicians is consistent with a view that education supports credential inflation not related to job requirements; and in-service communication skills classes can be easily made consistent with the view that education is mechanism of ideological control.

CHAPTER 4: PATTERNS OF ENGAGEMENT

The ways in which allied health care workers navigate the complicated terrain of occupations, training programs, and educational vendors supports the idea that this training and education industry is not driven primarily by "outcomes" or "needs" as they are conventionally understood. Indeed, as the second part of this chapter shows, the discourse of needs and skills gaps notwithstanding, administrators and educators have begun to incorporate nonlinear and halting patterns of engagement with training and education into their program goals—as if such patterns were intended. In this scenario, traditional outcomes are the byproduct of an industry primarily devoted to modulating sustaining workers' engagement and attention.

At the outset of this research, one of my goals was to use the in-depth interview format to document the full range of learning experiences which an allied health care worker might encounter. Most quantitative surveys of the American workforce and their educational history focus on the experiences that can be readily categorized by close-ended questions; including questions such as the highest degree obtained, parents' education level, and the like. Similarly, in common social science datasets education is measured as an achievement locked in time, and not the ongoing process it often is.[17] The number of interviews and my sampling strategy prevent me from speculating on whether

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[17] Therefore in a study on "Occupational Stratification Across the Lifecourse" published recently in the *American Sociological Review* (Warren, Hauser, and Sheridan 2002) using data from the Wisconsin Longitudinal Study, measured the occupational standing of 1957 high school graduates at several points until 1993/94, while educational attainment was measured only in 1964. It is therefore impossible to know the impact of any education attained after the study participants were roughly 24 years of age. While ongoing and adult education may be minimal for this cohort (though this is unknown), to stop measuring educational attainment at age 24 for more recent generations would undoubtedly produce a highly inaccurate picture of actual education levels.

the educational histories of these workers are typical or representative of a larger group. Nonetheless, I believe these interviews illustrate the ways in which a sprawling educational industry infiltrates the crevices of everyday life. To give a full picture of how "lifelong learning" is experienced, here I present three detailed snapshots of Grace, Marie and Cesar—three 1199 members who have navigated the sub-baccalaureate labor market in distinct ways.

Grace

Grace, a 31-year old immigrant from Trinidad, was working as a Diet Coordinator and just about to graduate from the Physical Therapy Assistant (PTA) program at New York University when I interviewed her. We met in a cramped office next to the kitchen in the bowels of Grandview, a major teaching hospital in central Brooklyn. The hospital and neighboring health facilities occupy several city blocks, constituting a buzzing health care metropolis in the middle of an economically-devastated urban area.

Following her mother, who was in New York working as a nanny, Grace came from Trinidad at the age of 17. She finished high school in New York and her first job was working as a cashier at a grocery store in Queens making $3.35 per hour. She wanted to go to college, but not "regular college" and wasn't yet sure what she wanted to study. Her older sister was working as a dietary aide at Grandview and helped her get the same job. It was an 1199 position and she started part-time at $4.50 per hour, in 1990. While working as a dietary aide, Grace attended Technical Career Institutes (TCI)—a private, for-profit, two-year college offering occupational certificates and associates degrees—full-time for nearly two years. She entered to study computer technology because "I love

fixing things with my hands." But, "I got into that program [computer technology] and they [TCI] did not want that program anymore in the school so they took it out and put me in electrical engineering. So I was in that program, then I decided I didn't like it any more so I got out of that." Grace had received financial aid to attend TCI and she left without a degree.

Grace said she "always wanted to be a nurse," and after watching the care her newborn son received from nurses in 1993, she attended a 3-month certified nursing assistant (CNA) program. The course was paid for by a state employment center, as determined by income eligibility. Grace then worked as a *per diem* nursing assistant on the night shift at a nursing home in Brooklyn, making over $15 an hour. At the same time she had become full-time at Grandview, working as an inventory clerk for the corporation subcontracted to run food services. She said that eventually her "back went out" working at the nursing home: "This was like 20 patients to one person. I was too young for that." Feeling that she was young enough to still do other things, Grace quit the nursing home.

By this time, around 1995, Grace had been promoted to her current position of diet coordinator at Grandview, for which she was making $13.57 per hour in 2002. In 1996, she paid $500 to attend a 120-hour Dietary Manager certificate course at NYU. She said she might have been reimbursed by 1199 TUF for that course, "but I said not everything you do is for the money." At the same time, she also began working part-time for a home health care agency, caring for a single elderly patient on nights and weekends until the patient's death in 1997. (Grace's mother was, by this time, also working as home health attendant.)

Hoping to combine her enjoyment of working with her hands, fixing things, and taking care of people, Grace looked into the PTA program at NYU (where she also taking a sign-language class). She went to take the entrance exam for the program in 1997 and sat next to an 1199 member who had been sent by the TUF to take the exam. It turned out that 1199 TUF provided funding for the PTA program. Grace passed the exam, signed up with the 1199 TUF, and was given paid release time from work while she attended school. Though there were a few hiccups along the way (she had to repeat a Biology course), at the time of our interview Grace was one month from graduation and had already been offered two jobs as a PTA – at a hospital and a nursing home. She said her starting wage as a PTA would be around $35-38,000 a year.[18] She hoped to eventually go back to NYU for the program in Health and Policy Planning.

Along the way, Grace also worked as a bartender off the books and as a crew leader for the census to make extra money. She had never been on public assistance. At the time of our interview, she lived with her boyfriend and sent her son to private school.

Marie

I first met Marie during an evaluation of communication skills program funded by 1199 TUF (Aronowitz, Ducey, Gautney, and Wetzel 2001), for which I shadowed her at work as a PCT in the emergency room of Bronx Hospital, a mid-size voluntary hospital. For this study, I interviewed her in her 1-bedroom apartment in the Bronx. It was filled with the small of banana bread and her 11-year-old son's books, toys, and videos. Marie

[18] Data from the American Medical Association *Health Professions Career and Education Directory, 2003-04* indicates the national average salary for PTAs in 1997 was $26,000.

was born in Brooklyn to Puerto Rican parents, who had since divorced. She has a close relationship with her mother, who has an active care-taking role for Marie's son. Her mother was, when we spoke, a medical records supervisor at another hospital in the Bronx.

Evidently a talented student, Marie was once accepted to Bronx Science High School (one of the elite public high schools that admits students based on the results of a competitive, city-wide exam) but, not realizing the import of that opportunity, chose to go to another Manhattan high school with her cousin. She dropped out of high school in her senior year in part because she was threatened by other students and distressed by the non-academic aspects of high school life. (Her son too faced bullying at school and Marie described her determined efforts to protect her son and get him into good schools and accelerated programs.)

After dropping out of high school in 1986, Marie worked in a clerical job at a company which administered hospice care programs for about two and a half years. She took home $365 every two weeks: "I thought I was rich!" she said. During that period Marie passed the GED exam. She described the test and the preparatory classes she took vividly and in strongly emotional terms; she had considerable anxiety surrounding tests and math in particular, so was overjoyed when she passed.

When the hospice company lost its major contract and shut down, Marie was laid off with severance pay. She started to attend Lehman College on a scholarship program and had been working for a few months doing clerical tasks for a Wall Street firm making about $9 an hour when she learned she was pregnant. The Wall Street firm fired her and

with her mother's support, Marie decided to put off college and concentrate on supporting herself and her son.

Marie lived with her son's father for a while, but they'd been together for a long time when she became pregnant and she already knew it wasn't going to work out. (He had very little to do with his son after their split.) When they split Marie lived with her mother for a few months and then qualified for the Section VIII (subsidized) apartment in which she lived when I interviewed her. After her son was born she went on public assistance and found it a demeaning experience, particularly using food stamps: "I got tired of every time I went to the supermarket they look at you like you took a poop on yourself."

As part of the effort to reduce welfare rolls, the state paid for Marie to attend a certified nursing assistant program. She paid $1,000 for the first program out of her own pocket, however, because the state would not pay for night classes. After going to the program part-time for 6 months, she said "I wasn't confident enough to take the test." She started a second program at a different school but sprained her ankle and didn't complete it. Finally, on the third try, she went to a program she liked very much and which was more hands-on; it sent students to do clinical internships and held practice job interviews. She completed the program and was hired in an 1199 job at a hospital in Westchester county, starting at $8.50 per hour. She was ecstatic to be off public assistance—though she was making barely enough money to get by. Some months later a friend told her Bronx Hospital was hiring nursing assistants.

In 1995 she started on the night shift an Bronx Hospital making just over $10 per hour and moved through several departments before settling in the emergency room.

Marie found the work interesting, saying "there's always something new to do." But by the time of our interview, she was tired of doing the same thing every day. In my estimation she was a skilled and compassionate caregiver, but "the work...is not challenging for me anymore." She said, "I want to continue my education, I don't want to stay the same way that I am." In 2000, she went through the hospital-wide upgrade to a patient care technician (PCT). She was making just over $14 per hour when I interviewed her.

In 2000, Marie started taking classes four nights a week at Lehman College again. She did not pass the math section of the CUNY entrance exam, however, and was assigned to a remedial math class. She took the remedial math class a couple of times, but either didn't finish it for failed the final exam. She said "I panicked and I couldn't pass." She described how poor some of the math teachers were, saying they didn't understand the preparation level of the students or how to teach them appropriately. (Once she brought her son to a remedial math class but her male classmates asked her to stop since he was better at math than they were.) Though Marie had taken and passed English and Sociology classes at Lehman, she couldn't continue there without passing all sections of the entrance exam. Marie became frustrated and discouraged and quit her classes in the second semester.

At the time of our interview, Marie was hoping to qualify for one of the LPN programs being offered at 1199 TUF's new training facility in the Bronx (in the space shared with CUNY on the Concourse and built jointly with a state grant). Becoming an LPN requires completing a 9-month, non-credit, certificate program and passing a state exam. Marie's most immediate hurdle would be to pass the LPN entrance exam, called

the C-NET and widely judged to be more difficult than the entrance exam for RN programs. Marie took satisfaction in caring for people and deeply desired to become a nurse, both for her own sake and to show her son that she could do it.

Cesar

Cesar was born in the Dominican Republic and came to the United States in 1978 at the age of 13. The well-tended, prewar building just off the Grand Concourse[19] where Cesar lived with his wife and young son had ornate, wrought iron bars on the windows and intricate tile patterns in the hallway floors, reflecting the neighborhood's affluent beginnings. Cesar's mother, who used to work in a garment factory but had retired, lived in the same building.

After graduating from a public high school in the Bronx in 1985, Cesar attended City College (a CUNY 4-year campus) for about two years, then he stopped and worked full-time for a while, and then he went back to Queensboro Community College (a CUNY campus in Queens). He never received a degree from either school, saying he was never sure what he wanted to study or do. At Queensboro he studied computers—a topic which was clearly his main interest and hobby. In his living room there were two computers and many computer books. He said he stopped attending Queensboro because he became tired of the commute and he started to have trouble paying for the classes. By that time, Cesar was working full-time at Bronx Hospital as a security officer, and though he received some tuition reimbursement from the union and some financial aid, it didn't

[19] To get a sense of the Bronx—and the Grand Concourse—before and after Robert Moses sliced it in two with the Cross-Bronx Expressway, see Berman (1982, section V).

cover all his tuition and Cesar felt obtaining union reimbursement was a too big of a hassle.

Though Cesar had no "real love" for security work and it was very difficult and aggravating at times, it was a secure 1199 job, it paid the bills, and there was a lot of camaraderie in the security department. Though the union was "always offering all types of programs," Cesar wasn't very interested in the health care field. He said "I'm a technical person." In 1994, however, he did sign up for a Pharmacy Technician program sponsored by the union and Bronx Hospital. He attended class five mornings a week for 9 months. "I completed the program, but at that time the hospital was in the process of automating the pharmacy so they were actually getting rid of the personnel...and weren't willing to take anybody new to train." There was no job for him when he was done. Though he might have been able to get a job at another hospital, Cesar had seniority and a regular schedule worked out at Bronx Hospital; he didn't want to move. Although he started to say the Pharmacy Tech training had been a waste of time, he diplomatically stopped himself and said it had come in handy later with the OR Tech program.

In 2000, Cesar saw a bulletin board posting for an OR Tech program for Bronx Hospital. Cesar talked to a friend who worked in the operating room about the job and decided it would be worth a try. He brushed up on his math skills to prepare for the entrance exam and was one of four Bronx Hospital employees (out of at least a hundred who applied) to be accepted. He was given paid release time from work and attended the program at the Consortium for Worker Education every day for 9 months. After completing the program, Cesar worked in security for 5 more months while he waited for

a position to open at Bronx Hospital. It finally did, and at the time of our interview he'd been an OR Tech for about 6 months, making just over $18 an hour.

Cesar said "I was never interested in the medical field before." He really didn't know what he was getting into when he started the OR Tech program: "when I first started I wasn't really sure that it was for me." The job is demanding—OR Techs prep the operating room, get all the instruments and equipment ready, and are at the surgeon's side throughout the procedure. The emotional aspects of the job are just as great as the technical aspects, but Cesar said he enjoyed working with the equipment and machines. He described how interesting it was to see an orthopedic knee surgery for the first time.

At the time of our interview, Cesar was finishing up a 10-week film production class at Lehman College, which would qualify him to produce a show for the CUNY cable television channel. He said he really likes school: "anything I can learn." He was also interested in taking some of the computer courses (non-credit, certificate programs) at the recently opened CUNY on the Concourse. He also expressed interest in becoming a medical equipment vendor, an occupation he discovered once he began working in the operating room.

♦

For Grace, Marie, and Cesar school and education has a permanent, if halting, presence in their lives. Either it is something about which they are constantly thinking or planning to do to keep moving forward, or they are actually enrolled in classes somewhere. All three have moved into and out of training and education programs, for a

variety of reasons—some of them personal but some of them clearly artifacts of a convoluted training and education industry.

All three encountered obstacles that resulted from inadequate information about the status or requirements of the labor market.[20] Grace and Cesar in particular both devoted considerable amounts of time to a training or education program that they did not complete. In Cesar's case, who would think that the union and hospital would pay for him to attend a training program for which there were no jobs? Not only did he not know the status of the labor market for Pharmacy Technicians, apparently neither did the union. The computer program Grace started at TCI was terminated before she could finish her degree. Perhaps wary of giving the impression that they were somehow ungrateful, neither Grace nor Cesar expressed anger or resentment about these experiences. Said Grace about not finishing at TCI: "It's just something I wanted to try, it's not what I wanted to do. It's not a big disappointment."

These interviews were conducted approximately 13 to 18 years after the respondents had completed high school and only Grace had obtained an associate's degree—but education and training had been a regular part of each of their lives during the period between high school and the interview. It may be tempting to ascribe this pattern of engagement with education to personal indecisiveness and a lack of motivation on the part of these workers. I suggest such patterns of engagement with education are in fact a inevitable product of the convoluted education and training industry. This is not due to the intentions and desires of individual actors—for instance, I don't think these

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[20] When considering a shortage of Pharmacy Techs at one hospital, or even several hospitals, the term "labor market" seems wildly inaccurate.

patterns can be explained, as a whole, by poor individual choices or the perfidy of shady educators (which is an appealing explanation when administrators at schools like TCI take the federal aid students receive to attend their programs and then close them down before students can graduate). Rather, such experiences, or patterns of engagement, are indicative of a general shift in expectations, values, and social forms. One element of this shift is that there is both considerable pressure to obtain credentials and an education while in another register education and training is rendered valuable regardless of the actual achievement of credentials.

Another aspect of this shift is the blurring of training and education; or, a certain indifference to their distinction. Though the distinctions between these various types of training matter when asking certain types of questions, just as ultimately the potential earnings of a college graduate and a high school graduate differ very much, I am here trying to capture the reality of what is, for many workers entangled in the education and training industry, an active and perpetual deferment of traditional "outcomes." In this always-liminal lived time, learning, training, and education are so embedded in the institutions and culture that the breaks—where credentials lead to advancement, or education is pursued apart from work, are difficult to distinguish.

♦

Given that health care workers can experience training and education in the ways described above, what are the conditions that make these experiences possible? How do those who plan and develop training program understand or even facilitate these patterns of engagement?

The JFK, Jr. Institute for Worker Education, a CUNY-affiliated nonprofit organization dedicated to improving the working conditions of direct care workers (i.e., home care workers), has recently developed several programs that would pay for direct care workers to take college courses. The ultimate concern of the institute is to improve the quality of care, and one way to do this is to improve the lives of those who provide care. There are substantial problems with turnover in the home care sector, in no small part because the hourly wages average around $6 and $7 an hour and despite the fact that a survey of these workers conducted by the Institute showed that 40% would like to stay in their job as long as possible or until they retired.

When the executive director of the Institute described one program to me, I asked "Wouldn't this undermine the Institute's goal of developing a more skilled, committed direct care workforce: after all, wouldn't these workers quickly leave their direct care jobs upon receiving an education?" He replied,

> It's true, you say well, people become supervisors or push upward. On the other hand, a worker who's going to university, working and going to school taking one or two courses, it takes ten years. So if the turnover rate for direct care workers is 1 ½ years or 3 years average and you had someone who was going to school, making their way, moving forward that way, and stayed for 7 or 8 years, that would be like, that's wonderful. A worker isn't necessarily going to college and getting a BA, which opens up other doors.

He reminded me that there are thousands of workers across the city pursuing college degrees this way: one course at a time, while working and, in most cases, raising a family.

The program the Institute had developed, a certificate in direct care generalist and disability studies consisting of a college preparatory course and four 3-credit courses,

would not move these workers substantially toward a college degree. Nor was it a certificate that qualified them for better jobs. But, apparently, what it *could* do was engage the workers, give them a sense of accomplishment, place the work within a context of more academic knowledge, all of which would potentially improve the quality of care—though undoubtedly the most concrete way care would improve would be through reducing turnover. As recent work in the sociology of emotional and caregiving labor has hypothesized, women and workers who do not feel coerced or trapped into their caregiving roles may deliver a higher quality of care (England and Folbre 1999; Folbre and Weisskopf 1998). The idea of this training program was that workers who participate in it might have a sense that they were moving forward (i.e., not trapped) and this would both keep them in their jobs and improve their attitude and feelings about their jobs.

This is why I discuss education *and* training as if they were synonymous, why I repeatedly use the phrase "training and education industry" though it encompasses a wide range of programs and institutional settings. Clearly there is difference between in-service training for communication skills and union-funded college courses. And, I agree with the CUNY college dean who argued that the ability to provide college credits is an advantage of CUNY initiatives over many other kinds of training programs. Ideally, such credits establish a base for these health care workers to pursue a degree. Nonetheless, it takes a working person many years to prepare for college, let alone obtain a Bachelor's, as the Institute director acknowledged—think of Cesar, Marie, and Grace. Since most educational programs funded by 1199 and employers are an occupational benefit rather than a social right, it is also difficult for students to stop working and pursue an education full-time without losing their funding and income. This fact of how education moves in

the lives of adult workers allows employers and training program administrators to consider, as part of the program development process, not only whether the program will result in outcomes like a new job or wage increases, but whether and how education and training will effect the worker's relationship to their (con)current job. In this case, college education is viewed, at least partially, as a means of keeping workers in their jobs for a longer period, not as a springboard out of low-wage jobs. The Institute was also involved in trying the improve the working conditions of direct care workers by initiating career ladders and seeking ways to improve wages and job security. But the use of education as a tool to make jobs more desirable or palatable or to alter the way those jobs are experienced is a significant twist in the relationship between employment and education.

In this situation then, college education is directly a form of vocational training—if by that we simply mean an educational experience oriented toward waged labor. Certainly it is not vocational in the sense that it teaches specific technical skills (and it would therefore pass under the radar of surveys and classification schemes designed to measure the extent of vocational education). Most critics of the "vocationalization" of higher education (Brint and Karabel 1989) are specifically referring to the increasing numbers of students enrolled in terminal, occupational programs. I am suggesting that perhaps the difference between vocational training and college education has been overdrawn, at least if we are asking how education relates to the economic or what is the nature of its commodification, or what exactly is so valuable about education that the state, employers, and unions devote so many resources to it.

Consider too the blurring of education and training from an almost inverse situation, that of the Consortium for Worker Education (CWE), a multi-union-funded

training center that does not offer college credit and one of the most powerful political actors in New York City workforce politics. CWE is the recipient of among the largest grants for training under state and federal programs. I interviewed the director of allied health programs at CWE in her new office: one corner of a sunny warehouse loft. The office windows overlooked the sunny southern Manhattan skyline, where the World Trade Center stood until a few months before. She had just moved into a newly created position to oversee workforce development projects implemented because of the economic downturn exacerbated—but not caused—by the events of September 11th, 2001. The loft had just been vacated by a dot.com gone bust—and the spatial transition from new media to training for entry level health positions seemed pretty much to encapsulate the economic state of the City. Reflecting on her work as a trainer and earlier, as a nurse, she said:

> There has to be an administrative decision to constantly nurture the workforce. If I had my way, there would be all kinds of continuing opportunities for self exploration and personal fulfillment. I think that those are linked to helping people to cope better with the kinds of jobs that they have in their lives, which are very rigorous and exhausting, emotionally and physically.

She described the kinds of courses which could provide such nurturance: in-services on topics like nutrition, stress reduction, body mechanics and health care worker's own physical problems. As she spoke, I was at first surprised that the director of vocationally-oriented training programs would emphasize fulfillment and nurturance as goals of training. I thought maybe this was an anomaly—a byproduct of the anxiety and uncertainty that resulted from the events of September 11th and the loss of hundreds of thousands of jobs in its wake.

These were not college courses, but their ends bore striking resemblance to the certificate program for direct care workers: to enable workers to rearrange their relationship with their work. Education and training might facilitate this rearrangement in a couple of ways: the self-exploration it can encourage might provide fulfillment in spite of work, i.e., allow students to "cope" with their work and the necessity of wage labor because the rewards garnered outside of work are so rich. But education and training might also infuse that very work with interest, re-constructing that work as an object or arena of stimulation and engagement. Infuse seems an accurate term since both of these administrators talked about the conditions of health care work, the physically onerous and exhausting aspects of providing direct care, as if they were given. These kinds of transformations, or subtle shifts in the modes by which training and education intervenes, are what interest me here.

In this situation, the value of training might be located not in the human capital workers acquire but in the invigoration of participation in work. I would say that the production of the tools to cope or of the will to persevere is the modulation of a very fundamental force: the will to act, to engage, to actively participate. Training can also be oriented toward inculcating skills and knowledge, but these are of little value if they are not also enacted. Skills and of affect are intertwined, but distinct.

Similarly, though I see affect as related to emotion and the concept of emotional labor, it is different. In fact it is more closely related to what Randall Collins calls emotional energy (Collins 1990; Collins 1993) or what Antonio Negri—following Spinoza—calls the power to act (Negri 1999). When education and training addresses affect it is concerned with motivation, desire, and engagement, not with specific

emotions. The often overlooked concept of emotional technology is also important to understanding how this training and education industry situates itself as worthwhile and valuable, as I discuss in Chapter 8. Training and education which focus on affect are also an attempt to capture that cooperation and investment and make it valuable and productive, in economic terms. I suggest that the training and education industry is a technique of producing and channeling emotional energy. It does this in addition to and sometimes instead of transmitting skills and knowledge and certificates of a more tangible nature. I believe that the affective dimension of training and education compels a tremendous level of economic investment *in the absence* of significant change in the way health care is delivered or health care work is organized.

In this industry and in this moment, the most immediate idea of the relationship between education and work is inadequate. Education appears here in the guise of a modulation of the relationship to work rather than a training program for new and better work or a valuable world of ideas in and of itself. It is noteworthy that neither educators or program planners I have quoted discuss training as vehicles for promoting critical faculties or politicized awareness. This would, after all, be one obvious way of enabling workers to "cope" with (if by that we mean understand and alter) the realities of their work. These are often seen as the true ends of education, from John Dewey to Paulo Freire. Even more moderate and less idealistic social scientists who describe the "vocationalization" of higher education (e.g., Brint and Karabel 1989) imply that "education" involves the production of critical awareness or well-rounded civil subjects while vocational training is largely devoid of these qualities. For instance, while concerns with fulfillment, coping, self, and meaning—a decidedly therapeutic language—

dominated the talk of some educational planners and career development experts I have interviewed, it is not unwarranted to suspect such concerns were largely superficial, masking and rationalizing a shoddy but lucrative business, detailing the latest product line in a vocationalized education marketplace. After all, the actual courses which the Center for Worker Education director described would attempt to address very serious issues in only the course of several days (if that). Similarly, the Direct Care Generalist or Disability Studies Certificate programs for direct care workers involved taking only a few college courses in relatively practical-vocational areas such as psychology, behavior management, and therapeutic recreation. These programs can be perhaps characterized by their focus on worker flexibility and adaptability to the stressful conditions of health care work. Training appears in this light as the production of engagement which is directed toward the reproduction of capitalist social relations. The trade in affect could thus be viewed as the latest innovation in forms of control.

That is a question I take up more thoroughly in Chapter 7, which discusses soft skills training. It is true that the focus on cultivating engagement is, in some ways, yet another variation in response to the ever-present problems of control in the workplace and the inevitable discrepancy between individual expectations and actual opportunities in a stratified society. On the other hand, something about the desire to nurture workers is wholly devoid of cynicism: it is lodged in the hope of transcending the discrepancy between expectations and opportunity, not in resigning to that discrepancy. Furthermore, the concern with nurturance, with making health care work fulfilling and rewarding, does seem to touch upon a very real and profound anxiety or disturbance. In this case that disturbance has been taken up in therapeutic terms and an emphasis on the goals of

training and education not immediately tied to skills, upward mobility, or compensation; ends like attitudes toward work, self-conceptions, and engagement. If affect is a vehicle for the exercise of control, then I would contend it is not a very reliable one. This training and education industry is profoundly shaping patterns of engagement with work and education. Affective technologies—or the discourses and practices surrounding emotional energy, motivation, and engagement—need to be examined as closely as sociologists have examined the parallel growth communication technology and cultural commodities.

CHAPTER 5: GETTING INTO HEALTH CARE

It may come as a surprise that—as I showed in the previous chapter—training and education for health care workers would focus on fulfillment and engagement. Though the stressful conditions of health care work are well documented, the health care industry has relied to a large degree on the idea that health care is a calling, that there are inherent rewards to becoming a care provider, and that health care workers like providing care, both to recruit and retain the allied and paraprofessional health care workforce. But the national shortage of health care workers (particularly registered nurses) suggests such a stance is no longer viable—that, in fact, health care is a workplace like all others, in which the same problems of motivation and satisfaction are evident. The idea that health care is a workplace like all others is still a controversial statement because a good deal of political and rhetorical positioning takes place around the idea that providing care is a unique form of labor.

How and why did the health care workers I interviewed enter the health care field? While the perspective of sociology generally recognizes the play of structures of opportunity and stratification on a person's occupational trajectory, I think nonetheless sociological studies frequently naturalize "careers" through recourse to the desires and traits of individuals. That is, occupational status is ascribed, ultimately, to individual "choice." In the realm of health care this tendency is particularly strong and problematic: the fact that most direct, hands-on care jobs are occupied by women has often been taken as an indication that women must *choose* to do these jobs because they are good at them

and personally rewarded by them. Social and political battles over persistent wage discrepancies between men and women and the "wage penalty" of caregiving work (England, Budig, and Folbre 2002) often unmask an argument that these discrepancies can be explained by the fact that women choose to participate in work that is rewarding so employers can therefore get away with paying less—an argument that is "plausible but empirically unsubstantiated" (England and Folbre 1999, pg. 44).

How do choice and opportunity interact in the lives of these health care workers? To what extent can we say that these health care workers are drawn to the dimension of health care work that involves providing care? What are their articulated motives for entering health care work? To recruit and retain the allied and professional health care workforce the health care industry relies on the idea that health care is a calling, that there are inherent rewards to becoming a care provider, and that health care workers like providing care. As we will see at the end of this chapter, the idea of health care as a calling is the basis for recent concerns about a "loss of meaning" in health care work. The nation-wide and interminable shortage of registered nurses suggests such a stance is no longer viable—that, in fact, health care is a workplace like others subject to problems of motivation and satisfaction. But do problems recruiting nurses suggest health care work is no longer meaningful? Should we be concerned if health care workers are not motivated by altruism or the desire to care for others?

In order to answer these questions, I analyzed the interviews with health care workers in relation to three variables: whether they 1) planned from early in their working life to go into an occupation specific to health care; 2) had worked primarily in

direct care jobs; and 3) self-identified in the interview as a caregiver, or indicated they took pleasure from providing direct care.

By "planned" to go into an occupation specific to health care, I mean that when the respondent needed to make decisions about the course of his or her working life, he or she decided to go into health care and took the steps necessary to do so. A few people I interviewed made this plan. Others, by contrast, didn't pursue health care as a vocation until an opportunity presented itself or life's vicissitudes finally made it the best option. In this latter category I include both people who had considered various health care occupations but didn't pursue them and people who simply never imagined working in health care until it happened. I view "planning" as an activity influenced more by expectations than aspirations; therefore my discussion of respondents' plans does not necessarily reflect their hopes and dreams and I do not tell the full story of how their aspirations become channeled into "realistic" expectations.[21] But, of course, that is a process that looms behind the stories I do tell, and it is impossible not to wonder what these interview respondents, like most of us, might have become in a slightly different world.

The designation "direct care" refers to staff who have regular face-to-face contact with patients and whose primary responsibility is to interact with and care for patients. So, direct care occupations typically includes doctors, nurses and nursing assistants, but

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[21] Jay MacLeod makes a clear distinction between expectations and aspirations, showing that expectations are based on the assessments of one's "realistic" chances and aspirations are the stuff and dreams and desires (MacLeod 1995).

not registrars, unit clerks, or security guards.[22] I focus on whether there are distinct motives and patterns associated with going into direct patient-care jobs, because these are the jobs around which the politics of care and caregiving labor hinge.

"Self-identifies as a caregiver" means that discussion of the pleasures of touching and caring for another person, or stories that illustrated the importance of personally taking care of others, emerged in the interview (as a response to a direct question or not).

These "variables" are heuristic tools and not destinations; applying dichotomous variables to in-depth interview data is distorting. I will, in the description below, flesh out these variables and the nuances they contain, while producing an initial schematic for drawing distinctions among the diversity of reasons for going into health care among those I interviewed. This analysis highlights the complex interface between opportunity and aspirations. Since I think there is a general perception that people who work in health care—particularly in direct care jobs—somehow identify as caregivers or are rewarded by providing care, I have divided this section into two parts: those who identified as caregivers and those who did not. I show that there is no necessary correlation between whether a respondent self-identified as a caregiver and whether the respondent works in a direct care position or planned to work in health care.

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[22] Hochschild's (1983) estimate of the number of occupations entailing significant amounts of "emotional labor" based on census categories was much more broad than this, including almost any occupation which involved contact with customers or clients, from lawyers to hairdressers (see Appendix C of her book). Also based on census categories, Paula England and coauthors (2002) make a distinction between "care work," in which workers "provide a face-to-face service that develops the human capabilities of the recipient" (pg. 455), and the more broad category of "service work." They include "health diagnosing technicians" as care-workers as well as more obvious health care occupations like nursing. While emotional labor and care work are undoubtedly elements of many (and perhaps all in the case of emotional labor) occupations, I do not think that waitresses and lawyers are what people have in mind when they lament a reduction in the amount of care. Similarly, in health care, I don't think people have security officers and unit clerks in mind, though they may have certain technicians in mind and certainly nurses and nursing assistants.

Self-Identified Caregivers

I would only categorize two of the health care workers I interviewed as people who unambiguously planned to work in health care, worked primarily in direct care jobs, and identified as caregivers—and they couldn't be more different. Wanda, a 45-year old immigrant from Trinidad, was working as a licensed practical nurse (LPN) when we spoke and hoped to become a registered nurse (RN). Steve was a 30-year-old respiratory therapist born and raised on Long Island and enrolled in a physician assistant (PA) program at the time of our interview.

After our conversation (held at a Barnes & Noble café), I could clearly imagine Steve every morning, jauntily walking into the community hospital on Long Island where he had worked since he graduated from high school in 1989, greeted by staff and patients at every turn. "It's a small town," he said, "my whole life is at Bayside Hospital." He even met his wife there (with whom he now has two young daughters), when she was doing her clinical rotation as part of her pharmacist training.

Though Steve started at Bayside as a housekeeper—not a direct care job and not a job specific to health care—he said it was a way to get his foot in the door of the hospital and make money while he attended college. He obtained an associate's degree from Nassau Community College and in 1995 completed his BA at St. John's University, majoring in Biology. Steve always had a plan to work in health care, though his specific aspirations went through some adjustment along the way. He said "PA [Physician Assistant] school is something I've been wanting for a while, since I started in college," but when he was a kid "all I could ever think of was being a doctor." His grades at

Nassau were not great and though they improved at St. John's, he had by that time given up the idea of medical school. Most PA programs require for entry a bachelor's degree, substantial credits in the sciences, and several thousand hours of clinical experience. Steve therefore decided to become a respiratory therapist so he could acquire clinical experience while being paid for it. In 1996 he switched out of housekeeping to a part-time job in the central supply department while he pursued a second associate's degree in respiratory therapy, again from Nassau Community College. He was hired by Bayside hospital as a respiratory therapist in 1997. In 2001, he began the 1199 TUF's Physician Assistant program, a forgivable-loan arrangement that paid for him to attend Touro, a private, not-for-profit college with a campus on Long Island. He continued to work part-time as a respiratory therapist at Bayside, though when he becomes a PA he may have to leave Bayside and work for a hospital in which physician assistants are 1199 members (a stipulation of his loan agreement).

Steve identified as a caregiver. He didn't want to go into the highest-paying PA specialty—surgery—because he wanted to interact with patients. He couldn't imagine doing anything outside of health care and explained this by saying "my parents were older when they had me, like 42, so the majority of my time was spent with older people...I realized there's a need for older people to be taken care of." His father also worked as a Chaplain at a local hospital on Sundays, giving patients the Eucharist, and would take Steve along. He even remembered the smell of hospitals fondly. Steve's Catholicism inflected his talk about working in health care, describing the work as having a selfless and almost sacred dimension. "People working together in a collaborative fashion to save another life—to me that's incredible."

Wanda's story was somewhat different; it had been less subject to advance planning than Steve's. I interviewed Wanda, 45 years old, in the sun-filled living room of her high-rise apartment in central Brooklyn. The building was owned by, and just two blocks away from, Crown Hospital, where she had worked since 1988. In 1987, Wanda, her husband, and their youngest daughter followed their two eldest daughters from Trinidad to New York. Wanda had sent the older daughters to New York for a vacation stay with their aunt and grandmother, during which time they started school and decided they didn't want to return to Trinidad. Wanda had worked as a student nurse at a hospital and nursing home in Trinidad, so when she arrived in New York City she "looked up the newspapers, and they were giving a course for home health aides. I didn't know what it was, but I said I'm going for that." After a brief period as a home health aide, a friend got her an interview for a part-time nursing assistant position at Crown Hospital.[23] Within a year, Wanda was full-time and an 1199 member.

She quickly decided that she wanted to continue her nursing education, commenting with a touch of laissez-faire: "I said well, if I'm here, this is the place that they say is the land of opportunities, I'm going back to school." So in 1989 she obtained her GED after attending a 6-month preparatory class paid for by the union. The test was relatively easy for her since she "had a good education at home" in Trinidad, in English. In 1994, feeling "I'm not comfortable just working like that," Wanda applied (with a friend's help) for a union-sponsored licensed practical nurse (LPN) program held at an 1199 TUF training facility in Brooklyn. The course was also paid for by the union and

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[23] Nursing assistants in hospitals at that time were not required to pass the three-month certification course that is now almost universally required

she attended classes part-time for two years in the evenings and on weekends. During that period, her husband left her.

Wanda wished she had continued with a registered nurse (RN) program immediately after finishing the LPN program in 1995, but she was told at the time that there was no demand for RNs and the union had stopped offering and paying for RN training.[24] At the time of our conversation, seven years later and well into a nation-wide nursing shortage, she was enrolled in a "pre-CUNY" course at the Training Fund, a catch-all reading and writing program aimed to prepare students with diverse needs and abilities for the CUNY entrance exam and college-level work. Since the LPN program was not a credit-bearing program, the RN program will be Wanda's first experience with college in the United States.

After graduating from the LPN program, Wanda continued to work as a nursing assistant at Crown Hospital for three years, waiting for an LPN position to become available. During that time she worked as a nursing assistant in the operating room (OR), cleaning and preparing surgical instruments. She never looked for a job as an LPN at another hospital, preferring to stay at the hospital where she had her seniority and from which she lived only a few blocks. She could have signed up with an agency and worked as an LPN on a per diem basis, but she "never really wanted to do two jobs." (She said this as if it was unusual not to want to work two jobs.) She would have made more money as an agency LPN, perhaps $20 an hour. When she finally did get a job as an LPN in the emergency room at Crown in 1999, her wage went from about $16 to $18 an hour,

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[24] This was an unfortunate blunder in occupational forecasting—a rather primitive science on which unions and educators rely to plan their programs and, obviously, counsel students.

"which is *no* money," she said. She expected a greater increase since the job description of LPNs is much closer to that of RNs than nursing assistants. The $28 median hourly wage of RNs in New York City was the major impetus for Wanda to go into the RN program, particularly since she felt she was already doing essentially the "same type of work" as an LPN.

After LPNs were downsized from the ER, Wanda was placed in the Pediatrics unit with the union's help. Mothers in this unit are apparently somewhat emotionally volatile— "if you don't come right away they start cursing"—because their babies are sick. "You can't go in [to the patient's room] with a serious face. You go in and say 'good morning,' and as you talk to the baby, 'hi! How are you?' with them, and the mothers will loosen up. That's what I like, when they loosen up. That's all I want to do, *I'm good for the day.*"

Like Steve, Wanda identified as a caregiver: "from the age of 10 at home I was always concerned about helping out my friends, like if they were not feeling well...I always had that, I don't know how you would call it, about helping people." She clearly found providing care on the pediatrics unit rewarding (and sometimes emotionally taxing). But she enjoyed all the changes she had gone through at the hospital (by virtue of upgrading, becoming an LPN, and shifting around to so many different units)—even those that didn't seem to necessarily expand her caregiving role. She didn't mind the period in the OR when she hadn't yet been hired as an LPN because "the work was different...it was good. Learning different—learning, learning, learning." In many of her positions at the hospital she'd gone through formal on-the-job training, including becoming a certified nursing assistant, learning operating room instruments, being sent as

a unit to a mandatory communication skills because of patient complaints, or attending a special program on how to handle combative patients.

Other health care workers that I interviewed also self-identified as caregivers but ended up working in health care, and direct care jobs in particular, even though they might not have planned it that way. Unlike Steve and Wanda, their ability and desire to provide care did not mean they pursued health care as wage labor. In their case social structures and patterns were clearly more important in how they came to work in health care than the influence of personal will, desire, or planning.

Veronica, for instance, age 55 when I interviewed her, worked as a nursing assistant at Parkview Hospital, a private hospital on Manhattan's affluent upper east side. She started traveling to the U.S. from Trinidad in the 1970s to work as a nanny, sending money back home to her husband and son. It wasn't until the 80s that she obtained her green card and was able to move to the U.S. permanently, where much of her family already lived. By that time, she "wanted something more than babysitting," so she located and completed a certified nursing assistant course and was hired by a nursing home in Brooklyn where a friend worked as a nurse. In 1994 she was hired by Parkview Hospital.

Though her story shows initiative, planning, and a decision to go into health care, Veronica's story also illustrates the constraints of the labor market, economy, and occupational structures. Veronica did not exactly have a choice of what to do for work without a green card in the United States: Caribbean women, particularly those who speak English, are hooked into international "nanny chains" (Hochschild 2000). The knowledge that they can get work as nannies informs their decisions to immigrate to—or take extended vacations in—metropolitan areas along the East coast. They do not

generally immigrate and then decide to become nannies. All of the immigrant women from English-speaking countries whom I interviewed (Winsome from Jamaica, Veronica, Grace, and Wanda from Trinidad) quickly entered direct care giving jobs—typically starting as a home health aide or certified nursing assistant in a nursing home. Patrice, from Ghana, worked for many years as a nanny and domestic (initially on a live-in basis) before going to college.[25] Though Veronica's options expanded once she obtained her green card, health care provided (and continues to provide) one of the few sources of stable wages and benefits for women (of color) without educational credentials.

Like other nursing assistants I interviewed, Veronica talked about not being appreciated and feeling disrespected at the hospital. "You're like a maid," she said. She went into health care because "that was the easiest way. What could I go into without having any qualification, except being a homemaker? I didn't want to go clean somebody's kitchen." Unlike Wanda, Veronica did not pursue health care training in her home country and her attitude toward education and moving up the health care ladder has been less instrumental.

Despite not explicitly identifying herself as a caregiver (as did Steve and Wanda), Veronica's descriptions of her interactions with patients vividly portrayed that she found the work important and rewarding, despite being treated like a maid. "Some tell you their stories," she said of the patients. "I mean you picture this person being head of household for so many years and ending up in the nursing home, and they tell you how many dinner

[25] Milagros and Isabel—who are not discussed in this Chapter—are both from the Dominican Republic and did not enter direct care giving work right away—possibly because of language issues and how ethnic enclaves are structured in the labor market of New York City. Milagros worked in a towlette factory for several years and then as a school bus escort; Isabel received public assistance and held a part-time, off the books job as a bartender at a night club.

parties they went to and how they felt, and you're there consoling them because you know your time is coming. And you make them feel good." Veronica seemed to take this kind of empathy for granted and consequently did not articulate it as a particular ability that she had.

Shortly after becoming an 1199 member at Parkview Hospital, Veronica started a GED preparatory class at the union's main training center on 42nd street. Indeed, she had taken at least one class every semester since then. She took the GED exam three times before she passed it in 1996. Then she stayed on with the same teacher in the 1199 reading and writing program to prepare for the CUNY entrance exam. She passed that the first time. "I said well, if I finished the CUNY exam I may as well try to get some courses in." When we spoke she had taken and passed four college courses. When pressed, Veronica said she wanted to get an associate's degree in nursing, but she was also taking school one step at a time, not setting a goal too far ahead. This was perhaps because of the stage of her life and the newness of formal education. "I know I should aim higher...but for me I always say if you go little by little—that's how I take it. I don't know if I'm holding myself back, but that's how I look at it."

Another group of respondents also identified as caregivers and like Veronica, an explicit plan to work in health care was not the most important factor in how their employment came about. But, even though they identified as caregivers, this group did not work in direct care occupations and some did not work in health care-specific occupations at all. Shirley was a Registrar, Grace was a dietary aide (soon to be Physical Therapy Assistant), and Linda was a Security Guard for many years but had recently become a Surgical Technician.

Shirley was working as a registrar in one of the emergency departments at Bronx Hospital when I interviewed her. She was raised by her grandmother in North Carolina. After high school and a brief marriage, Shirley moved to New York City in 1985 at the age of 22 with her 2 year old son. Most of her family, including her mother, was already in the New York City area and Shirley eventually brought her grandmother up as well so that she could care for her. During her first 7 years in New York, Shirley held a variety of part-time jobs, primarily in retail, and collected unemployment briefly when she was laid off. But in 1992, Shirley enrolled in a certified nursing assistant course in the Bronx to "better understand" what she was doing for her grandmother. She said she took the course for personal reasons only. She also started taking her grandmother to a day program for the elderly at Bronx Hospital and a doctor and counselor there—who were generally impressed by her—suggested Shirley apply for a part-time job available in one of the psychiatric units. It happened that the opening was for a clerical position, a unit clerk, "where I would be doing paperwork instead of actually working with the patients." Shirley remarked that "I guess God knew where to send me." Although nursing assistant positions opened up during her time as a unit clerk, she was by then "well into paperwork" and making more money as a clerk.

Around 1997, Shirley participated in a hospital program to upgrade some unit clerks to registrars who would work in the growing number of ambulatory care clinics which the hospital was opening (with federal waiver infrastructure monies). To become a registrar she was, among other things, trained to use the computerized billing and admissions system. Upon completion, Shirley was assigned to the emergency department, for which she received a pay increase of about $3 per hour. (Her pay rate had risen to $15

an hour by the time we spoke.) Shirley said she takes her job "very seriously" because "if the hospital is going to get paid I have to get that insurance in right, I have to get that billing address right, get that name right."

"I've always like to be around where I feel like I'm needed and that I'm doing something worthwhile" she said. "Grandmother always said I brought home every sick cat in town anyway." Even though she had worked exclusively in clerical positions in the hospital, Shirley identified herself as a caregiver and as having a desire to help people; even in her position at a desk behind a glass panel, Shirley had gotten to know and help the "regulars." "I always feel that helping sick people is God's work...And sometimes they just need a touch or a hug; it's the little bit of medicine that I can give without a prescription." She considered going into nursing "until I started working with nurses. I found out that they do more paper care than patient care."

In 2001, Shirley enrolled on her own time in a medical terminology class offered for free at Bronx Hospital because it was a prerequisite for certified coding classes. She had been exposed to the basics of billing and coding when it was initially "just thrown on" the new registrars. (This practice was eventually stopped, in part by the union, who saw this as a form of broadbanding registrars so the hospital could save money and fire more costly, specialized coders.) Nonetheless, the exposure to what was clearly a valued skill in the hospital made an impact on Shirley. "I said, if I can do this on my own, teaching myself from just what I have on hand, can you imagine what I could do if I went to school and really got it right? And make the money. And then I found out I can make $100,000 a year after you get the three certifications, I was like, forget it, this is for me."

She "almost panicked" when the hospital decided not to offer a billing class because it had no open positions in that area, but "a blessing came" when CUNY on the Concourse opened. She enrolled there in its first semester of operation. "I was ready," Shirley said. She passed the medical terminology entrance test, and enrolled in an entry-level billing and coding certificate class that met two days a week from 6 to 8:30 p.m. The courses had gotten her "blood boiling." "I want that certificate."

Although the hospital currently had no positions open for entry-level billers and coders when we spoke, Shirley was confident that she would get a job in the hospital, saying "I am going to *claim* a job." Although she was already vested in the union-run pension, Shirley did not plan to leave Bronx Hospital until she had received the highest level of coding certification, at which point she though she might be able to set up her own business and work from home, potentially even moving back South. When we spoke she was very excited by the possibilities. She had been receiving some on the job training in billing that "helped me with the class that I'm taking. So what I'm doing everyday goes hand in hand with what I'm learning at school. I love it."

Shirley never attended college and explained that when she was younger she needed to prioritize her grandmother and son. Her grandmother died in 1995 and her son is now an adult, so Shirley pointed out "this is the first time in my life that my time is my time" and "I haven't even gotten used to the freedom yet." At the age of 40, she had entered a new phase in her life.

Linda, age 44 and born in Brooklyn to Puerto Rican parents, similarly ended up in the health care industry when she needed a stable job, working for many years as a hospital security guard. Like some of the women I interviewed, she said that as a child

she wanted to be a nurse—becoming a doctor didn't even occur to her as an aspiration. Like Shirley, Linda was the main care provider for a sick family member, her mother. "I'm a compassionate person," she said. She had just become a surgical technician through a joint hospital/1199 training program. Surgical technology is a line of work that, like security, would not be considered direct care. She didn't really know what Surgical technology entailed when enrolled in the training program, but it was available, she passed a competitive entrance exam, and her work as a security officer was the source of stress and recurring knee injuries. Like Shirley, Linda felt after spending time in a health care setting that nursing was not the best outlet for her compassion, given what she perceived nurses to actually do (though she was considering that as the most logical next step in her health care career when we spoke).

Shirley, Linda and Grace—all self-identified caregivers who ended up working in the health care industry above all through the force of circumstance and constraints of structures of opportunity—give cause to reconsider the notion of a concept like "direct care" and its analytical purpose. First, it is not solely direct care work that requires substantial emotional labor or intense kinds of personal involvement. Linda for instance described work as a security officer in emotionally-laden ways. "As a security officer, we do more than people think. We respond to codes, we are in the ER we watch all kinds—I have seen some things here that probably medical students haven't even seen." Her first knee injury occurred when she was kicked by a combative patient. She described how even working at the main desk in the hospital lobby, giving passes to visitors, was an intense experience requiring her to maintain authority over "men who have no respect for you." "People say 'I'm going upstairs to visit somebody,' but they're going upstairs to

maybe look through people's bags when the doctors and nurses aren't paying attention." She was getting worn down by the work. "Security makes you hard here, it hardens your heart."

Second, the concept of "direct care" work tends to suggest a strict division between work involving care and work involving technical skills. Grace held a variety of direct care and non-direct care positions in health care: she had been a dietary aide making meals, an inventory clerk, a dietary supervisor, a nursing assistant, and she had just graduated from a PTA program when I interviewed her. Just after high school she also went to a local proprietary school to become a computer technician. To the extent that she had a choice, Grace sought work that would take advantage of the fact that she liked fixing things with her hands. According to her, there is a similarity between being a computer technician and a nursing assistant: they are both "hands-on" work, though one would be considered caregiving and the other not. Shirley, I have already pointed out, felt like she has been able to express compassion as both a unit clerk and a registrar—both of which are primarily clerical positions in which patient contact is kept to a minimum.

Finally, it is already evident that the process of becoming a health care provider or working in a direct care job is not, in any simple way, an expression of whether someone wants to do that kind of work. Furthermore, some people who might seem to be the most motivated to do direct care work choose not to or end up in other kinds of occupations. And in the next section I will suggest that some people who do work in direct care do not necessarily see themselves as caregivers.

The idea of direct care work as inherently unique is often used to conjure an image of selfless, devoted women who would gladly remain in health care work given

slightly improved working conditions. Such an image obscures the real political, economic, and social disparities that surround getting a job in health care, even for those who clearly enjoy taking care of others. The fact that the particular workers just described, who identified themselves as caregivers, did not necessarily see health care work as a calling or necessarily end up working in direct care jobs points to the incongruence between intentions and outcomes as well as ability and occupational achievement.

Distance from Care

This section describes the experience of allied health care workers who did not readily identify themselves as caregivers and didn't—for the most part—work in direct caregiving jobs. They also did not originally pursue a health care career, but found themselves working in health care for a variety of reasons.

When I interviewed Daniel, 36, he was an instructor at a surgical technology program at a private hospital. Surgical Technicians, also known as "OR" (Operating Room) Techs, is an occupation/profession in flux. Currently, most employers require completion of a 1-year certificate program (which need not entail college credits) and a high school diploma. Though training programs are typically accredited, they are not yet under the control of universities or colleges (and thus students do not typically have access to the perks of college-affiliation, like federal student aid; tuition for this program in particular was about $11,000 for the year). Neither the nature of work nor of training for OR Techs is completely standardized. Because OR techs can start with a salary over $30,000 a year in the New York City area, the occupation has one of the best earnings to

education ratios in the allied health care field. This was undoubtedly its initial appeal to Daniel.

Like Steve, Daniel was raised in a heavily white (and ethnic) area of Long Island. After high school he worked in the construction industry, but lost his job in the recession following the first gulf war. Tired of the fluctuating nature of construction work, he decided to get a bachelor's degree "to fall back on." He broke up with his long-time girlfriend ("that's how serious I was about going back to school") and with single-minded focus earned a BA in Biology, Chemistry, and Political Science in three years from State University of New York at Stonybrook. He discovered the OR Tech program "just looking through occupation guides, seeing what things there are. And surgery struck me as pretty cool. The nice thing about it was, I said, okay, I'll do the year; if I don't like it, it's only one year wasted time...which is important because I was getting a little bit older at the time."

For everyone I've interviewed, it's impossible to know how much of their decision-making was based on "rational" calculations or what sort of information went into making those decisions. Almost everyone retroactively creates logic out of their own personal histories, not least when they're being asked to do so. But there are clues to what largely irrational and often unpredictable events go into making a life. So Daniel, echoing others I have described so far, said with hindsight: "I always wanted to do something with operating and surgery because I'm mechanically inclined...It's something I did my whole life, I always worked with my hands." This is undoubtedly true, but his occupational choice also hinges on a day of "looking through occupation guides." "Even when I was a construction worker, I would tell the guys I want to do something in surgery

some day." That "something" was, once, to be a surgeon; he went through an adjustment of his expectations in that regard and clearly wanted, in the interview, to talk about how hard it is to become a doctor and why it wasn't possible for him.

Unlike many of the other people I interviewed, Daniel mentioned "helping people" largely as an afterthought. But his descriptions of the OR were riveting and vivid: "It's a tough, rough place. It's like being in the Army or Navy." It's a "rush" and "intense" where much hinges on the personality of the surgeon (who could be "calm" or "stressed out...yelling and screaming") and other staff in the OR. "Who you're working with...is going to determine what your day is like." Whatever the accuracy of this portrait, clearly for Daniel the OR was an emotionally-intense environment, a job for which "the hardest part" was dealing with co-workers and their personalities.

In the case of Patrice and Winsome, neither quite identified themselves as caregivers or planned to work in health care, but both found themselves in direct care roles—Patrice as a domestic and nanny, and Winsome as a nursing assistant. I interviewed Patrice even though she had not yet started working in health care because she was enrolled in an associate's degree program to become nuclear medicine technologist. Patrice came with a friend to New York from Ghana in 1987, at the age of 24. Her first job was working as a live-in nanny and domestic for a family in the affluent Westchester county. Most of that time she was being paid under the table—she only received her green card in 2000. When I interviewed her Patrice she was still working part-time for the same family, though she lived in her own apartment with her daughter.

Patrice took and passed the GED exam soon after arriving in New York. She said "I wanted to go [to college], but I let other things stop me." She said she had a lack of

confidence and her former husband continually disparaged community college. But she was not "using all of her abilities" as a housekeeper and Patrice finally enrolled at a CUNY community college in 2000. Patrice's first love, academically, is math and it was a math teacher at Bronx Community College who suggested she look into the nuclear medicine technology program after seeing that Patrice had changed her major three times. Another professor told her the program was a bad idea because it was "terminal," but Patrice clearly enjoyed the technical aspects of the program and was really looking forward to being able to fully support herself financially.

Strictly speaking, it is not accurate to say Patrice did not identify as a caregiver. She said she didn't want to go into nursing because "I easily get attached" and she finds it too emotionally difficult to deal with sick people. As a NMT, she would have fairly circumscribed contact with patients. Patrice was clearly attached to the children (now adults) for whom she had been a nanny for close to 16 years. But, Patrice became a nanny because there was nothing else she could do without a green card—she did not "decide" to become a care worker because of her natural aptitude for it. And, in the transition to health care, she decided to stay away from a direct caregiving role as much as possible. I look at this as a situation in which someone is compelled by the structure of opportunity to care.

Similarly, Winsome worked in a direct care role—as a nursing assistant—but did not identify herself as a caregiver or talk about the unique rewards of that role. She did plan to work in health care—she had been a dental assistant in Jamaica—and when she came to the United States work as a home health aide was most readily available. Winsome moved back and forth between Jamaica and the United States for many years

before becoming an official resident in 1996. She paid $850 for a certified nursing assistant course and eventually found an 1199 job at a hospital in Manhattan. When I spoke with Winsome she was caught up in the emotional demands of her job and frustrated by the fact that she could not understand what was expected of her: "I don't know the standard right now, what they really want." She had recently been disciplined for a miscommunication with a patient and sent to a communication training seminar. "Some patients--it's like it doesn't matter what you do for them, it's never good enough," she said. She felt her demeanor was judged only in a superficial way and that she had been treated unfairly in some instances because of racial and cultural differences with the patients and her supervisors.

For Winsome, who was enrolled in the college-preparatory courses at the TUF, school represented a way out of a job where she felt regularly demeaned and misunderstood. Winsome mentioned a few instances of being told she was a good caregiver or being appreciated by a patient, but she did not talk about herself as a caregiver nor seem to take much comfort in those isolated moments.

The experience of Winsome and Patrice shows that working in a direct caregiving role does not always mean that workers find it particularly rewarding or identify with the ineffable value of providing care. Furthermore, their stories reveal the tremendous cultural and structural forces compelling women in their socioeconomic position to work in direct care roles. Health care is the best available option for waged labor. And even if women enter direct caregiving roles wanting to do that kind of work and finding rewards in it, everyone must learn to some extent how to be "caregivers" in that context and how to tolerate the sometimes volatile emotional environment of many health care facilities.

For some this is an ongoing struggle, for others, their difficulties are gradually counterbalanced by those moments when patients tell them they are good at their job or their hard work is acknowledged.

♦

Among the general patterns that emerge from these stories of getting into health care is that work involving care and emotional labor is not restricted to jobs providing hands-on or direct care. Additionally, among the health care workers I interviewed, I found no consistent correspondence between the desire to be a caregiver and work in a hands-on or direct care job. Some people who wanted to be a caregiver worked in non-direct care jobs while a few people working in direct care jobs did not desire to be direct caregivers. Nonetheless, it was true that many of those respondents who seemed to really be rewarded by the process of providing care had, or were about to, work in a direct care job. Similarly, the respondents who explicitly planned to go into health care, and had largely organized their work and education in order to make that possible (Steve and Wanda), were drawn to health care because of what makes it unique—it is where care is provided to the ill. The "non-caregivers" were perhaps drawn to other unique aspects of the health care industry, like its technical and diagnostic specialties, and went into health-care specific jobs like surgical technician. Both caregivers and noncaregivers might have been drawn to work in health care, even in non health care-specific jobs (like security) because in New York City most jobs in hospitals are unionized, providing benefits and job security which they would not in private industry and a layer of opportunity for normally marginalized workers.

Though it may seem like a trivial or obvious point—that people end up in health care work for a variety of reasons and that their occupation may not correspond with their ideas about what they should be doing or where their natural talents lie—it is worth repeating. Even in the limited number of interviews I conducted (23), there was no systematic relationship between whether respondents indicated that they were good at or took pleasure from caregiving and the kind of job they held in the health care industry. For instance, one might expect, though I did not find, respondents who readily self-identified as caregivers to be in what the health care industry labels "direct care" jobs, such as nursing assistants. This finding confirms another obvious fact: very few people have complete control over what they will do as wage labor and very nearly everybody has to get a paid job doing *something*. Though I would not go so far as to say "like the weather, work 'happens' to people" (Bowles and Gintis 1976), there is an element of truth to this—even in health care. There is little reason to expect that the occupational category a person fills accurately reflects their abilities, desires, or choices—as many of us can confirm by thinking about our own occupational histories.

In addition, many workers I interviewed felt their talents were wasting away in their current jobs—even in direct care jobs. Said Marie, a patient care technician: "don't get me wrong, I like my job. But it's just that it's the same thing repetitive and I'm not growing." When Marie's neighbors ask her if she's a nurse, she tells them she's a "professional butt cleaner"—to remind herself of where she's at and where she hopes to be. Or as Juan, a registrar at a hospital clinic put it flatly, "I feel that I'm wasting here." Caregiving work—like most other forms of work—has rewards and limitations. And, as

the diversity of jobs occupied by caregivers shows, the ability to care can be expressed in a number of occupations and settings, not all of which are repetitive.

The question of the impact of "motives to care" on the quality of care is a thorny one. Given the current shortage of health care workers and concerns over how western countries will care for their growing elderly populations, this question has taken on increased importance. The answer will have strong political and racial implications. For instance, economists Nancy Folbre and Thomas Weisskopf (1998) have developed a typology of motives for care service labor on a spectrum from altruism to coercion, with monetary reward (wages) one step away from coercion. They suggest that care service labor provided involuntarily or out of self-interest is likely to result in a less caring interaction; the "*quality* of the [care service] labor supplied is functionally related to the motivation for supplying it" (pg. 192).

On a societal scale, Folbre and Weisskopf are concerned that the expansion of labor markets means more caring will be provided under market relations. In particular, as women who traditionally provided caring enter the labor market they will have less time to care and less interest in caring, since the rewards (both monetary and emotional) are relatively few. Therefore, labor market expansion means more care service labor will be provided by waged workers and, presumably, motivated by self-interest rather than love or altruism. On the other hand, Folbre and Weisskopf point out that the expansion of labor markets could have a positive effect on the supply of caring labor because it reduces another form of coercion to provide caring labor: when women have access to labor markets and career options those who provide caring labor may do so out of choice rather than coercion. But, while some middle class white women are freed from the

oppressive norms and values that compelled them to do the bulk of caring labor, lower-class women of color from around the world are compelled to provide care by the growing market for care service labor. Folbre and Weisskopf attempt to theorize how the substitution of patriarchal norms and values that force women to do caring labor (what they call "coercive socialization") by market forms of coercion affects overall care levels.

Their model suggests that true caring labor can only be provided by people who do so voluntarily and, at least to a degree, selflessly. It is unclear in Folbre and Weisskopf's model if the mere existence of coercion is enough to undermine true caring or if it also has to be experienced as coercion and if so, to what extent. It opens the question of whether the immigrant women in my study compelled by international labor markets or cultural values to do caring work must be "conscious" of these forces as coercive in order for them to undermine the quality of care.

I once attended a conference for nursing attendants where one of the keynote speakers, in an attempt to valorize the contribution of immigrant women to the health care system, praised at great length a nursing attendant from Africa who gave exemplary care because she was raised in a tradition of caring and community values largely absent in the United States. As much as the story romanticized African village life it condemned wayward and immoral American culture—its lack of caring values. Folbre and Wiesskopf, who are not opposed to paying higher wages for care service labor, predict exactly this problem: "higher pay alone...will not solve the problem that we point to: the erosion of norms and preferences by a competitive process in which those who provide care gradually realize that others are free riding on their altruism" (189). For them, the realization among those who provide care that they are exploited may result in a reduced

willingness to care: people become less altruistic and in the long run, fewer people are socialized into the norms and values of caring for others. At the same time, they do not wish for a return to coercive patriarchal culture (even if was more effective in producing care givers).

Has care deteriorated in the United States as life is secularized and commodified? Since the African nursing assistant was socialized into caring values and perhaps doesn't feel coerced into a caregiving role, does that mean the quality of care she delivers is better? Even if it is, should care be accepted under those conditions? Do immigrant women who move to the US and become care providers experience an opening of possibilities and opportunities, which means their caregiving isn't coerced, or does their entry into the paid market for care service labor mean that selfless motives to provide care are corrupted by self-interest and the need for wages?

It makes sense that caregiving will suffer when the people who provide it are coerced into doing so. The stories in this chapter of how health care workers get into health care supports the idea that various factors compel women to enter health care work, that there is no real freedom to choose health care work. But I do not think these facts can be seen as evidence that the quality of care is diminished. Care (and its quality) is a relational and situational process, not determined in the first or even last instance by individual states. The "organizational aspects of caring" (Scott, Aiken, Mechanic, and Moravcsik 1995; see also Chambliss 1996) are just as important to the quality of care. Looking at work in hospitals and the stories workers tell, it would seem that the organization of care work and the quality of work life is a far greater threat to caring relationships than the specific motives of individual care givers.

It is possible that the very act of making health care a commodity and of paying people to provide health care corrupts the caring relationship, but I am wary of assuming this is so. This is a version of what Viviana Zelizer calls the "Hostile-Worlds" view, in which commodified relations are seen as incompatible with intimate, caring relations. "Explicitly or implicitly, most analysts of intimate social relations join ordinary people in assuming that the entry of instrumental means such as monetization and cost accounting into the worlds of caring, friendship, sexuality, parent-child relations, and personal information depletes them of their richness" (Zelizer 2002b: 276). This point brings to mind a criticism of Hochschild (1983) that has been made in the past: the argument that commercialization dilutes emotional labor is greatly oversimplified. But even if the integration of caregiving with markets undermines care, it must be admitted that just as there are more ethical and humane ways of conducting business, there are more caring ways of organizing health care work.

The relationship between articulated motives to care and quality of care has also yet to be determined. My fieldwork experience in health care facilities suggests that outward expressions of motives or intentions do not necessarily or simply correlate with behavior. Similarly, individuals are complex, capable of articulating and acting on a variety of motives simultaneously.

Finally, the idea of identifying and measuring "motives" is, in my opinion, flawed. Motives are "typical vocabularies having ascertainable functions in delimited social situations" (Mills 1940)—that is, they are linguistic expressions offered in a social context. The vocabulary of motive available to anyone when you ask "why do you do this?" is limited by the available cultural terminology and influenced by the situation in

which the question is asked. The "reasons" people I interviewed gave for getting into health care are not indicators of internal, individual states as much as situationally-defined justifications. Even if there were ways to measure and ascertain such individual states—and this would be necessary to test Folbre and Weisskopf's model—I see very little reason to do so since they would capture states at one moment in time, isolated from the continually changing situations in which they are experienced.

In the realm of caregiving, there is profound discomfort with the possibility that people might work in health care for the money or because it was the best alternative given a limited amount of choices in the structure of opportunity. 1199 faced this perspective from the earliest days of its attempts to organize hospital workers, when the perspective was instantiated in laws forbidding unionization of the voluntary health sector, ostensibly because the aims of unions were at odds with patient safety and the provision of care.[26]

More recently, hospitals and health care policy experts have responded to the apparently indefinite shortage of nurses and other care workers (actually a shortage of native or naturalized care workers) in the United States by appealing to the idea that care work has become less meaningful and using this explanation to account for the vulnerability of their hold on a committed labor force. For instance, a recent report by the American Hospital Association Commission on Workforce for Hospitals and Health

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[26] In 1947 under intensive lobbying by the American Hospital Association (AHA), Congress attached an amendment to the 1937 Wagner Act exempting nonprofit hospitals from provisions requiring employers to hold elections to determine whether workers wished to be represented by a union. The amendment was justified by the argument that nonprofit hospitals were charitable organizations and union demands for wage increases would undermine their ability to treat those who could not pay for hospital services. In 1962, an 1199 strike forced then Governor Rockefeller to pass legislation that would include nonprofit hospitals under the State Labor Relations Act (Ehrenreich 1976.; Fink and Greenberg 1989, pg. 16-17).

Systems titled "In Our Hands: How Hospital Leaders Can Build a Thriving Workforce" (AHA 2002) proposed that "fostering meaningful work" is one of five keys to solving the workforce crisis in health care.

> *People enter health careers to make a difference in the lives of others.* But hospital work is also demanding, hard, and exacting, requiring skill, focus, and attention to detail. As the demands on each caregiver and support workers have increased, the work has become less meaningful and more tedious. (pg. 13; italics added).
>
> Today, many in direct patient care feel tired and burned-out [...] with little or no time to experience the one-on-one caring that should be the heart of hospital employment. (pg. 8).

The AHA report presented the loss of meaning in health care work in the tone of a confession: note these brave hospitals who are willing to admit that hospital work is demanding and difficult. The link between meaning and caring is maintained through romantic myths that one-on-one caring was once the heart of hospital work and that people enter health careers to make a difference in the lives of others. One need only read a few histories of hospitals to come to a contrary opinion (e.g.,Reverby 1987; Rosner 1982) about the status of one-on-one caregiving in these institutions. The assumption that people enter health care work to make a difference in the lives of others is similarly oversimplified. The general anxiety that lurks behind the wish for programs that nurture workers (see Chapter 4) appears as well in this AHA report. This worry about meaning is a distraction from the many substantive recommendations for redesigning health care work that the report makes.

In the end, powerful images of care work as meaningful and selfless (and the anxiety over a loss of meaning which such images make possible) are part of a

constellation of ideas and cultural codes that animate the training and education industry for health care workers. However meaning is measured—as an "objective" attribute of particular jobs or as a product of the way the jobs are socially regarded, respected, and valued—is irrelevant. Education and training thrives in either case: if meaningfulness is the measure of particular jobs, then education and training industry, particularly in health care, creates credentials that confirm the presence of meaning and proceeds to credential people (for a fee). If the problem of meaning is that of how jobs are regarded, then education and training becomes a vehicle for elevating the status of some occupations or compensating for a lack that is ascribed to people in non-meaningful jobs (for a fee).

In my fieldwork experience, numerous people suggested to me that the problem with the quality of care in New York City is that unionization protects workers who are not truly caregivers and not devoted to the work. But nursing assistants nationally have annual turnover rates approaching 100% (Fitzpatrick 2002; Hollinger-Smith, Ortigara, and Lindeman 2001). In New York, unionization substantially reduces those rates. The case of workers who stay too long as well the case of those who leave too early could, I suppose, be explained by the notion that those people do not understand the true value of health care, do not find the work meaningful in itself. But where would that leave us? With a workforce a crisis that is apparently the outcome of too much job security and too little.

The evidence in this chapter has shown that some people who work in health care do so because they "wish to make a difference in the lives of others"—but some people work in health because they also wish for job security, chances for mobility, and because there are no better options. Many people who work in health care do not fit the traditional

expectation of health care workers as motivated by the calling to care. I suspect, based on my ethnographic experience in health care facilities, that the articulated desire to make a difference in the lives of others or identifying as a caregiver does not determine whether one performs a health care job well or whether one will be able to persevere as a paid health care provider.[27] But this requires more research. In addition, the fact that individuals turn to a discourse of always wanting to be a care provider when explaining their career may not be a reliable indication of their feelings about the work or job performance.

The difficulty creating a stable and committed health care workforce does not stem from problems of individual motivation—particularly if motivation is simplistically constructed as a selfless and romantic desire to care—nor does it stem from a purported loss of meaning. It likely *does* stem from poor working conditions and settings in which health care workers are not adequately valued—in terms of money and respect. In an act of considerable contortion, education and training has been proposed as way to infuse work with interest, enable workers to cope with the difficulties of their work, and if all else fails, enable transitions out of jobs that are unsatisfying. Trainers in this industry will occasionally acknowledge it is not the commitment of the workforce or their desire to perform their work well which is a problem, but the organization of health care and

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[27] Anecdotally, I was always struck by the frequency with which patients are infantalized by health care providers. I believe our ready-to-hand definition of good caregiving is good mothering—a problematic conflation which encourages and rewards infantalization. But I'm not sure it is a productive conflation for providing care to the sick and elderly. Of course, different patients and caregivers strike different mutually acceptable tones of interaction, which is one of the things that makes caring such a complex process. Nonetheless the category of "good care" is not entirely relative and surely one of the most difficult aspects of growing old is not just the real loss of ability and independence, but the institutional forms of incapacitation—among which I would count infantalizing interaction—which exacerbate feelings of helplessness.

health care work. As one trainer said, "as they say in training, when you have a problem, you don't solve the problem: you train."

CHAPTER 6: THE REWARDS OF SMALL CHANGE

Why hundreds of millions of dollars to train health care workers? In this chapter, I start my analysis from a genre of justifications for this industry—more vocabularies of motive, if you will—that stem not from a distant narrative of skill shortages and economic needs but from a deeply-felt narrative about the human need for respect, dignity, and growth. These are the terms interview respondents used when they began to reflect on what they enjoyed or valued about their participation in the training and education industry, terms that hint at the contours of what I am trying to identify and discuss in this dissertation. In this chapter I trace the discourse of both trainers and health care workers as it skims the surface of what might be called affect—I have pulled together moments when respondents talk about satisfaction, engagement, growth, meaning, learning, transformation and moving forward. This training and education industry rides a kind of physical and emotional momentum; it sustains and is sustained by the compulsion to move forward, to transform, to expand. I take this compulsion as evidence of an affective register in which and through this training and education participates, though other terms might do as well to describe this register (like emotional energy). This compulsion is voiced in a discourse of meaning and personal improvement, but such a discourse only gives partial expression to the energies which make up the level of affect. And, as I make especially clear in the next chapter on soft skills training, this discourse does not point so much toward ideology, as to something immanent and only partially taken up in rationalizations, justifications, and vocabularies of motive.

One of the themes that emerged from my interviews with trainers and educators, in all kinds of education or training, was the rewards of teaching, as when teachers attended "graduations" or saw life improve for their students. Sometimes the rewards took the form of thank you gifts that teacher received from their students. I have seen a teacher of communication skills applauded by her students. While trainers' and educators' goals for their students varied to some degree with the kind of training and the educational setting, most interview respondents from the industry spontaneously reflected on how they felt like they were doing important, significant work. One teacher of reading, writing and college-preparatory programs described his job this way:

> It's very meaningful work, in that you are actively trying to help people understand how to transform themselves. And how to change. Nothing to me is more poignant than that. And the ways in which it's incredibly rewarding.

He went on to describe how some of his students had read novels in his classes for the first time and described their enjoyment of the experience. He was the only teacher I interviewed who taught in a setting not explicitly vocational. Given the goal of teaching students to read and write and prepare for college-level work, he exercised a great deal of autonomy over curriculum and pedagogy. He saw his job as not only to introduce students to the pleasures of reading and transforming oneself, but also to separate education from certain traits associated with the "educated":

> ...they [the students] have an idea about education because they see it—they see it in their workplaces. But the vast majority of people who are highly educated in their workplaces are busy exploiting them. So they don't particularly like the people with educations, and they have a knee-jerk feeling that people with educations have no common sense. And in a lot of ways I think they're right...So they have to sort of rethink their ideas about education and that's part of what a good adult ed classroom is,

> in my opinion. It forces students to reflect on where they are, how they got there, where they want to go. So that's my job: to structure that in.

That education is a process of self-transformation, a vehicle through which to reflect on one's self, is a classic presentation of how the true ends of education should be beyond immediate material or subjective needs.[28]

It is also a way of characterizing the aspects of education which seem extraneous to the economic value of education or the needs-assessments which are supposed to inform all training and education programs, particularly vocational programs. Education can be understood as an industry that relies largely on immaterial labor—labor which handles and manipulates information, cultural symbols, and communication—and makes immaterial products—such as personal transformation, affective investment, and emotional energy. As an originator of the concept of immaterial labor puts it:

> The particularity of the commodity produced through immaterial labor...consists in the fact that it is not destroyed in the act of consumption, but rather it enlarges, transforms, and creates the 'ideological' and cultural environment of the consumer. This commodity does not produce the physical capacity of labor power; instead it transforms the person who uses it" (Lazzarato 1996, pg. 138).

The face value of the term "immaterial" is limited given the material embodiments of information, communication, and culture. Nonetheless, this view illuminates how education can be viewed not just as a production system for skills or

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[28] As Hegel put it: "The final purpose of education, therefore, is liberation and the struggle for higher liberation still; education is the absolute transition from an ethical substantiality which is immediate and natural to the one which is intellectual and so both infinitely subjective and lofty enough to have attained universality of form. In the individual subject, this liberation is the hard struggle against pure subjectivity of demeanour, against the immediacy of desire, against the empty subjectivity of feeling and the caprice of inclination. The disfavour showered on education is due in part to its being this hard struggle; but it is through the educational struggle that the subjective will itself attains objectivity within, an objectivity in which alone it is for its part capable and worthy of being the actuality of the Idea." *Philosophy of Right*, pp. 135-6 (Paragraph 187).

knowledge in the physical or technical sense, but also for affect and emotions and meaning—products for which need may never be satiated. This is not so much a new observation as a matter of emphasis. I am attempting to go underneath the view that education operates as a system that responds to and animates the "economy"—which is the assumption of most Marxist theorists of education and all human capital theorists—and expose aspects of the training and education industry for allied health care workers that become visible in the disconnects between needs assessments and outcomes.

The discourse of personal transformation surrounding education is not in itself surprising, but it is noteworthy that trainers involved in even the most fleeting and ostensibly vocational forms of training employ such a discourse. After all, this is a segment of education for which the noninstrumental ends of education would seem to be least relevant. A consultant who provides customized, on-the-job training on issues related to communication and working with geriatric patients (primarily to nursing assistants) described the outcomes of her seminars this way:

> One is, they're very positive about the educational experience and many of them come to the class saying this is just bunk and leave saying, wow, I really learned something, this has really helped, and everybody should take this course: management, my peers, everybody. My first couple of courses are—I've gotten cards from my participants, little gifts, flowers. I mean they've really been engaged by the process.

She believes an outcome of her courses is to reorient the worker-students' understanding of education, making them "positive about the educational experience" and "engaged" by the process of learning. She feels that her courses can dismantle a certain amount of skepticism and cynicism towards education. In this case, however, education (in the Hegelian sense) has been effectively blurred with on-the-job training,

and it is not clear if students in her classes are initially resistant to the "educational experience" or just on-the-job training seminars. But as we will see from some of the workers, this continuity between on-the-job training and more traditional forms of education is not only the representation of trainers attempting to legitimize their work.

This trainer also identifies another immaterial product or satisfaction generated by the training and education industry—the sense among trainers and educators of being involved in meaningful work. An administrator at a union-funded training institution that primarily offers non-credit vocational programs and classes, reflected on her earlier work as a health educator:

> I loved the direct education part, just as I used to like direct patient care, because I felt that I really impacted greatly on people's lives and was able to have the gratification of seeing change in people...I still see people on the street that I remember from doing certain education programs, and they come up to me, 'oh, how are you?'

While it is tempting to see the gratification of trainers and educators as an epiphenomenona of what is really the core product of an education and training industry—knowledge and skills—actually such gratification is central to understanding the tremendous financial and psychic investment in this industry. So much of this training cannot be explained by improvements in productivity, the attainment of credentials, or achievements in knowledge—the patterns of engagement with education and training among health care workers in this industry attest to the relative indifference (at a systemic or structural level) to these kinds of outcomes. Given that the training and education industry for allied health care workers does not purely function to fulfill labor market demand, the gratification and sense of purpose garnered by the trainers, educators, and planners involved in the industry take on extra importance. This is not because those who

are satisfied by their involvement in training and education are necessarily individual power brokers who, through their charisma and position, build institutions that fulfill their personal ideals of important work, regardless of the "needs" of those being helped. This is a likely dimension of this training and education industry—as it is a dimension of charity and philanthropy more generally. Rather, the gratification of trainers emerges from a strong cultural tendency to privilege work that is meaningful or contributes to the greater social good. Of course there is no universal principle of what constitutes "meaningful" work, but the comments of these trainers reveal the extent to which consumerism and material acquisition as ends in themselves are regarded with suspicion and even distaste.

The connection of this industry to charity is more than discursive, however. Aspects of the training industry function as social services for the city's marginalized communities, particularly those training programs that prepare workers for their first job in health care or for initial entry into paid employment. Because of labor unions and the existence of occupations with clearly defined educational requirements, health care is one of the few service industries that offers anything resembling a career ladder or the prospect of jobs with decent wages and benefits.

The dean of a proprietary, not-for-profit training school for certified nursing assistants (CNA) and medical assistants (one of those schools that always places large ads in the subway system, targeting new immigrant women) explained that their school "has its place":

> It does what it needs to do to offer people a chance to enter into the health care field, and I really do believe that we change people's lives, both on the receiving end by the skills they get... as well as in their own

> individual lives. They might be single parents and we're their last available chance at getting skills so they can work and raise their kids.

The dean showed me a letter from a student who had dropped in and out of the 4-week, 120-hour CNA program because of complications with child care and in which the student asked the dean not to give her another chance in the program. The dean recognized the significance of the health care industry as a step into paid labor and was emotionally torn about whether or not to let the student remain in the program. Daniel, a former surgical technologist and instructor at a hospital-based surgical technology program, said that the change the program makes in the lives of students is "my greatest satisfaction":

> I've had people who are on welfare, living like 5 people in a one-bedroom apartment, who left the program and now they have 3-bedroom townhouse in Pennsylvania. That makes me feel good when I hear those stories. Or single moms who...you know I hear all kinds of stories, because my door's wide open and you can just imagine some of things people tell me in their lives...That's why I do this.

Some parts of the training and education industry for allied health care workers in New York City are directly connected to welfare functions. One of the largest home health care agencies has contracted with the city to hire and train welfare recipients for jobs as home health aides and attendants after they have been through a 9-week work preparation class run by the city. The agency's human resources director recruits employees from the 9-week course and has attended their "graduations":

> It's a real self-empowering, um, these are women that have been through a lot already and trying to get them back on their feet. Try to get them to feel positive about themselves and their lives. I loved it. I mean I used to go down, I still--I have it in here [pulls out program]--they invited me back to one of their graduations. Its really cool. Really fun, they bring their whole families...In about the 7th week [of the city course] we'll come in and we'll make a pitch to try to hire as many of them as we can.

> And for us, these are people that are really serious now, they've been through this really difficult 9-week class.
>
> I still get letters from the first six months of classes that we hired here from these women because they're still with us. They're like the best employees we have.

The gratification of the trainers was in some ways most intense when it came to programs that seemed to allowed participants to "get back on their feet" and make enough money to support their children. But even the trainers and educators in those programs that target groups struggling to make ends meet from day to day articulated an affective dimension of their training programs, in the case above that participants "feel positive about themselves and their lives." This kind of "outcome" may compensate in the minds of some trainers for just how little difference their training programs make materially. At this home health agency, for instance, wages start around $6.00 an hour and are capped at $7.50 an hour. While there is a real disparity in whether the training programs encompassed by the training and education industry effect substantial changes in the standard of living of those who participate, there is a consistent effort to construct these programs as valuable irrespective of the economic rewards.

A former director of training and upgrading at a major hospital talked about her favorite programs:

> The ones that I think I've loved the best are the upgrading programs, where people started in much lower level positions, like housekeeping and dietary, and moved up, like to registrar receptionist, mental health worker. Because the anecdotes that you get back from the people, it's like one woman had been a dietary worker for 25 years and suddenly became a registrar receptionist. And it wasn't that her salary increased that much—it maybe increased $3,000. But she was so proud to now be a white collar worker. Going from a dietary worker to a clerical worker is like...you know, it's like tremendous mobility for her.

Mobility in this sense consists of a change in status, the emotional and social aspects of which are ultimately more important than the economic rewards. Indeed, as one instructor reminded me, these are workers who wear uniforms—the experience of getting a job which does not require a uniform has intense emotional and cultural significance.

These quotes reveal how trainers and educators are rewarded in ways beyond their salary. It is not surprising that work in the training and education industry—not unlike work in the health care industry—is constructed as a kind of calling that transcends mere economic motives, even when some interview respondents would also discuss training and education using highly commodified terms (see Chapter 3). Of course teachers' and educators' sense of personal reward is fueled by actual instances of gratitude on the part of students and cases in which students are able to effect concrete change in their lives as a result of training or education (be that change material or symbolic). Because these were interviews about the history of one's work and career it is natural that respondents would want to talk about the inherent value of their work. This would probably be the response of someone in any kind of work to participating in such an interview. But even if these were self-presentations marshaled for the benefit of a sociological researcher, the interviews reveal dimensions of the training and education industry which can be accessed when needed.

In contrast to the emphasis on noninstrumental personal satisfaction and rewards (for themselves or their students), some trainers and educators also indicated that they felt a responsibility to make sure their programs enabled students to get jobs—so much so that they would quit their position if the program failed to prepare students for work. The

instructor in the OR Tech program said, "I wouldn't even be teaching in this if there weren't jobs out there. Because I don't want to teach somebody something, they spend all this money, and then they don't find jobs." The dean at the proprietary school for nursing and medical assistants said she finds the owner of the school "ethical or else I wouldn't work here":

> ...there are times when I think proprietary schools are negatively viewed ... and I think all of it depends on who the owner is, and what their vision is, and their ethics. I feel comfortable working here, I feel like they've got the right ethics and vision. If it changed, I'd be gone tomorrow, and I am very much aware that it's a business, it's definitely a business. If I don't meet the needs of my clients then I shouldn't have any more clients. But if I'm meeting the needs then my door should be overflowing. So I'm comfortable with that.

The director of health sciences at one private college was hired to oversee a new associate's degree program in health information technology, but shortly after he started he realized there was no job market for the students, they weren't being hired. The director shut down the program and the 90 majors were largely grand-fathered into a newly designed health office associate degree program. The director was motivated to cancel the information technology program and develop a new program for its students not just because of ethics, but because his job depended on it—such programmatic mistakes would severely damage the college's reputation and ability to recruit students. Nonetheless, the jobs for which students in the health office associate program are prepared—working in private medical offices—are not well-paid nor are they a direct stepping stone into more well-paid clinical occupations. The director expects graduates to make $19-20,000 a year for full time work.

> This is an associate's degree and we explain to the students right up front that you know what, you have to crawl before you can walk and

> you are going to start at an entry-level salary. And don't get me wrong, I've been in an intro class, the first night of class, and people's expectations are a lot higher than that, it's almost unbelievable sometimes to hear what students say...[like] 'I'm going to make $100,000 a year aren't I?' ...One thing that's very important to us is to give them a sense of the reality of what it's like out there working and what you're going to earn.

The need to link these training programs with real jobs has the quality of protesting too much; they reveal that certain sectors of the training and education industry hang by only a hair to "the economy" or requirements of the labor market. The programs run or administered by the people I interviewed might not be so precarious, but the need for some interview respondents to establish distance from that possibility betrays the very real risk of becoming disconnected from jobs and outcomes that are materially significant, as is evidenced by the failed health information technology degree.

I felt that to suggest in the interviews, through certain lines of questioning, that some forms of education and training are known to have very little impact on earnings or chances for mobility, or that there is a certain satisfaction in being a trainer/educator or that is divorced from the efficacy or content of the training itself, would reveal little new or interesting about this kind of work while it was also presumptuous, if not hypocritical. I am, after all, an educator and it was evident to me that college and university-based education is in many respects not so different from vocational and on-the-job training. And yet, there is something about the affective dimensions of this training, the sentiment of *transforming* people manifest in these interviews, which deflects the possibility of judging the training and education itself, from calling into question certain of its forms. It is an industry that places itself outside of criticism in this regard, daring its detractors to challenge the very idea of self-improvement and personal growth.

♦

The reasons health care workers I interviewed were engaged in training and education varied as did the those of the trainers and educators. Milagros and Isabel, both immigrants from the Dominican Republic and aged 29 and 40 respectively, met in a nuclear medicine technology program (an associate's degree program) at a community college. Though their lives had taken substantially different paths, they became friends because of their common background and language as well as goals. Both had struggled to succeed in college in the U.S., largely because of second language issues, and both found that attending college had made it difficult to maintain earlier friendships. After coming to New York, Milagros worked in light manufacturing for six years (in New Jersey) and was a school bus escort when we spoke. Isabel, who was married at 14 and divorced at 24, came to New York with her husband and worked for years off-the-books as a bartender in a New Jersey club. She said she never received encouragement from her husband and others in her life to do more. I interviewed them together, in Isabel's apartment.

Ariel: So, I'm curious, how are your lives going to change when you do start working in nuclear medicine?

Isabel: Oh my God!

Milagros: A lot.

Ariel: In what way?

Milagros: Everything. I'm going to get more money because I'm only getting $8.65 [an hour] right now as a school bus escort, and my bank account will increase.

Isabel: I'm not thinking about money, I'm not thinking about money.

Milagros: (surprised) What?

Ariel: You have to be, don't you?

Isabel: You know why? I was making $2000 something every week.

Ariel: Doing what?

Isabel: Bartender...One night, I did a party for $500, something like that. So, I'm not doing it for the money. I want to do it because I want to be satisfied as a professional. Something different. It's not like that in a discotheque, the smoking and everything, the men do not respect you. It's not the same. I am 40 years old, I got a grandson, I got a daughter. So I want another lifestyle. It's not the money. It's the satisfaction that I can do it if I want.

Milagros: That's true. But I think that goes hand in hand: when you're doing it for money, you're doing it for your own satisfaction. Like, when you have a commitment to do it and you finally get there, it's like oh my God, I did it. There's a satisfaction, too. But in the other way, you also do it to have a better life and to get a better job. Save some money, give your children a better life.

Neither Milagros nor Isabel were working in health care or in a union when I interviewed them. Both started community college unsure of what they would do, though both had already ruled out one of the most obvious career choices—nursing—for different reasons. Nuclear medicine technology seemed to be a profession in which they would be respected as well as a relatively easy way to make a decent living. This brief conversation makes very clear that tangible outcomes in terms of money and providing for your children are intertwined with emotional and affective outcomes like satisfaction and respect.

Milagros described some of the cultural reverberations that accompany the decision to attend school:

> ....when you go to school and you try to get a degree for yourself, people look at you a different way... when you say "I work and I go to school" they look at you with—I feel, with some kind of respect, or different than everybody. It doesn't matter what you study, it's the fact

> that you go to school. It means that you're looking for something in life, that you don't just want to be chilling and doing nothing.

What is interesting in Milagros' comment is that there is a way in which it doesn't matter what you study—the content of education is almost (but not quite) beside the point. Milagros certainly enjoys nuclear medicine technology, but her decision to enter nuclear medicine was largely a result of circumstance and good fortune. There are not many nuclear medicine technology programs in the city, as it is a small and nascent field, but there just happened to be one at the community college Milagros attended. She knew someone who graduated from the program and she was attracted to the medical field in general. Milagros started the program knowing very little about what nuclear medicine technologists did nor what kind of salary they made.

For Milagros going to school garnered respect from others and provided a sense of direction, of moving forward. Of course a sense of moving forward has to be accompanied by actually moving forward in terms of becoming more qualified for something, otherwise the result may be disappointment and alienation. But given how chaotic and poorly organized the training and education industry for allied health care workers is, it often seemed that it doesn't take much to provide a sense of moving forward. The process of going to school is often long and drawn out, full of interruptions and sidesteps; the mere existence of training and education courses and the valiant attempts of students to navigate their way through them seems to sustain a collective sense of moving forward.

Although education can be a very real and important vehicle of mobility, Milagros' comment exposes the importance of participation in organized education as a

legitimized response by poor and minority community members to the many permutations of the judgment that they are responsible for the conditions in which they find themselves. *Whatever the content or outcomes* of going to school may be, it is—in the first instance—a sign that "you are looking for something in life." This observation diminishes neither the personal experience of getting respect nor the real courage and perseverance which it takes to change and improve one's life, but it does throw into relief the ubiquity of disrespect—of feeling worthless—as well as the paucity of venues and criteria for claiming worth. While the ideology of individual responsibility pervades all aspects of American culture and has been thoroughly internalized, for marginalized groups the grounds for demonstrating responsibility are circumscribed.

The education and training industry for allied health care workers thrives in this environment; it is an effective medium for symbolic expression, personal satisfaction and intangible value beside that of qualification. In one of the more exaggerated expressions of this phenomena, Shirley, a registrar studying to become a coder and biller, described the many courses offered through her hospital's training department that she had volunteered to attend over the years:

> I'm always up to volunteer for classes...we had...well all these courses I'm taking now are voluntary [coding and billing], but we used to have all kinds of little classes. They had a cooking class that you cook without using flames, you would use like nuts and grains and vegetables, but nothing went on the fire. You prepared the food without fire, salads, and they used beets and made a meatloaf out of beets. That was a great class here for in-patient psych because we had some patients that feared fire. And I was in a diversity class, everybody cooked something and brought it in and we saw the difference in food.

Shirley had also been in communication skills training and what she called "courtesy class" (probably a form of customer servicing training). Cesar, 38, who had

enrolled in postsecondary education programs on and off since finishing high school, several times without completing the credential for which he set out to achieve, seemed to experience school as a kind of open-ended exploration; he said "I like school. I like learning, anything I can learn" and showed no signs of frustration with his educational experiences that were, by any traditional measure, false starts. For some of the people I interviewed, then, almost any kind of training or educational experience was met with enthusiasm. The training and education industry thrives on general interest and desires to grow and expand. As Marie explained: "I want to continue with my education, I don't want to stay the same way that I am."

In the case of health care, where the extreme division of labor and hierarchical organization of tasks in the labor process make workers acutely aware of differences in status, training and education also takes advantage of feelings of inferiority generated at the workplace. As the American Hospital Association report discussed in the previous chapter showed, the health care industry itself has become painfully aware of the fact that many health care jobs are perceived as less than desirable, so it is feverishly attempting to (re)attach "meaning" to work in health care.

Health care workers feel the impact of these ideological messages that health care work is or should be regarded as meaningful. The messages promote a kind of insecurity for which the education and training industry is poised as a solution. Veronica, a nursing assistant, told me about why she switched from working at a nursing home to a hospital:

> I figured if you get into the hospital [and the union] I could do LPN [Licensed Practical Nurse] or something. I always wanted a job that means—you know, it's something, but as a Nurses' Aide you don't get no res—I mean you get treated—it should be an important job, because you

> take care of people, you listen to their problems, you console them, and yet you get treated as if you're nobody. Especially by the nurses.

Veronica started to say that she always wanted to do something meaningful, like become an LPN. But she corrected herself, reminding herself that her job as a nursing assistant does in fact mean something, it is an important job, the problem is that it is not treated as if it is an important job. People who occupy that job are treated with disrespect.

55-years old at the time I interviewed her, Veronica had nonetheless begun to turn toward education as a potential way to manage the process of aligning her sense of what is meaningful with what is culturally valued or held up as meaningful. She spent two years from 1994 to 1996 in a union-funded GED program, passed the exam on her third attempt, then enrolled in a union-run college preparatory course which helps participants acquire the language and math skills necessary to pass the CUNY entrance examination, passed the entrance exam, and as of 2002 had completed four college courses. School had been an ongoing, concurrent activity to her work and home life for close to ten years. She hoped eventually to obtain an associate's degree in nursing.

As the desire for meaningful work, or a job that warrants respect, gets filtered and perpetuated, it may be fair to ask whether that meaning can in fact ever be found. Or, whether education and training is not predicated on the limitless postponement of meaningful work. Veronica was aware that how a job is perceived is not synonymous with its meaning, but at some level meaning was the discourse most ready-to-hand to explain her desire to move up in her career. The education and training industry takes advantage of this desire for meaningful jobs, though it does not necessarily provide them.

One can see how meaning might become perpetually deferred, but the engagement that the desire for meaning produces—affect—is continually reinforced.

Meaning figures in the discourses of workers, employers, trainers, and consultants but it is impossible to pin down, to identify what constitutes meaningful work and declare when it is achieved, because it is a free-floating engine of growth and production. One might call the channeling and direction of the desire for meaning the bread-and-butter business of an affect economy. The training and education industry is well-positioned to trade in the affect economy since it can offer itself as a vehicle for achieving meaning while the industry's existence, in fact its growth and profitability, is only strengthened by the failure of the occupational structure to provide meaning.

Once the training and education industry is established as a vehicle for the investment of desire, it need not depend on individual "choices" to return to school. It does not operate according to the laws of a market with independent sellers fulfilling the exogenous demands of buyers. Wanda's story, in particular, illustrates the extent to which school and its affective dimensions saturate the lives of these workers such that choice (or demand or need) cannot be seen as the motive force behind the industry.

After following her two children to the United States from Trinidad, Wanda wanted "to continue my education because I started it at home... So I said well if I'm here, this is the place that they say is the land of opportunities, I'm going back to school." Wanda's ability to go back to school, and desire to go back to school, was partially a product of the opportunity structure she found available. She entered into a unique industry with opportunities rare for a worker of her color and background, and she gained access to an adjunct educational complex which facilitated and channeled those

opportunities. As soon as Wanda landed her first union (1199) job as a nursing assistant—a year after immigrating from Trinidad in 1987—she obtained her GED through a union-funded program. She obtained her LPN certificate in 1995 after attending a part-time, union-funded program for two years.

> Ariel: So after you became an LPN you stopped going to school for a while?
>
> Wanda: Yeah. I should not have done that because I got my [LPN] certificate in 95 and if I had continued I would have been finished by now [with the RN degree].
>
> Ariel: Why did you take a break?
>
> Wanda: Well, at that time, when I graduated, they were not hiring RNs anymore. They were laying-off the RNs. So I said what's the point, you know? And I just kept on working as an LPN. And then the union had stopped giving that course, paying for that course, because it [the RN shortage] was not so extreme then. And until it was...we got some flyers saying that had started paying for the RN course. So I said look, I'll take the opportunity.

Wanda said she would have continued with school without union support, but there is little doubt that the union education programs dictated, to greater or lesser extent, the course of her career. The short-lived and ill-founded predictions of a registered nurse surplus in the mid-90s eliminated nurse training programs so that health care workforce experts were caught off guard by the substantial, nation-wide nursing shortage apparent only five years later. By the time I interviewed Wanda, the Training and Upgrading Fund of 1199 had started several programs in response to the shortage, for which Wanda hoped to qualify.

What is ultimately of interest about Wanda's story is not only that her career movements had not been entirely a matter of individual choice, but that they had also not

been dictated by a personal quest for meaning, respect, or fulfillment. The "compulsion to move forward" I described at the beginning of this chapter is an immanent compulsion—immanent to this industry and maybe to other specific instances of social institutions and organizations. After obtaining her LPN certificate in 1995, Wanda worked as a nursing assistant for three years, waiting for a job to open up at the hospital where she worked, from which she lived only one block and which owned her apartment building.

Ariel: In that period when you were an LPN but you were still working as a Nurses' Aide, did that change how you did your job as a Nurses' Aide?

Wanda: Well, when I became an LPN I was working in the OR [operating room]: I wasn't dealing with patients, I was dealing with the instruments. As the instruments came out from the OR we had to wash them and we had to set them, set the trays. And then sometimes we had to sterilize them. So it was a different job altogether. I worked for 3 years in the OR.

Ariel: So you left the OR when you became an LPN?

Wanda: Yes. Why I went to the OR? Oh, you know how I went to the OR? They were downsizing one year and they closed one of my floors, 3T, and I was floating, working different floors until I got the appointment in the OR.

Ariel: How did you feel about that?

Wanda: I felt good about it. Because I think I needed a change. Because I welcomed the change, the work was different....Learning different—learning, learning, learning. I learned how to set the trays for the different operations. I did that until I got the appointment to be an LPN. Then I went to the ER. [laughs] That was another thing, whew!

Ariel: How did you feel about *that* change?

Wanda: I liked that change because it was something new. Remember I was going as a nurse now. When they said they did not want any more LPNs in the ER—

Ariel: Why?

Wanda: I don't know. We got new Administrators, I don't know what took place. And that is how I came to be working in Peds [Pediatrics]. The union took up the cause, because we would call

> that displacement, and then we had a meeting and they asked me where I wanted to work and I said I think I want to work in Peds, with the children. So that's where I went. It's nice working with the children.

Wanda found aspects of her work that engaged her in the varied kinds of jobs she has held. She became very animated when discussing her interactions with the mothers in the Pediatrics unit in particular; but she also lit up when describing working with the instruments. Wanda both sought out and was exposed to numerous training and education experiences. The course of her career was steered by her personal needs (both practical and ideal), the organization of the training industry, and the vicissitudes of the health care industry. A survey questionnaire might reveal that she was first a nursing assistant and presently an LPN, *not* the variety of units on which she worked or the fact that she received two months training on the Peds floor, or that when she worked on the 5th floor the entire unit was sent to a mandatory communication class because of patient complaints, or that she took a computer class while working in the OR for her own edification. "Learning, learning, learning," animated her occupational history. Wanda did not embark on an explicit journey to track down meaningful work; she stepped into the circuits of an affect economy where learning, growth, and engagement are the promised products.

Like Veronica, the "outcomes" commonly attributed to education and training—a new job, better pay, knowledge—did not follow in an immediate, or even linear, manner. Three years passed before Wanda put her LPN degree to use, and when she did her $18/hour salary was only two dollars more than what she had been making on the second shift as a nursing assistant. She waited to go on in school until industry predictions of a

nurse surplus passed. She went into the OR and into Pediatrics because of hospital downsizing and/or work reorganization. Wanda didn't demand these kind of changes, but she found that the learning each change entailed sustained her over the years in these jobs. The expansion of the education and training industry may be in a sense self-generating—the industry is a productive apparatus that takes advantage of the desires it encounters but also modulates affect independent of the needs of individual workers or employers.

Taken as a whole, the reactions of workers to school mark the affective impulses and emotional energy conducted in a variety of training experiences; they also suggest a fundamental sameness between these kinds of training experiences and other more elite or privileged forms of education. From a standpoint of material outcomes or quality of training, there can be stark differences between programs included under the broad umbrella of training and education for allied health care workers and even greater differences between this whole industry and elite higher education institutions or even on-the-job training for corporate executives. And I have already suggested that the affective dimensions of the training—the experiences of personal transformation and meaning—can be the basis for a silencing of political critique or substitute for the assessment of outcomes. But I propose that the expansion of this industry is dependent on the spread of affective ripples.

Wanda—like all the health care workers I interviewed—may be unique in important ways. Almost everyone I interviewed had been involved in education or training programs in addition to those required for their jobs and may therefore have been more predisposed to see education as a vehicle for engagement, interest, or emotional

investment. I was also struck too, in almost every interview, by the lack of bitterness or resentment toward some of what seemed to be arbitrary obstacles to moving forward—whether those obstacles were the result of simple ineptitude or systemic forms of discrimination. Naturally this lack of bitterness was part of a layered presentation to me—a woman, a white woman, a white American woman, a young white American woman. But I have interviewed health care workers who are bitter in the course of ethnographic research in health care settings and I have heard the expression of discontent with power structures, including unions and hospitals. Most of the people I interviewed were proud and self-determined, hesitant to express bitterness because it might also be to admit powerlessness. It need not be so, of course, but these were respondents who lived by a deep sense of responsibility for themselves and their families.

Engagement can be encouraged and it can be stifled, and this education and industry does not have uniform effects in this regard. For some health care workers I interviewed, organized schooling was something they wished to engage with as little as possible. Juan, a registrar and physical therapy assistant, was trying to arrange his life so that he could have a more flexible work schedule, still support his son, and spend more time on the clothing-design business he had started. He could work as a physical therapy assistant on a part-time, per diem basis, and though he found college work relatively easy, it was primarily a pass-through for him. Similarly Grace said she "hates the idea of school," but knew she had to further her education to become something other than a dietary worker. For some health care workers, there is probably nothing less pleasant than a customer service in-service. One trainer I interviewed discussed how many health care workers, particularly in the heavily regulated nursing home sector, are bombarded with

dull and stultifying in-services. Indeed, education has been rightly viewed as a strategy for "cooling out" expectations (Clark 1960) and stifling interest and engagement. This was evident when the director of allied health sciences at one college said he has to tell students they must "crawl before they can walk" when they enter his classroom anticipating $100,000 annual salaries.

While education may certainly channel and stifle expectations, I am uncomfortable with the embedded assumption that this is somehow functional—that what employers (or capital) really wants (or needs) are people stripped of desires and aspirations, performing their routine work roles because they are convinced they aren't worth anything better. Actually, there is something more subtle and complex going on. There is a way in which engagement and motivation is also sought and cultivated, as the work of corporate trainers and managements consultants attests. That said, I don't think the training and education industry for allied health care workers effectively channels affect toward identification with work, or towards increased motivation to be the best worker—though some of its forms may attempt to do so. Based on the evidence presented in this chapter, the training and education is sustained by the noninstrumental "rewards" to participants and these rewards, in important respects, bypass any "functional" connections to employers or the economy.

CHAPTER 7: AN INDIFFERENT STIMULANT

In 2002 the Commission on the Public's Health System, a non-profit advocacy organization, sued New York State in order to gain access to records of how eligible public and voluntary hospitals had so far spent the $1.25 billion in grants dubbed the Community Health Care Conversion Demonstration Project (CHCCDP) (Robbins 2003). As I described in Chapter 2, 25% of this money – or close to $300 million – was allotted to training and education. The imperfect data the Commission obtained (Commission on the Public's Health System 2003) showed that for the first cycle of CHCCDP, 43,363 of 104,603 funded training encounters[29] were for customer service training. In the second and third cycles of CHCCDP, the majority of training encounters proposed by participant hospitals were likewise for similar non-job specific training, in particular customer service (53,095) and cultural diversity (24,230) training. Other popular training courses were for foreign language, computers, and managed care. The Commission was troubled by the fact that training proposals were nearly identical among hospitals, raising "questions about whether these projects are designed to meet local needs" (pg. viii). The uniformity of this training agenda is indeed interesting, suggesting that the soft skills training I observed, and describe in this chapter, is part of larger trends in the health care sector.

The first page of 1199 TUF's internal Executive Directors Report on the use of the first cycle of CHCCDP grants by voluntary hospitals indicated that 21,239 workers

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[29] Employees may participate in multiple training courses and some courses have multiple sessions. The number cited reflects each of these encounters, not the number of individual employees trained.

"were served" in 207 programs. The union reported that the top five programs, in terms of the number of institutions offering the program, were customer service (19), operating room technician (15), computer education (14), crisis intervention (14) and lab tech cross-training (10). The "most popular" vendors for training included the Consortium for Worker Education (CWE), CUNY, Pace University, and Long Island University, though this list does not exhaust the many educational and consulting entities contracted to train health care workers.

In a quasi-evaluation prepared for the Association of Joint Labor-Management Educational Programs (of which 1199 TUF is a member), the Conference Board of Canada (2002) identified the perceived "skills gains" and benefits of joint labor-management training programs, contending that employers, unions, and workers all stand to benefit from such programs. Among those gains were "improved job-specific skills," but the list of skills gains was otherwise limited to non-job-specific and/or relatively "soft" outcomes. I include in the latter category "improved literacy skills," "improved communication skills," "improved decision-making," "better personal management," "increased self-confidence," and "greater adaptability." The reported benefits of these programs for participants included "improved customer service," "better personal management," "better communication," "better understanding of job tasks," "improved attitude," and not least, a "greater appreciation of learning."

While the definition of what constitutes "hard" and "soft" skills is by no means universal and the epistemological grounds of such a dichotomy warrant question, I follow Moss and Tilly (2001, pg. 44) in defining soft skills as behavioral and social skills as opposed to formal and technical knowledge. Moss and Tilly distinguish two clusters of

soft skills based on their interviews with employers: *interaction*, such as friendliness, teamwork, and appropriate demeanor; and *motivation*, which includes qualities such as enthusiasm, positive work attitude, and commitment. In general, soft skills are not usually job-specific and cannot be easily standardized and/or translated into productivity measures. Certainly it would be correct to suggest that communication skills, for instance, contains dimensions that might be easily standardized and measured, but in my observation communication skills training emphasizes diffuse topics like anger management, attitudes, and demeanor (see also Ducey, Gautney, and Wetzel 2003). These kinds of skills are labeled "soft" in reports such as those produced by the Conference Board because of ingrained associations between such skills and those intangible, emotional aspects of interaction coded as feminine. Another reason, then, to use the term "soft skills" is because it marks the subtle way in which gender stratifies the training and education industry.

On the whole, the implication of the Conference Board Report is that joint labor-management training programs are concerned above all with problems of commitment and control on the shop floor. Even though "hard," presumably measurable impacts such as "increased productivity" and "fewer errors" were listed and sections of the report alluded to gains in "human capital" or to the upward mobility such training might produce for workers, the most pressing problems for which training was proposed as a solution were those of motivation, attitude, and flexibility.

The Report represents not an idealistic statement of managerial ideology so much as the best rhetoric that could be mustered given the diverse operations of the joint training programs under study (which included 1199 TUF). Few of these programs had

undergone any systematic evaluation; in fact, the evaluation of communication skills training for which I was an investigator (Aronowitz, Ducey, Gautney, and Wetzel 2001) is one of the only evaluative studies cited in the report (and done so highly selectively). Use of the phrase "greater appreciation of learning" to express a program benefit—and not simply "learning"—is the product of public relations efforts and a rhetorical smokescreen for the lack of evaluations. Outcomes such as "greater appreciation of learning," "increased self-confidence," and "better personal management" show the extent to which education/training has been lifted out of the scene of instrumentalism: such outcomes can be valued even if the training programs fail to provide skills and knowledge.

The enclosed rhetoric of the Conference Board Report renders education and training a self-valuing entity such that learning is undertaken in order to appreciate learning. Self-confidence, self-management and an appreciation of learning are outcomes that that can, perhaps, be channeled into productivity and profit; but to suggest—as does this report—these are the outcomes of training and not merely its byproducts indicates a kind of suspension, or disengagement, from the nature or content of education. It is not unlike going to school as an ethnographer: you are not there to learn the curriculum, but to appreciate the process of going to school.

Such a view of the benefits of training ultimately poses a dilemma for the training and education industry itself. On the one hand, if training and education can produce self-confidence, communication, greater adaptability—the very stuff of personal interaction and sociality—its potential social role and importance is heightened. On the other hand, this view deprives training and education of a unique or irreplaceable social role (to

produce and distribute specific kinds of skills or knowledge). This kind of rhetoric surrounding education simultaneously lays the groundwork for its expansion and dissolution. Such education and training sits on the precipice of the excessive, the product of an affluent society.

I take the Conference Board report as confirmation that the emphasis on customer service, communication, and other soft skills in health care is also apparent in joint labor-management training endeavors in other industries (telecommunications, and hospitality—in the Report). There are a few published case studies of joint labor-management training programs (Ferman, Hoyman, Cutcher-Gershenfeld, and Savoie 1991), but to my knowledge the phenomenon has never been analyzed from a social science perspective that is theoretically informed.

In this chapter, I draw upon several sources of evidence to analyze the nature of soft skills training in New York City's health care industry. Most importantly, I have observed soft skills training in three settings: a hospital-based communication skills program, a hospital-based "retreat" on customer service in general, and in-services at one of the City's largest home health care agencies. The first series of observations were conducted as apart of a larger evaluation of communication skills training, previously cited and funded by 1199 TUF. In addition to observations, I interviewed several people who had taught or developed soft skills training programs—as independent consultants, hospital-based training directors, and university or college-based administrators, including the teachers of the hospital-based programs I observed. Through these interviews I learned about the circumstances of soft skills training programs I had not observed.

Soft Skills Training

In *White Collar*, C. Wright Mills (1951) wrote that "in a society of employees, dominated by the marketing mentality, it is inevitable that a personality market should arise." In the market for manual labor, the employer bought the workers' labor, energy, and skill, but in market for white collar services the employer "also buys the employees' social personalities":

> Whenever there is a transfer of control over one individual's personal traits to another for a price, a sale of those traits which affect one's impressions upon others, a personality market arises. (pg. 182)

Mills was well aware that labor with one's personality constituted a distinct kind of labor, sketching the contours of a phenomenon filled in by Arlie Hochschild (1983) 30 years later when she coined the term "emotional labor"—a labor process in which employees have to manage their own feelings as well as those of others. For Mills, as for Hochschild, the sale of one's personality entailed considerable risk, even a "sacrifice" of one's self. He quipped that "tact is a series of little lies about one's feelings, until one is emptied of such feelings" (183). The norm of tactful behavior required in the modern white collar organization was a realm of managerial control which posed new hazards because employees could become self-alienated or even come to think of those behaviors as their genuine selves. "What began as the public and commercial relations of business have become deeply personal: there is a public relations aspect to private relations of all sorts, including even relations with oneself" (187). Personality had become the domain of a new cadre of experts and trainers, dedicated to rationalizing and standardizing

interpersonal relations. Mills viewed this change with cynicism, declaring that every interaction was now conducted with "a winking eye, for one knows that manipulation is inherent in every human contact" (188).

Among the evidence that the ethos of the personality market had spilled out of its corporate container was, to Mills, self-improvement literature. Through a content analysis of success manuals, Nicole Biggart (1983) documented the rise of the personality ethic, an ethic that like its predecessors stressed effort and initiative as the keys to success, but newly promoted the selling of the self. Such an ethic was the basis for the post-war ascendance of success manuals that emphasized self-management. Biggart concludes that, as evidenced by success manuals, 1950s white collar workers were not alienated by their bureaucratic work settings, but in fact "internalized instrumental rationality" and came to "view themselves as objects to be controlled and manipulated."

In Biggart's analysis it makes little sense to speculate about a genuine self: once instrumental rationality, or the self-management mechanism, is internalized, that is the self. For Mills, true internalization is not possible because there is, even if hidden and alienated, a genuine self ultimately incompatible with selling itself. Mills' apparent ability to see into people may be the product of his political imagination as much as any empirical investigation, but he had faith in immanent resistance to workplace control. Whatever the status of the "real" self, Mills saw that workers were asked and expected to make a genuine internalization as part of their involvement in the white collar world. My question in this chapter is not whether workers do in fact internalize the ideologies of work or success, but whether or not workers are *expected* to internalize those ideologies and how such expectations are related to questions of affect and workplace control.

This may seem like an odd question to apply to health care workers since it would appear obvious that they are expected to invest of themselves (and indeed must) to provide quality care. As we have already seen in this dissertation, the relationship of health care workers to their work in terms of personal motivation and engagement are varied and complex. I have shown in the previous chapter that a good deal of the discourse about why training and education is important centers on ideas of personal transformation and improvement, which represents an ideology of self-improvement. Some of the discourse I presented in the last chapter also suggests the strength of an ideology that holds individuals responsible for the circumstances in which they find themselves. Though such ideologies are present and are manifest in the vocabularies of workers and trainers, I have argued that training and education intervenes at a level of affect, which these discourses do not fully reach. My conclusion in this chapter is that soft skills training operates at a level which is indifferent to such ideologies.[30]

Health care is an interesting case because so much literature on the transformation of work and control is based on observations or ideal constructions of a transition from a manufacturing to a service economy, from blue collar to white collar work. This literature often fails to take into account the paid and unpaid services provided by women and people of color which have long been based in the realm of affect and personality. This

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[30] It may seem I using the term "ideology" in its obvious and crude form—a set of ruling ideas that are imposed on workers from above or outside. But in fact, I think my analysis holds as well if the reader has a more nuanced notion of ideology in mind, such as that of Althusser (1971), for whom ideology is a "set of material practices through which people live their experience of capitalist social relations" (Aronowitz 1991, pg. 118) and into which people are "always already" subjected. I think "ideologies" of self-improvement and personal responsibility are deeply felt, part of lived experience, and written into institutions like education. That said, as Althusser would concur, ideology is accessed and experienced through discourse—and ultimately expressed as ideas which function to reproduce capitalist social relations. Affect, on the other hand, as an energy source which runs though both the human and nonhuman, the conscious and nonconscious, often eludes expression and capture.

oversight may be ascribed to the fact that such unpaid services were not often considered work and when paid, such services were seen as the natural extension of those workers' abilities and desires. Health care work as a contrasting case therefore throws into relief what is really "new" or unique about work in the global political economy.

This chapter examines expectations vis-à-vis the self conveyed in soft-skills training for health care workers. Examples in this paper are drawn from communication, customer service and other soft skills training created as a response to immediate workplace problems and justified on the basis of increased competition in the health care sector. There is lack of consistency in the discourse and practices of soft skills training as they are enacted in the health care industry. The exposition that follows shows how the training and education industry for health care workers in New York City has taken shape—it does not represent the cutting edge of training theory or managerial ideology. I suspect my experience and observations very much reflect the day-to-day realities of what attending a retreat or in-service is like for the majority of workers in firms and industries riding the coat tails of managerial trends. The mish-mash of ideologies about work that I am about to describe are probably the outcome of diverse and often conflicting strains of management theory newly pressed into the service of the health care system. The training programs I observed tried both to persuade participants to identify with and personally invest in their work but also encouraged a set of superficial techniques for behaving at work which would allow someone to "pass" without making a substantial self-investment.

Personalize It

The consultant I interviewed about her geriatrics and communication course for nursing home workers said:

> In the course information is offered to them, not just to understand the residents, but to understand their own aging process and their own life and the things that are happening to them and the people around them, so that they can personalize being that person in the nursing home and make a decision, how would you want to be treated?

Most trainers I have interviewed and courses I have observed at some point encourage health care providers to identify with patients. Health care workers are told to 'treat the patient as you would want to be treated,' or 'how you would want a family member to be treated.' Several health care workers also told me in interviews that they use their imagination this way in their work. The suggestion that workers identify with patients demands effort—what has been called emotional labor—and it asks the workers to make their expressive effort consistent with their sense of themselves, to make a link between what they are doing at work and their own identity. In the quote above, the expectation is that work is more than just a job.

In likewise fashion, at the one-day retreat I attended we played a raucous game of Pictionary (which I was the only person apart from the instructor to have played before). Interviewing the instructor/human resources director later, I asked her about the logic behind having the group play pictionary. She said,

> I thought pictionary is a very interactive game, and also part of psychology is you ask people to draw their feelings and how they express themselves is how they're feeling, so it also brings them to a lower level where they're not thinking, they're not analyzing data, they're just doing it spontaneously and we want some spontaneity.

This approach is akin to the initial stages of integration into a total institution, described by Goffman (1961), during which the participant is broken down to a "lower level" and their prior identity stripped away. The instructor's comments reveal the disciplinary element of this training, wherein the goal is to reduce a person to their real or most base feelings so that they are vulnerable to a new order, the rules of their new institutional home. Naturally the instructor overestimates the capacity for a one-day "retreat" to achieve such a re-socialization process, but her discourse and approach has pretenses to touch the self itself, to reform the whole person.

Just after describing how the goal of pictionary was to bring participants to a lower level, the instructor talked about the goal of another exercise, for which the health care workers were asked to write advertisements for the hospital. "The reason we want them to do advertising is for them to think positive," she said. The discourse of "thinking positive" has roots at least as far back as the 19th century "New Thought" movement (Bendix 1974). Though thinking positive strikes me as a superficial technique of self-management, the instructor wove it into a more invasive and therapeutic language. She continued by saying,

> an advertisement is never negative, and if they [the workers] are negative about where they're working then my suggestion is going to be look, look at yourself, you can't even say anything nice about where you work, maybe it's time for a change for you. I'm not going to tell you that, but that is a sign. Sometimes people realize that 'this may not be for me, that's why I'm miserable for the last 20 years.' And so I have to bring it to their consciousness. There's other issues obviously involved, finances and stuff, but hey, if you're not happy you're going to disrupt the team.

I suspect that this trainer has never convinced a unionized nursing attendant with 20 years on the job and only a few left to retirement to leave her

job because she has suddenly gotten in touch with her unhappiness. There *are* other issues involved. But the overall impression a participant in this training course might take away is that teamwork requires an honest assessment of yourself and your desires.

The sources of these training strategies and curricula are culturally diffuse and situationally specific. Somewhere between the general circulation of ideologies about meaningful work and this individual trainer's background and preparation are guides which attempt to mold general managerial trends for the specific setting of health care. J. Philip Lathrop's *Restructuring Health Care* (1993), for instance, is a management guide which legitimizes and inspires the multiskilling initiatives described in chapter 2. His book explicitly links the reorganization of work to issues of personal investment and motivation.

Cross-training (multiskilling) is for Lathrop a key and often neglected structural change in health care reform. But "The Real Training Challenge," as a chapter subheading portends, is "to change the way people act and the way they *think*" (pgs. 166-7). He illustrates this with the case of an admitting clerk who had been cross-trained to handle a greater array of patient paperwork. The result? "In her new job, she works carefully and well because if she does not, the patients will get hassled by their insurance companies and the hospital business office...She now has control over enough of the patient's paperwork that she herself can assure its accuracy and completeness. Furthermore, she feels an *intense personal ownership of the work on the patient's behalf*" (167, italics added). Shirley, a worker I interviewed who had recently been upgraded

from a unit clerk to a registrar receptionist in the emergency department described her new job this way:

> With this job we're at the front window for everything that comes in so we really have to try to get the information right. It starts right here. ... I take it very seriously because if the hospital is going to get paid I have to get that insurance in right, I have to get that billing address right, get that name right. They're a lot of things that you really have to be aware of just getting the patient in initially.

Shirley, as I described in Chapter 5, identified as a caregiver and felt she could affect patients even in her non-direct care giving roles. When Lathrop says personal ownership over work is taken on the patient's behalf he exploits the responsibility for patients that is unique to the health care industry. This vision of "patient-centered care" imagines that increased connections to patients will compel more motivation and careful work. It is another example of how the health care industry attempts to rely on providing care as a unique and valued kind of work. Lathrop even uses the dysfunction of insurance and payment systems as the basis for creating more motivated workers. Lathrop's model requires only providing "enough" control to give the worker a feeling of personal ownership, not real control or real ownership. Lathrop argues that staff enjoy acquiring new skills, even without extra compensation. Shirley's new position, however, was accompanied by an increase in wages, she was trained to work with computers for the first time, and she was exposed to the world of billing and coding—a potentially lucrative career path—which may account for her enthusiasm as much as her concern for patients. With other forms of multiskilling, such as the transformation of nursing assistants into patient care technicians, staff have indicated they enjoy learning new skills but they are at

the same time profoundly unhappy with what seems like an initiative aimed to increase their work load.

What these training encounters and managerial discourses reveal are the ambitions to make health care work personally meaningful. I have already argued that the training and education industry for allied health care workers intervenes in an affective dimension that is distinct from a dimensions of productivity and skills, but I want in the following page to begin to distinguish the idea of affect from emotions and subjectivity.

Keep It Light

At the one-day retreat, the instructor suggested that staff "keep it light." She made the suggestion in a discussion of how to behave during an upcoming site visit from the Joint Commission on Accreditation of Healthcare Organizations. The instructor advised the class participants not to complain, not to air their "dirty laundry" in front of the joint commission, to smile and appear professional. But she also recommended this strategy as a day-to-day technique, one that would minimize conflict and strife. For instance, she advised staff never to use the word "no" with patients or coworkers, offering many examples of how to sidestep a request without appearing unhelpful. "Keep it light," in this course, meant keep it apolitical, keep it non-controversial, keep it superficial.

Similarly, an independent training consultant I interviewed said that when issues of short-staffing or of poor working conditions came up in her classes, she would explain to the class participants that it is simply the way the industry works: the health care facility has to make a profit and the workers can't really change that. "It takes the personalization out and allows us to see it from a broader perspective…hearing that from

me as an outside instructor kind of helps them understand it, it neutralizes it." She hoped to get health care workers to divest from their interest in the conditions of their work and be able to accept them without being personally affected by them.

In most of the classes I observed on communication or customer service the topic of body language came up, and instructors were able to demonstrate poor body language and suggest that its correction is a matter of choice and self-discipline. In one in-service for home health aides, the instructor—full of aphorisms—advised the aides not to not to yell or "fight fire with fire" when having trouble with a supervisor. Likewise they were told never to "badmouth" other aides, because such acts undermine their credibility. Many of these recommendations are about teaching black and Hispanic women "professionalism" and middle class behavioral codes, but what I wish to highlight now is how these recommendations focused on superficialities.

In one in-service, home health aides watched a video tape on "dealing with difficult people" produced by a professional management consultant, Dr. Rick Brinkman, in which he enacted with his colleague Dr. Rick Kirschner (making them "Drs. Rick and Rick") a series of "Saturday Night Live"-style skits dramatizing examples of poor communication. In one skit of a boardroom meeting, a female participant is reprimanded by Drs. Rick and Rick for prying too deeply into her coworkers' feelings. Workers are taught in the tape to mimic the body language of the people with whom they are dealing; to pace their responses and "create a shared experience that reduces the differences

between us"; to ask a series of questions that backtrack and clarify in conversations.[31] The tapes focus on explicit behaviors which alter the course of an interaction. By no stretch of the imagination do they entail or suggest that workers personally invest in their work.

Of course the tapes were not created for health care in particular and therefore do not have recourse to the value of caregiving to produce motivated workers. But deployment of distancing techniques in these training sessions confirms how much caregiving work requires the use of superficial techniques and the need of workers under incredibly taxing circumstances to learn shorthand strategies for handling the emotional dynamics of their work. When one teacher was reminding aides that company protocol was to call an ambulance when a patient falls, rather than help them get up themselves (unless the patient was in immediate danger), she said "don't let your compassion take precedence."

These courses, or training encounters, lasted only for a few hours and were largely divorced from any efforts to reform the organization of the health care labor process as a whole. The courses presented strategies for managing one's self at work, but

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[31] In one particularly rich skit, Rick and Rick reveal how to "state your intent." The scenario is a female (white) secretary trying to persuade her male (white) boss that she has done an analysis of her time and determined the two hours a week she spends getting coffee is not a good use of her time. In the wrong version, the secretary is "passive-aggressive" and says "I'd like you to look at this report which shows how you are mismanaging my time." In the good version, the secretary says "Do you have a moment? I know you are quite busy. I want to start off by saying that I want to be the most efficient secretary that you've ever had, and make this the most efficient unit this company has ever had. Therefore, I have prepared this analysis of the use of my time which I thought you could look at." Of course, the boss looks at it and immediately declares "oh my! I can't have you spend all this time getting coffee, I'll get it myself." Rick and Rick point out that in the good version the secretary spoke her intent. One has to wonder if her intent was to be the best secretary ever, or merely not to deliver coffee. One also has to wonder if this scenario is disingenuous—the most plausible outcome is that the boss, deciding his own time is most valuable, continues to ask his secretary to get his coffee or passes the time-consuming task on to someone less well paid and with less bargaining leverage than his secretary.

strategies that did not necessarily demand a full investment of self or belief in the work one is doing. "Keep it light" was a mantra that suggested the most effective way to pass through daily interactions is with a detached lack of investment, a persona of the trouble-free. All of these are forms of *distancing* oneself from the organization and one's occupational role as a mode of coping with the difficulties of work. As long as discontent did not cause ruptures in the veneer of good relations, trainers expressed in these moments very little concern for whether workers were able to construct, out of the fabric of their work, a true identity, a sense of self, and an internalized self-management.

♦

A mix of superficiality and depth of expectations vis-à-vis the self characterizes much of the training I have observed. What accounts for these discrepant expectations of health care workers in soft skills training? Clearly evident in this training is a tension over whether workers are expected to identify with their work and/or their employing organization. This is probably both cause and consequence of the ambiguity in approaches to control evident in the training. One approach to control—what has been called a normative approach (Etzioni 1975)—is evident when workers are motivated to work effectively because of the positive values, norms and ideas they associate with their work and organization. Perhaps because health care workers provide care, trainers and educators assume that they can tap into the workers sense of self and identity, that they can expect a deep commitment to the work. This is what makes it possible for a trainer/manager to even imagine that she can, in a one-day retreat, provoke workers to get in touch with their real feelings about their work and themselves.

Existing theories of control in organizations suggest that normative control induces positive, stable, and authentic forms of investment in and identification with work (Etzioni 1975). Because the material of the health care industry is providing care—a kind of work that is presumed to be inherently meaningful and rewarding—health care organizations might naturally tend toward normative control. Barley and Kunda (1992) have suggested that there are surges in types of control, and that normative control also tends to be operative in conditions of economic contraction, when profitability is most dependent on the productivity of labor (rather than capital). Since health care has always been a labor-intensive industry (and the work revolves around providing care), we might infer that normative control has always been the paramount approach in this particular industry. Similarly, in so far as the American economy has become more dependent on service-based industries, one might expect normative control to remain the more prevalent managerial ideology while it also continues to splinter into new forms.

But quite unlike the imperatives of normative control, another tactic used in the training and education is to cultivate a kind of individualistic and polite façade, a distance from the conditions of work that circumvents conflict. The worker is, in this model, a communicator who can convey a message without investing it with meaning and without caring about the connection between the messages he or she transmits and the feeling he or she has about them. This portion of the training attempted to modulate communication, not feelings and beliefs. That is, workers were expected merely to *appear as if* they were conforming to a normative compliance structure.

Gideon Kunda (1992) has shown that situations of normative control do not in practice produce the authentic experiences of loyalty that are expected. In fact,

individuals experience simultaneous attachment and detachment, embracing and distancing from the expectations of their employing organization. The organizational self is a "balancing act" in which equilibrium is fleeting (see especially chapter 5). This is many ways what health workers—given the twin messages of keeping it light and personalizing it—experience. But the difference in this case is that normative control as a demand does not really exist in the first place, in the cases I have observed. The training, which presumably communicates managerial expectations, does not conform to the dictates of normative control the very moment it suggests workers can get by with superficial niceties. The kind of training I have observed demands a performance, an effort of some sort, but it is not consistent with the theory of normative control.

Lack of consistency in approach may be a result of the fact that expectations are less defined or rigorously applied to workers of lower status (such as nursing assistants). Some studies of the organizational culture and management ideology have suggested that lower-status workers are expected only to behave appropriately at work, while higher-status workers are also expected to make an investment of thoughts and feelings (Kunda 1992, pg. 214). Similarly, studies of stratification in the education system suggest that for those in the lowest level of the occupational hierarchy education centers on discipline and rule following, while for those at the higher levels education focuses on the internalization of norms and motivational control (Bowles and Gintis 1976). The examples I have described, though addressed to lower status health care workers, do not easily conform to either suggestion. The training in communication skills does not solely revolve around discipline or internalization: it combines them both.

In certain respects, it is a mistake to read too much into the courses I have observed: they were hurriedly produced by a network of union education staff, hospital administrators, and consultants of various stripes who needed to quickly spend millions of dollars. Though this may also make the courses even more significant: as such sudden and slap-dash efforts, course planners may not have had the time to layer over the conflicts and contradictions of work and ideology in health care, therefore exposing them in crystallized form. These conditions also show, in exaggerated form, how education can be produced and marketed without considered regard for whether the education produces skilled or efficient workers or whether it solves problems of the labor process.

At every turn in the training courses, the suggestions offered by the trainers for how to behave at work proved inadequate. Though the games we played in our daylong retreat were meant to encourage spontaneity, teamwork, and self-reflection, they produced a good deal of tension and anxiety among participants (particularly a competitive team exercise which involved building a Lego helicopter). The only truly collective moments of the day were the laughter when the messages of the training were undermined. In one instance, a trainer asked participants to find out something new about the woman sitting next to her, some "dark secret." When we went around the room to share what we had learned, one nursing aide said about her neighbor "I learned that her dark secret is she has 8 children by 8 different fathers." This was met by peals of laughter – "oooh, they'll be talking now," said one woman. This send-up of gossip, this commentary, which criticized racial stereotypes through humor, was the lightest it got, and yet it also implied that co-workers getting to know one another may not conform to managerial desires.

This kind of training should be taken seriously if its characteristics prove persistent over time: the discrepant expectations of workers apparent in the curriculum; its *ad hoc* and just-in-time form; the real ambivalence about the nature and requirements of care-giving work. Indeed, based on the content of soft skills training, it is hard to draw a firm distinction between the work of a nursing assistant and that of a fast-food clerk. In general, I have found that the training education industry is rather indifferent to distinctions between a committed worker and a worker merely playing along; or caregiving and technical work or care and politeness—not to mention an indifference to the distinction between training and education.

These indifferences may, in the end, be productive for the training and education industry itself—which is able to continually reinvent itself because it never solves any problems. It also points to the cultural power granted to any kind of "learning," such that training or education is valued just because it happens. This kind of educational industry also fits nicely with an inconsistent managerial style. Education can always find a market niche in the continual modulation of demands, needs, and desires on the part of both management and workers. These eternal modulations – the process of responding to and encountering continual shifts and demands – is affective labor. And I think the training and education industry sustains and capitalizes on affective labor, making the inconsistencies of expectations one of its major products.

Given the indifferences I have described, what should be made of the tantalizing thesis that for contemporary capitalist production to succeed and grow it must focus investment in developing subjectivity? That the "personality market" has become of major importance in the economy? This thesis has appeared in new forms more recently,

as when it is argued the "raw material" of immaterial labor is subjectivity or "the worker's personality and subjectivity have to be made susceptible to organization and command" and work now involves the "investment of subjectivity" (Lazzarato 1996, pg. 134).

The lack of consistent messages in this training and the haphazardness with which the training is organized and implemented suggests, in the first place, a relative indifference to how individual workers respond to the training or to how they assimilate the messages of the training into their sense of self. This is most obvious in respect to emotion. It would seem that a hospital manager would be deeply concerned if staff are displaying their investment via anger or sympathy, for instance. But my experience in some of the training, particularly when it became tense and animated (like when we played pictionary) was that the goal was animation and investment of any kind. In so far as training and education industry is a medium of affective production and exchange, then any kind of engagement or investment is rewarded and desired. The attempt to commodify and control affect is indifferent to particular emotions and therefore to subjectivity. This makes the exchange and control of affect simultaneously more fundamental and more superficial than that of emotions. It is more fundamental because it taps into the undertow of energy in social life, but it is more superficial because it isn't directly concerned with how specific individuals end up molding or understanding their affective investment in the ongoing construction of self.

In the kind of training I have observed, the effective completion of work—the organization of the labor process—is left to the workers. They may be provided with an affective "toolkit" for modulating communication and relationships on the shop floor, but

particular situational choices are not specified. In such a labor process there is no Taylorist control in which conception is carefully divided from execution. It is incumbent upon employees to generate productivity (in and outside of the workplace). This potentially explains the lack of attention to the conditions of health care work; attempts to organize the labor process have been, in the design of this training, given up in favor of open-ended tactics of control and modulation. This has been argued in the case of the communication skills training in particular (Ducey, Gautney, and Wetzel 2003).

Affect refers to a dimension of experience which is accessed in cases where emotional labor is subject to more formal managerial attention and standardization—as has been described in the airline industry (Hochschild 1983) and Disneyland (Van Maanen and Kunda 1989)—and to cases where emotional labor is left to relatively chaotic and individualistic practices, such as the health care settings I have observed. In each type of case, training and workplace control are concerned with the same ends: motivated, engaged workers. The first seeks to achieve this end by taking decisions about emotional labor out of the hands of the individuals who perform it, without regard for whether they find the methods amenable to their self-identity; the second seeks the same end by leaving individuals to their own devices, using whatever self-identity works best for them. This does not mean that emotions are not manifest or experienced—they certainly are, and individuals have "real feelings" surrounding this work and training. But both ways of addressing emotional labor are in fact indifferent to the quality of those feelings. In the training I have observed, contradictions and inconsistencies in meaning that appear at a self-reflexive level (cognition, emotions) are expected and unavoidable. It

may be that these contradictions actually feed back into further engagement, becoming the raw material in the next cycle of affective modulation/production.

For C. Wright Mills personality was an element of the packaging of the product—an element which facilitates exchange but is not itself an exchangeable good. So for instance the smile of a McDonald's clerk makes a customer feel like returning to McDonald's, enabling the sale of more hamburgers. Changes in political economy suggest personality and affect have become valuable in themselves—what marketers refer to as "branding," or the "experience economy." The affective association with a product or brand is sought not just because it encourages the sale of the product, but because it triggers a host of secondary interactions as transactions which are the basis not just of consumption and exchange but of meaning-making as a whole. The smile of the McDonald's clerk makes that encounter not just about the sale of food, but also an experience with the concept of McDonald's, which will have valuable consequences in a multitude of less immediate and less obvious ways.

Marketers and advertising executives have made affect an explicit part of their strategy. For one executive, his trademarked approach to advertising "focuses on the most compelling aspect of the human character; the desire to transcend material satisfaction, and experience emotional fulfillment. A brand is uniquely situated to achieve this because it can tap into the aspirational drives which underlie human motivation" (Gobe 2001, pg. xv). He dubs this approach "emotional branding," but when he refers to "aspirational drives which underlie human motivation" he is, in my opinion, referring to affect, which conditions and underwrites specific emotions.

Michael Hardt has written, "the new social regime seeks to control the citizen as a whatever identity, or rather an infinitely flexible placeholder for identity" (Hardt 1998, pg. 36). There is control in the sense I have so far been using it—that of organizational sociology, which assesses the characteristics of specific organizations as variables and typologies. Then there is control in the sense that Hardt uses it, its Foucauldian sense: a social regime; a pattern of power relations which runs through all social institutions; an energy source that institutions can use but which also creates those institutions as such. Brian Massumi calls affect an "apparatus of power"; a control mechanism that is "an impersonal *flow* before it is subjective content" (1998, pg. 61). Jonathan Beller writes that "from here on the development of capital will be unthinkable without the simultaneous development of technologies for the modulation of affect and the capturing of attention" (1998). Antonio Negri, drawing on Spinoza (see Negri 1991), calls affect simply the "power to act" (1999).

Affect is a different ontological register than subjectivity, emotions, and ideology as they are usually formulated. These latter concepts are consistent with a register of identity and refer to a process which converts experience into meaning and explanandum (not unlike what I am doing now). The level at which much of the training and education industry operates bypasses or short-circuits the conversion into meaning and identity, such that the sheer physical force of its happening and the patterns of engagement which it conditions make it valued and valuable. There is still important action at the level of meaning and ideology, so it is accurate to say that "*even when appealing to the human subject*, these technologies [of control] aim to affect the subject's sub-individual bodily

capacities, that is, capacities to be moved, to shift focus, to attend, to take interest, to slow down, to speed up and to mutate" (Clough forthcoming).

CHAPTER 8: AFFECT AND INEQUALITY

A major criticism of education and training is that it has been reduced to a holding pen for the labor market. All pretense to idealism has been beaten out of it. "Culture and education are increasingly judged primarily by their practical usefulness in situations of daily work and life" (Jansen and Wildemeersch 1998). Education has been reduced to its technical and practical components; it has become "vocationalized" and conforms to narrow technocratic imperatives (Kincheloe 1999). Paul Willis wrote recently, "the socially reproductive function of schooling has shed its liberal clothes" and been nakedly exposed as the "attempt to regulate and prepare labor power for insertion into capitalist labor processes on employers' terms" (Willis 1999, pg. 139). (Many of the trainers and educators I have interviewed dearly wish for such transparent "employers' terms.") Willis admits that such an insertion meets resistance and has unintended consequences, but for him as for others, schooling is now nothing but the crude tool of employers and labor markets.

Schooling, however, has also been taken up in cultural markets, its consumption an act of symbolic expression as much as credential acquisition. Willis argues that "schooling may be becoming increasingly marginal to the actual formation of subjectivity, identity, and culture," while leisure, consumption, and cultural commodities have become increasingly important frames for identity and meaning-making. I, on the other hand, see a continuity between some of the training I have observed, particularly in soft skills, and cultural commodities as they are both arenas for the negotiation of self, identity, even community. But these arenas succeed and expand only in so far as they

cohere at an affective register, modulating the investment of emotional energy. Affect is a useful concept for situating changes in consumption and value because it reflects what I believe to be a real indifference to the identities played out on its surface, be it in schooling or the consumption of culture. The flattening and blurring of spaces like school and leisure is characteristic of an affective register.

This chapter, which is largely theoretical, takes up the implicit thread in this dissertation about whether the training and education industry for allied health care workers can be theoretically reduced to a political and economic function of a capitalist regime of control. Why launch a vast training industry if you are indifferent to those outcomes that have so often served as the measure of value and worth? Who benefits and who loses in this industry? As a continuation of my effort to make affect visible to sociology, in this chapter I explore the articulations of affect and mainstream economic sociology—an exploration which is helpful to demystify the "economy" and the apparent logic of capital: to commodify and subsume ever more aspects of life. I take my cue from Stanley Aronowitz, who has suggested that "the logic of subsumption is no more than a *tendency*" (1991, pg. 82). This exploration shows that both conventional economic sociology and certain influential strands of contemporary Marxist political economy are poorly equipped to assimilate and respond to new forms of inequality molded in an affective register.

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The experience of Veronica is a wedge into how the affective articulates with capital and value. Her experience shows that there is marked indeterminacy in how affect

is channeled into value and for whom. Some educational leaders I have interviewed suggest that one of the ideal benefits of their programs is that they channel the desire to be engaged and sustain workers in their jobs—such benefits would become measurable as (among other things) job satisfaction and lower turnover rates. I asked Veronica during our interview several times whether "going to school has had any affect on how you feel or behave at work?" Firmly, and without hesitation, she said "no" each time. Veronica said that she keeps work and school separate; only one or two people at her place of employment even know that she is trying to get a nursing degree. Veronica was concerned that if others at work learned she was in school, particularly supervisors and nurses, it would confirm their impression of her as someone who does not respect authority or understand her place—so to speak.

Then, near the end of the interview, Veronica mentioned that she talks about the books she is reading in her classes with patients at her hospital (a private, non-profit on the tony upper east side of Manhattan). Going over to a bookshelf, she pulled out a folder of hand-written notes from patients. One note included Howard Zinn's *People's History of the United States* and Noam Chomsky's *Understanding Power.Com.* Another note, written by a patient who had been a teacher, was three full pages of books. Veronica had read some of these books and referred to the lists when she was choosing what to read next. Employers who provide and fund training are banking on the fact that employees who are going to school make better workers—they bring what they are learning to the workplace, they are more engaged when they can see a future. Although Veronica told me she didn't see any connection between her work as a nursing assistant and the content of her college courses, the patients with whom she discussed books probably experienced

a connection and her hospital benefited indirectly from what was undoubtedly a pleasurable interaction for both Veronica and her patients.[32]

What is produced and traded in this kind of educational arrangement is not just technical skills per se, or knowledge, but affect. Although affect is not a product that the hospital can easily calculate or include in its measures of productivity, it is of certain value since it sustained Veronica at work in a way the explicit tasks of her job did not. And of course education was not without material value to Veronica, who may in the long term may acquire a college degree. But in the immediate course of her daily life, she used her attendance in college to create interactions based on respect and sharing (what might be called solidarity), in contrast to the disrespect she usually encountered. In Veronica's case, this does not mean she then identified more closely with the hospital or was more satisfied in her job, but it does mean her education had overtones in her job that were in a sense valuable—perhaps not capturable and measurable, but productive. The potential and importance of an economy of affect is considerable in an education industry where the ends—a better job, more pay—are delayed by many years (and even then are not guaranteed). As Antonio Negri puts it, "*value* is now an *investment of desire*" (Negri 1999, pg. 87).

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[32] In neoclassical economics this would be an example of the "free rider" problem: a situation in which goods and services provide such widespread benefits that people who have not paid for them benefit from them. As England and Folbre note, "anyone who treats another person in a kind and helpful way creates a small benefit that is likely to be passed along. The beneficiaries of caring labor, who extend beyond the actual recipients of the care, are thus free riders on the labor of those who do caring labor" (England and Folbre 1999, pg. 45). In this case, the hospital has paid for the service (in wages to Veronica) but it is also a free-rider, gaining additional benefit from aspects of the work for which it does not compensate because it cannot calculate its worth. Rather than attempt to control these escaped benefits, however, what is of interest here is how the phenomena of free-riders is not so much a problem as a necessity.

A pivotal, and oddly overlooked, jumping off point for understanding what I have called affect in sociological terms and for beginning to theorize its relationship to economy and value, is Randall Collins' theory of interaction ritual chains and emotional energy. He argues that "actual every-day life microbehavior does not follow rationalist models of cognition and decision making" (Collins 1981, pg. 985). Specifically, most of everyday life is based on noncognitive (and often nonconscious) processes that determine how and when an individual engages in interaction. Collins draws upon Goffman's studies of interaction rituals in every day life to suggest that "any conversation may be looked upon as a ritual...It signifies membership in a common group for those who truly respect it" (pg. 998). Social life, therefore, is made up of a series of conversations—what Collins dubs *interaction ritual chains*—which aggregate into larger social entities such as state, economy, culture, and class.[33] Interaction ritual chains form the "*mechanism* by which conditions—certain arrangements of microsituations—motivate human actors to behave in certain ways" (pg. 990). Specifically, actors seek to participate in interaction rituals that will enhance their emotional energy and solidarity.

Collins defines emotional energy and cultural resources as the two major ingredients which effect whether or not a conversation/interaction ritual in fact successfully (re)produces solidarity for those involved. Cultural resources (a concept related to that of cultural capital) and emotional energy derive in turn from chains of previous interactional experience. Investment of emotional energy is necessary to sustain a common "mood" or "tone" in interactions. Furthermore, a stronger emotional tone can

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[33] For a critique of how Collins' notion of "aggregation" is inconsistent with the ethnomethodological theory that Collins claims to absorb into his analysis, see Hilbert (1990).

yield greater emotional payoff in two forms: greater group solidarity and a greater emotional charge (Collins 1993, pg. 211). Therefore, "the interaction also serves as a *machine* for intensifying emotion and for generating new emotional tones and solidarities" (Collins 1981, pg. 1001). When Collins offers testable hypotheses of his model, emotional energy is therefore typically presented as a dependent variable, an outcome of specific types of interaction rituals (Collins 1990, pg. 50). On the whole, though, emotional energy is both a condition for and product of interaction rituals, and everyday experience is composed of an ongoing series of such rituals.

Collins suggests people are drawn toward situations with strong emotional energy often without conscious volition, though people may feel retroactively that they exerted choice in the matter. Thus he says that emotional energies are "transmitted by contagion" (1981, pg. 994). This dynamic illuminates the experience of Wanda (see Chapter 6), who did not "choose" the ways in which she engaged with education but was nonetheless energized by these relatively intense experiences of learning and swept into a current of investment in learning. This point is important too, because though Collins' analysis often shades into a discussion of emotions, *emotional energy* is in fact a register of experience which is precognitive, largely physical, and transpersonal. Collins' displacement of individual agency and volition is resonant with my view of the training and education industry as a drift, rather than a collection of choices, toward forms of engagement which do not make sense by traditional methods of assessment. Such drift carries along the willingness to engage in education and training despite "rational" evidence that much training and education is, in terms of time and money, a waste.

The displacement of agency from individual subjects also allows the possibility of viewing other assemblages of bodies—in my case an assemblage called the "training and education industry"—as actors. As I have argued throughout, the basis for this multimillion-dollar industry to train health care workers is not the "needs" of employers, workers, or even structures such as labor markets, which are aggregate individuals in many explanatory models. The industry's excessiveness is evidence of its extra-individual force.

The idea of emotional energy passed through contagion elicits an ontology of the vibrations between bodies, not an epistemology of communication between subjects.[34] This ontology is, I believe, an accurate portrayal of many encounters with the training and education industry which I have documented. It is also the condition of the proliferation of cultural and immaterial commodities, which are means for the expression of emotional energy. Collins writes "parallel to the introduction of new communication technology and generalized-culture-producing specialists, one can think of the historical introduction of new emotion-producing 'technologies' including shifts in the number of emotion-producing specialists" (1981, pg. 1009). Indeed, many of the trainers and educators I interviewed seemed to be, primarily, emotion-producing specialists, generating emotional energy and passing along vibrations.

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[34] Such an ontology has affinities with Spinoza, and Collins' openness to conceptualizing emotional energy in this way may be a residue of his encounter with Goffman. Two quite different traditions of social philosophy are combined in Goffman—one stemming from Durkheim and the other is latently Spinozist. This is especially clear in Goffman's writing on interaction rituals (which Collins has of course read closely), where he talks about the self. Goffman writes that he has "implicitly been using a double definition of self: the self as an image pieced together from the expressive implications of the full flow of events in an undertaking; and the self as a kind of player in a ritual game who copes honorably or dishonorably, diplomatically or undiplomatically, with the judgmental contingencies of the situation" (Goffman 1967). I think the Collins' concept of emotional energy is consistent with Goffman's first definition of the self, which rings of Spinoza more than Durkheim.

Collins also theorizes how emotional energy and interaction ritual chains are related to markets for the exchange of material goods, which opens up the larger discussion of what exactly an "affect economy" might be. Collins argues that each interactional encounter is a marketplace in which the chances of achieving solidarity are negotiated (most frequently at noncognitive and/or nonconscious level). Emotions are therefore the basis for all interactions, and in aggregate the result is "a series of cultural and emotional 'prices' at which individuals can negotiate interaction rituals of different degrees of solidarity and domination with one another" (1006). This theory is an extension (with notable modifications) of rational choice theory—Collins applies the metaphors of neoclassical economics to interaction rituals.

Collins does not, however, only subject noneconomic behavior to economic metaphors; he has a stronger argument. The "market" for interaction rituals is continuous with the market for material goods and services in so far as the interaction ritual market is the "ultimate determinant of valuation of goods in both markets" (Collins 1993, pg. 214). Collins does not contend that individuals will necessarily value social solidarity and emotional energy more highly than material goods, only that "emotional energy is the common denominator facilitating choice" between goods in both markets. What markets for material good and immaterial interactions have in common is that choices of what goods or interactions to produce and consume can always be made at least in part on the basis of the emotional energy or group solidarity that may result. For Collins, interaction ritual markets have *primacy* over those of material goods because human beings develop material goods and services to make possible more extensive and elaborate interaction rituals; the reverse however, is not the case—human beings do not pursue interaction

rituals in order to expand material production or wealth. (Work, or labor to produce material goods, is of course social, so these settings are also occasions for interaction rituals and the deployment of emotional energy.) Interaction ritual theory is "an empirically determinative mechanism for the flow of motivation to work and to invest, from the realm of social interactions into the realm of economic quantities" (Collins 1993, pg. 217). Ultimately markets for interaction rituals are *economically* valuable only indirectly, when their production compels participation in material markets. Although Collins applies a model of exchange to his analysis of interaction rituals, *he does not mean that interaction rituals are themselves commodified*, where emotional energy is literally bought and sold.

The dominant form of economic sociology has been premised on applying (neoclassical) economic metaphors and models to noneconomic relations and transactions (the "noneconomic" includes things like emotions, culture, and politics). It is exemplified by the rational choice theory of James Coleman, and Collins' theory of emotional energy is indebted to this perspective in so far as he applies market terms and models to interaction rituals and emotional energy. Talcott Parsons, a founder of economic sociology, saw this as "economic imperialism" because he felt economic models were abstractions of aspects of social life and not models of an empirical—even if hypothetical—world (1991 [1934], pg. 172). Therefore its tenets could never be applied as a complete explanatory framework to the whole of social life. Viviana Zelizer calls this view a type of "Nothing-But" argument, which in this case reduces all relations to examples of "individual choice under conditions of constraint" (2002b, pg. 277). This

approach has had tremendous appeal, as is evidenced by the influence of the work of Coleman and Gary Becker (an economist).

When Collins argues that interaction rituals and the desire for greater solidarity and emotional energy are the basis for material and economic exchange, he is making another type of argument. In economic sociology, this is the argument that the noneconomic (culture, values, politics, emotions, beliefs) influences the economic and/or "rational" decision-making. This includes a wide variety of arguments about the specific articulation of the economic and noneconomic, not least Granovetter's (1985) formulation that economic action is embedded in social relations. In this category I am including what Zelizer has called explanatory strategies of *context* and *alternatives*. In the former strategy, the noneconomic (culture, in her argument) is understood as the *context* for individual decision within constraint. In the latter type, cultural, structural and relational analyses are employed to construct *alternative* models of behavior to that of rational choice (Zelizer 2002a, pgs. 104-9). Economists have also begun to address the influence of emotions and noncognitive processes on economic decisions and outcomes (Bowles and Gintis 2002; Elster 1998).[35]

But there is another approach that Collins explicitly rules out, as does conventional economic sociology: the noneconomic *is* economic; it is or becomes commodified and subsumed by capital. This is the perspective of *political* economy, and it posits underlying trends and tendencies of economic regimes. The study of emotional labor and caregiving work has produced many examples of this kind of analysis—

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[35] In fact, it is the recognition of noneconomic influences on economic transactions which explains why the corporate world frequently relies on forms of workplace control—such as normative forms—which target employees' attitudes, emotions, and motivation.

essentially commodification theories (e.g., Glazer 1993; Hochschild 1983). I am sympathetic to this theory. Chapter 3 of this dissertation, in which I discussed how education and health care were increasingly understood in commodified terms, lends support to the idea that services seemingly antithetical to markets now function according to the dictates and needs of private industry and profit-making. The limitless reach of commodification seems to be confirmed when economists start plugging emotions and culture into cost-benefit equations (see Elster 1998 for a discussion of this trend).

But this approach has a major limitation when it comes to theorizing an affect economy and understanding the power of the training and education industry I have studied: unlike economists who admit their models are partial abstractions, and unlike economic sociologists who are forced to critique economic models as they stretch them ever more thin, commodification theory takes the "economy" and the process of commodification for granted. Value is not a problematic concept—the agenda of commodification theory is to identify when and how aspects of social life are taken up in capitalist economic exchange, but the rules and principles of capitalism are typically given.

Randall Collins is again instructive on this issue. He retains from the rational action model of behavior the core idea that "social action is explainable in terms of individuals attempting to optimize their expected benefits relative to costs of their actions" (Collins 1993, pg. 203), but many of aspects of his theory are formulated as corrections to neoclassical economics or utilitarian-based exchange theory. For instance, he suggests that an individual's position in the "interpersonal market" depends upon the emotional and cultural resources acquired in previous interactions (path-dependent

consumption); since an individual's market position affects their motivation not through rational calculation, but through emotional energy, decisions are readily made in the absence of perfect information or methods for comparing one's options; each encounter is also shaped by the previous interaction ritual chain of each of its participants (i.e., preferences are not exogenously determined); since an individual's emotional payoffs can only be proportionate to their emotional investment, there can be no free-riders. Collins opens up a critique of conventional economic thinking (as John Kenneth Galbraith called it).

The implications of Collins' approach are central to the conceptualization of an affect economy and the position of training and education for allied health care workers within that economy. One is that rather than merely argue that that market transactions are additionally informed by non-market relations, he subjects the ideal of market transactions to scrutiny. But the idea that all relations are transactions exposes the immanence of calculation in sociality, while the conclusion that such transactions are not necessarily commodified also exposes the contingency associated with generating economic value. Collins' definition "calculation" is like his definition of the "decision" to engage in interactions: it is process that cannot be qualified as rational or irrational and that does not appear in observable or conscious steps. Though this is an interpretive extension of Collins, I believe that he models a theoretical space in which the logic of the market/capitalism can be questioned and for speculating on the economic force of emotional energy/affect.

As I pointed out in Chapter 2, one of the ways in which this training and education industry participates in the economy is that it has become a "jobs program for

trainers," an economic engine for the city's various educational institutions. Education also, like the culture industries, creates products (though they are not "durable goods") such as information, knowledge, values, desires—and these are the frontiers of capital's expansion and economic growth. I would add to this list affect—though affect entails a particular disruption of value as profit or capital.

In the shifting terrain of value and production, one can hardly speak of "commodification" as a distinct process—one might say that the relationship of affect to economy is that of perpetual attempts at capture. Michel Callon (1998a; 1998b) has argued that marketization is the continual reenactment of framing, the process of identifying overflows (i.e., externalities) and reframing them as integral to certain transactions and not others. "Once identified and acknowledged, overflowing, if it is to be framed...has to be measured...this measuring involves the establishment of a metrology" (1998a, pg. 21). Education and training that attempts to frame and measure affect is therefore contributing to the marketization of this domain of social relations, subsuming affect into the fold of accounting and evaluation. This occurs when, for example, it is hoped that the engagement triggered by enrolling in education will reduce turnover.

Although Callon seems to be describing the oft-documented process of commodifying ever new realms of sociality, in fact he wishes to undermine arguments which suppose the market can take over everything (and that an effective political response is therefore to be against commodification). For Callon "the economy is not a universe whose expansion is contained by other universes" (38). He bristles at the notion there can be uncommodified cultures or societies in which "agents do not calculate." Callon marshals the evidence of anthropology to suggest there is a great diversity of

markets and that reality can be simultaneously organized by "incommensurable and antagonistic logics" (38). Callon says "speeches" on the inexorable growth of the marketplace "have no foundation in fact. If only because of the role played by the technosciences in what we are pleased to call advanced societies...the market must be constantly reformed and built up from scratch: it never ceases to emerge and re-emerge in the course of long and stormy negotiations in which the social sciences have no choice but to participate" (1998b, pg. 266).[36]

Such a view could be consistent with economic sociologists who identify a "diversity of markets" which have been largely ignored in the process of theory-building by economists (and economic sociology) (Lie 1997). An affect economy, therefore, could be considered one type of market, with its own rules, institutions, norms, and measures. Relations and transactions based on affect could one set of what Zelizer calls "differentiated ties," which "compound into distinctive circuits, each incorporating somewhat different understandings, practices, information, obligations, rights, symbols, idioms, and media of exchange" (2002b, pg. 277). This is a view which privileges

[36] Some critics take issue with the fact that Callon "understands measurement and calculation generally to have anti-political effects" (see Barry 2002; Barry and Slater 2002, pg. 185)—that is "framing" certain relations as market relations de-politicizes them and defuses controversy, a perspective that once again reifies the market as something beyond or outside culture (Miller 2002). Though this is true, Callon (Callon 1998b) also argues that contemporary society is increasingly dominated by "hot" situations, where the identification of overflows and determination of how to measure them are increasingly controversial. As an example, he discusses mad cow disease. He attributes this change to the "movements of the technosciences, which are causing connections and interdependencies to proliferate" (pg. 261). This is where a connection to Negri enters: "In this 'hot' world, which is becoming increasingly difficult to cool down, the work of economists is becoming ever more arduous because the actors they are tracking are faced by non-calculable decisions" (pg. 263). Could this be the nature of the decision to pursue education and training? For Callon, this means the anthropology of science and technology (AST) is "in a position to keep track of controversies" and "provide the actors with a cartographical outline of overflows in progress" (pg. 263)—which also makes AST—as well as the social sciences more broadly and this dissertation more specifically—an actor, a performer of the economy.

historical and structural specificity over seemingly transhistorical and transcultural laws like subsumption.

I am suggesting then, that the training and education industry for allied health care workers is what Collins calls a "machine" or a "technology" and what Callon calls a "technoscience" for building up a market for affect. One of the logics according to which the training and education industry is organized is that of skills and knowledge, while another of the logics is that of motivation, engagement, and affect. Furthermore, affect is not a new territory which capital simply conquers, rather the possibility of measurement and the practices of accounting are upset and reconfigured in the attempt to capture affect.

For Marxists informed by Italy's *autonomia* movement there is a characteristic of affect which makes it impossible to be entirely subsumed: its necessarily social character. Lazzarato, quoted earlier, writes that "immaterial labor produces first and foremost a 'social relationship' (a relationship of innovation, production, and consumption). Only if it succeeds in this production does its activity have economic value" (1996, pg. 138). In immaterial labor—which produces cultural, symbolic and informational commodities and which includes affective labor—the possibility of production is ultimately in the hands of laborers, not capital or capitalists. "Immaterial labor immediately involves social interaction and cooperation. In other words, the cooperative aspect of immaterial labor is not imposed or organized from the outside, as it was in previous forms of labor, but rather, *cooperation is completely immanent to the laboring activity itself*" (Hardt and Negri 2000). Hardt and Negri concur that immaterial laborers are in fact less dependent upon capitalists to provide the means of production, thereby potentially freeing this class

of workers from a fundamental constraint on their autonomy and providing new grounds for political activism.

I showed in the previous chapter that training and education in soft skills for health care workers is in important respects indifferent to the identity of workers. Lazzarato has proclaimed that the terrain of immaterial production is subjectivity, but I contend that in so far as training is directed toward affect, it does not need to address or control subjectivity per se. Now, in so far as the training shifts the responsibility for the accomplishment of work onto the workers—also a result of indifference—then it is possible to say that this labor process is social, that innovations in the labor process are directed by the workers themselves and that this is ultimately where economic value inheres. This seems true of Veronica and her patients; on paper, hospitals like the one where she works are struggling economically, their reimbursements are too low and their personnel and capital costs too high—one of its only sources of new or expanded value may be in interactions that are caring and respectful. The education and training industry I have studied attempts to channel this value by stimulating engagement, emotional energy, affect.

But ultimately this theory of immaterial labor, like conventional economic sociology, does not grasp the extent to which inequality is the condition of labor and markets. "What affective labor produces are social networks, forms of community, biopower" (Hardt and Negri 2000, pg. 293). While this description is evocative, it is not very precise. For one thing, it betrays a certain romanticization of "affective." Hardt and Negri say that affective labor can be understood by "beginning" with the idea of caring labor and this supports their general argument that affective labor creates community. For

them, affective labor is or can be the basis for new forms of cooperation and community and solidarity. This folding of caring labor into their concept of affective labor is problematic because as I have shown in this dissertation, caring labor is a complex activity which cannot be reduced to the simple positive connotation given to it by Hardt and Negri. Hardt and Negri rely on the idea of caring and affect as a potential positive force without recognizing the extent to which caring and affect have been the sites for control and oppression.

Negri has elsewhere argued that a product and residue of capitalist development is the "accumulation of potentialities" that capital has been unable to exploit (1989, pg. 89). Indeed, the pattern of lifelong learning that I have described in the lives of these health care workers could be an example of one such potentiality. Capital's failure to fully exploit the potentials unleashed in education can be seen in the case of Veronica, whose new found engagement creates a kind of value that can't be entirely captured or measured. It can also be seen in the many interview respondents who felt as if their talents were *under*utilized by school and work, that neither took advantage of their abilities and they were therefore bored and exhausted. In their case, schooling was one of the few, if not the only, socially legitimized path to engagement and respect.

The fact that the soft skills training I have observed is indifferent to the particular emotional or subjective reactions to the training, and the fact that the training and education industry as a whole is relatively indifferent to the outcomes of the training traditionally defined (degrees, certificates, wage increases), is troubling. It would be overly optimistic to see this training and education industry primarily as evidence of these workers' growing freedom and autonomy. Like any economy, the affect economy

results in its own forms of inequality, in which wealth and resources are unequally distributed. In this dissertation, I have attempted to describe how the training and education industry intervenes at the level of affect, attempting to channel and capture it. The risk of theorizing affect without paying attention to this capture process is that the sources of affective inequality cannot be explained—and the specific ways in which that inequality can be remedied remain unknown.

Though Randall Collins identifies affect (emotional energy) as an important force in immaterial and material production, he answers the question of how affect and affective labor is differentially molded and captured with apolitical and circular reasoning. Jonathan Turner (1987) encapsulates the implicit nature of motivation in Collins' theory as the need for group solidarity. Collins does indeed say that group solidarity is the desired end of interaction rituals while emotional energy makes possible, or is the mechanism of, solidarity. On the other hand, in some of Collins' writing on the topic, emotional energy appears as an end in itself which motivates action. He stresses the quantitative aspect of emotional energy, by suggesting that a higher level of emotional energy (or cultural resources) may allow a person to obtain conversational dominance and/or shift up in ritual position. Therefore, "the sheer amount of emotional energy is the common denominator" in deciding the "attractiveness" of interactions, including those revolving around obtaining material goods (1005). This could imply that actors might seek out high levels of emotional energy even if that means undermining group solidarity—that is, it is possible, in theory that emotional energy is translated into many different kinds of emotions. One can imagine interactions with high amounts of negative emotions, which do not result in group solidarity.

In that case, emotional energy could be understood to animate all human interaction without distinction between good and bad kinds of emotional energy. Collins tends in this direction when he is explicit that emotional energy is something other than or prior to specific, qualitative emotions, as when he defines it as a "readiness for action" (Collins 1990, pg. 39), or a long-term emotional tone which is the "baseline" (pg. 42) against which short-term outbursts—what we normally think of as emotions (fear, joy, enthusiasm, anger)—may be identified. Applied to the case of training and education for allied health care workers, participation in education is sustained by the emotional energy, by the engagement and readiness for action, that it generates.

But emotional energy without qualitative specification would hardly make it an adequate concept to *explain what holds society together*, which is Collins' ultimate goal. Collins pulls back from the idea of emotional energy as its own end by giving emotional energy a *qualitative* aspect as well as a quantitative one. He suggests, for example, that successful interactions produce not only high *levels* of emotional energy, but that if an individual is accepted into the group during an interaction ritual (the only kind of successful interaction ritual), the individual will acquire *positive* emotional energy "manifested as...confidence, warmth, and enthusiasm" (1981, pg. 1002). This implies different qualities of emotion energy. He suggests that an *accumulation* of emotional energy is akin to self-confidence and *low* emotional energy akin to depression. In the end, high levels of emotional energy are really one and the same as group solidarity.

Even though Collins is ambiguous about whether positive emotional energy takes the shape of specific emotions, equating high levels of emotional energy with qualities such as "confidence, warmth, and enthusiasm" short circuits the process of how

emotional energy is molded, appropriated, and differently valued. And because it equates high levels of emotional energy with benevolence it ultimately legitimates the status quo. To put it more clearly, Collins suggests in circular fashion throughout his work that high levels of emotional energy are associated with those of higher status and more power. "The more powerful the group within which one successfully negotiates ritual solidarity, the greater the emotional confidence one receives from it," he writes (1981, pg. 1002). "Successfully using high-status symbols in an encounter both generates local solidarity, and a feeling of high rank; whereas successfully generating solidarity in a low-ranking group generates less emotional energy" (1990, pg. 39). When discussing "power rituals" (1990, pgs. 35-7) he recognizes that such rituals are based on coercion but maintains that those who participate in such rituals experience a shared emotion, though it is "heavily mixed" on the part of those who are subordinate.

Brian Massumi, who writes explicitly about how emotional energy is molded, appropriated, and valued, calls confidence "the apotheosis of affective capture. Functionalized and nationalized, it feeds directly into prison construction and neocolonial adventure" (2002, pg. 42).[37] Massumi opens the political implications of Collins' normative insistence on giving emotional energy a qualitative identity—at high levels, that of confidence and solidarity. If the only or primary motive of human beings is group solidarity, then it is very difficult to conceive of the origins of violence and coercion. It is possible to explain inequality and violence once it has emerged because hostility toward outsiders is often the correlate or condition of solidarity. Therefore "evil is disbelief

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[37] Also, the gendered quality of equating high levels of emotional energy with "confidence" warrants greater attention.

in...the symbols...that hold the group together" (1981, pg. 999). But, the process by which certain people become outsiders is avoided. Statements like "property...is based upon a sense of what kinds of persons do and do not belong where" (pg. 997) may illuminate experience, but it is hardly an adequate explanation for the disenfranchised. Collins is clear that the consequences of interaction rituals may be different for those who have the "capacity to enforce the demands of their members on others," but the theory does not explain how the capacity to enforce came about.

Michael Hammond, who has also proposed a macro-theory in the sociology of emotions, works from the same assumptions. He writes that "as a species we are constructed to seek positive emotional arousal" and humans will "manipulate their worlds" to evoke a strong pattern of such arousal, an endeavor Hammond calls *affective maximization* (1990, pp. 59-60). According to Hammond's model, "this drives us to prefer experiences where such arousal can be had. It also leads us to erect certain social and idea structures, that is, if they provide us with positive arousal" (pg. 58). This will also drive us to seek out affective attachments, because such ties over time provide a stable source of positive arousal. Because of cognitive and time constraints, individuals devise a variety of differentiation strategies to assist in creating affective ties. According to Hammond, such differentiations are often mimicked and reinforced by social differentiations of class, race, gender, etcetera, which means social differentiations in turn are sustained by the drive for affective maximization.

While Hammond does not hold that *specific* social differentiations (which, I would add, are also *stratifications* representing different levels of power) are inherently functional, differentiation in general serves the purpose of delimiting the field of potential

affective ties and is hence functional (pp. 69-70, 72). His model does not mean that the current state of society in terms of differentiation has evolved because it provides the optimal positive affective arousal for the most people (note the embedded critique of neoclassical economics). Hammond clearly suggests at several points that some kinds of differentiation might lessen the chances for affective arousal for some people, and they will have to seek arousal elsewhere. Nonetheless, like Collins' theory, since differentiation is *inevitable,* the theory does not require the explanation of specific forms of differentiation and inequality.

I am concerned with how the education and training industry is an affective technology operating in the context of specific inequalities of race, class, and gender which profoundly impact the lives of the health care workers I have interviewed. The education and training industry is engaged in the politicized production of "capacities" in an affect economy. Therefore, I am ultimately ambivalent about the implications of the spread of soft skills training and a multimillion dollar investment in workers who, it is sure, have long been denied real chances to obtain an education. On the one hand, communication skills and customer skills training are praiseworthy attempts to make up for the failure of other institutions to teach "prosocial emotions." Indeed, lack of fluency in such emotions is gaining recognition as an important variable in the intergenerational transmission of poverty (Bowles and Gintis 2002). On the other hand, prosocial emotions such as a sense of self-efficacy, and certainly "confidence," do not necessarily serve positive social ends (though they may be essential for individual achievement in current social relations) and are themselves cultural norms created in stratified society. Prosocial emotions—that is, the correct attitude and demeanor—are not inherently right or good.

And of course, what such training is in principle is far different from what it is in practice—in my observation, it can be haphazard and superficial—though no less affective. I have documented in this study that training and education can be the basis for engagement and for interactions based on respect and sharing. The question that remains is whether the necessary condition for the drift toward affect in this training and education industry is the vanishing horizon of real wage growth and intergenerational mobility.

CHAPTER 9: THE PROMISE OF MOBILITY

1199, initially a union of pharmacists and retail drug store employees, organized its first voluntary hospital—Montefiore—in 1957. Under the charismatic leadership of a group of radical and primarily Jewish immigrants, 1199 was organized as an industrial union of the service sector, representing the interests of health care workers at a variety of skill and wage levels—including kitchen and laundry workers, maintenance and technical workers, nursing assistants and housekeepers, and in some hospitals, nurses and pharmacists. Though this created obstacles to solidarity and coherent bargaining positions, 1199 implemented several mechanisms to minimize such difficulties. It was (and remains) divided into separate divisions, mostly because of the desire of the professional groups to maintain a sense of professional identity and autonomy. A joint labor-management program called the 1199/League Education, Training, and Job Security Program (ETJSP), which includes the Training and Upgrading Fund, offers a variety of benefits like job training, placement services, and counseling to current and laid-off union members. The 1199 National Benefit Fund, a self-administered, self-insured, non-profit, Taft-Hartley welfare trust fund, provides health care, pension, disability, and life insurance benefits. The 1199 Health Care Employees Pension Fund alone has assets of over $5.8 billion and provides benefits to more than 30,000 retirees and their beneficiaries.

One could argue that it is the Training and Upgrading Fund which is the most important mechanism in sustaining an industrial model of unionization. This is because

all workers perceive the existence of opportunities to achieve occupational mobility within their union and they intuit that the union is not resistant to such mobility since, unlike craft unions, it will not destabilize the membership base. The union therefore is legitimized not just because of wage and benefit increases achieved in collective bargaining—which were extraordinary in 1199's formative years as hospital workers' wages were rapidly elevated above those of servitude—but because it contains the promise and possibility of occupational mobility. A 1970 *Health PAC* editorial captured the view of health care work which was the context for 1199's most dynamic organizing years: "the stagnant hierarchy, supported by elaborate credentialing requirements and arrogant professionalism, turns most hospital jobs into dead-end jobs: a porter or aide is stuck forever as a porter or aide" (Health/PAC Bulletin 1976, pg. 251).

DC 37, the city's largest municipal union whose members include public hospital workers, has adopted a similar emphasis on services for its members and job training and upgrading in particular. Though the DC 37 Training Fund has less autonomy and money than its 1199 counterpart, it too provides basic education and skills training to enable its members to qualify for open positions in the hospitals as well as further their education. The College of New Rochelle runs a branch for union members at DC 37 headquarters in lower Manhattan. "DC 37 is a leader in the transformation of many unions into a private welfare state" (Aronowitz 2000, pg. 96). As such, the goal of such training programs has been to compensate for the limitations of health care jobs and the organization of health care work thereby making those limitations more tolerable and more entrenched.

And beyond the labor process, a concern about 1199—which became apparent in the 1970 contract negotiations to former union-staffer Elinor Langer—is "1199 has never

questioned the hospitals' version of their economic situation" (1976, pg. 266). If the hospitals said they were in financial crisis, 1199 took them at their word and was consequently compelled to become the hospitals' chief lobbyist at state and federal government for increased funding and subsidies. Marie Gottschalk has argued that organized labor more broadly has long accepted some dubious claims about the political economy of health care, including that rising health care costs threaten the competitiveness of U.S. firms and the economy, limiting labor's ability to take a critical and independent stance on national health reform (Gottschalk 2000, ch. 6).

The charge that 1199 has proven incapable of or unwilling to address broad health care policy questions, many of which are crucial not only to the quality of patient care but also the quality of daily life for 1199 members, has shadowed the union since its beginnings (Ehrenreich 1976). This criticism is often entangled with the criticism of 1199 (and unions more generally) for not taking a political stand on many issues of concern to the left. This is, of course, a central thematic concern of the literature on labor unions. But 1199's early leaders were among the most radical in the trade union movement and 1199 was a leading organization in the civil rights' movement—the point being that this bore no necessary relationship to 1199's position on issues closer to home, as it were. Langer (1976) argued in 1971 in the *New York Review of Books* that the union's best opportunity to effect a radical agenda was in the "fundamental texture of the industrial system itself" so it should more carefully address the economics of hospitals and take a "fundamental look at the whole notion of skills and training in this society, since in the hospitals it is the rigid classification of skills and jobs which plays a key role in keeping the workers down." She speculated on what might happen "if skills could be demystified

and training programs initiated which were realistic (instead of, as at present, immensely costly because they help to reinforce the divisions in the system they are trying to reform)" (pgs. 284-5). Thus Langer was disappointed when a 1970 contract proposal that would have considerably expanded the Training and Upgrading Fund founded in 1968 titled "Establishment of Career Ladders Within Each Hospital" was shelved (pgs. 271-3).

1199 leaders in that period were comforted by the criticism they did not impact the organization of health care delivery: this had been a strategic condition of their organizing success. "From its very inception 1199 faced down industry charges that collective bargaining would seriously impair the functions of health care institutions, interposing a dangerous third party between patients and health professionals" (Fink and Greenberg 1989, pg. 202). In 1992, by which time 1199 had organized the industry and established itself as one of New York's most powerful political forces, Dennis Rivera included a single-payer, national health care plan as part of his agenda (Roberts 1992). But by the end of the Clinton health care reform fiasco in 1995, organized labor was in shambles over health reform (Gottschalk 2000, ch. 7)[38] and 1199, along with DC 37, was faced with threats of massive layoffs as hospitals braced themselves for the effects of managed care. As I described in Chapter 2, the unions reacted to immanent layoffs by focusing on the ameliorative possibilities of training and upgrading, which largely left intact the organization of the health care labor process and took a conciliatory tone

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[38] Gottschalk ascribes organized labor's failure to obtain passage of national health care reform to the attachment of many of the large unions to their Taft-Hartley pension and benefit funds (of which 1199's ETJSP is an example), which essentially made the unions health insurers with considerable control over the costs and quality of the health care received by their members, not to mention giving them a significant vehicle for securing member loyalty. Rivera's endorsement of a single payer scheme would seem to contradict Gottschalk's thesis. I am indebted to Joel Vandevusse, who is conducting research in this area, for drawing this to my attention.

toward hospital's presentation of their workforce problems. 1199's Training and Upgrading Fund is, as its officials regularly remind outsiders, not an agent of the union—it is overseen by a joint labor-management board of directors and its strategies vis-à-vis occupational change and the healthcare workforce are formed in collaboration with the administrators of major health care facilities.

The Training and Upgrading Fund is now a behemoth compared to 1968, but it has not pursued the path suggested by Elinor Langer. The counselors and assessment test administrators who stand as sentries to training programs and occupations do not suggest that skills have been demystified. Rather, in the process of securing millions of dollars of state and federal funding for training, the union and health care workforce planners continually resort to a rhetoric of skill shortages and worker inadequacies, not competence and ability. And the labor union has clearly not developed or championed a remedy to the hierarchical division of labor in health care that would both protect its members from exploitation and free them to express the range of their abilities and desires to provide high quality care. While the rigid classification of skills and jobs both limits occupational mobility and, arguably, contributes to poor patient care, on the other hand it provides a semblance of order and criteria for training in what is otherwise a highly unpredictable sub-baccalaureate labor market.

The Bread and Roses Cultural project serves as counterpoint to the training and upgrading fund. 1199 initiated a series of cultural and educational programs under the stewardship of Moe Foner in the early 1950s, well before it organized its first hospital in 1957. Foner, who was in charge of 1199's communications and was its public relations guru for 30 years, described in his 2002 memoir how theatrical and staged performances

were central to the union's organizing campaign at the hospitals. In one case, the union staged a "mock funeral" for the meager, 2-cents an hour wage increase offered by a Brooklyn hospital. Said Foner, "the workers loved this kind of thing" (Foner and North 2002, pgs. 57-8).

In 1978, by which time the union was established in the hospital industry, Foner founded the 1199 Bread and Roses Cultural Project with a planning grant from the National Endowment of the Arts. The name came from the motto of the 1912 Lawrence, Massachusetts textile workers strike: We Want Bread and Roses Too. Said Foner: "it captured what I envisioned for 1199ers: economic gains to meet their material needs and cultural programs to enrich their lives" (pg. 86). The Project organized (among other things) concerts, musical revues, street fairs, exhibitions, theater programs, concerts at worksites, and conferences and lectures. Many of these events were carried out by professional artists, sometimes they were written or performed by union members and workers. For Foner, the Bread and Roses Project was simultaneously a public relations vehicle for 1199, a space for union members to express themselves, a source of entertainment, and a way to "advance union principles such as solidarity, opposition to racism, and support for women's rights" (101). Foner perceived it as a source of cultural capital and enrichment for 1199ers.

The Bread and Roses Cultural Project can be seen as an illuminating contrast to the Training and Upgrading Fund. It reflects an impulse to move away from established institutions and create independent sources of knowledge and culture whereas the Training Fund further embeds workers' aspirations in existing institutions and structures. The readings that Ossie Davis and Ruby Dee did of Langston Hughes poems on workers'

lunch breaks, recorded in a 1980 television documentary on the Project, are funny and subversive. The Project aimed for the kind of consciousness raising consistent with its political era.

And yet, these were black and Hispanic workers essentially organized from the outside by a group of white radicals—the consciousness raising efforts also foreshadowed how classes in racial tolerance and cultural diversity could quickly dovetail with those in customer service. Writing in 1974, Al Nash noted that the 1199 leadership desired and cultivated intensive membership involvement in non-decision-making activities like "dances, boat rides, sports, civil rights celebrations, rallies, peace demonstrations, political rallies, and utilization of union services" while it created blocks to member participation in decision-making activities (Nash 1974). Foner's phrase—the workers loved that kind of thing—of course contains the paternalistic kernel of many of the cultural projects (no doubt an outgrowth of the union leadership's old ties to the American communist party and its emphasis on the role of the party as the intellectual and cultural tutor to the working class). Though the Project expressed a "conscious opposition culture" it was not "organized by the workers themselves" (Aronowitz 1973, pg. 15).

Nash, who wrote his doctoral dissertation on labor-management relations at Montefiore hospital, did not foresee how tensions around whether the union leadership adequately mirrored the membership, in terms of culture, race, and occupational history, would surface after the union's charismatic and all-powerful president Leon Davis retired in 1982. Race became an explosive issue during the short-lived presidency of Davis' handpicked successor Doris Turner (Fink and Greenberg 1989, ch. 10). Only a new

charismatic figure, the Puerto Rico-born Dennis Rivera, was able to moderate the racial tensions in the union. While Nash found that 1199's headquarters "modern but modest" and the officials "easily accessible to the members" (pg. 551), today the lobby of the training fund is separated from the huge floor where training fund staff work by doors that open only with key-card access. The training fund staff work in identical cubicles—a *sine qua non* of bureaucracy—while administrators, naturally, occupy the windowed offices around the perimeter of the building. One union insider described the offices angrily, asserting the space symbolized how the union had traded "struggle for service." This charge is not new (Aronowitz 2000; Ehrenreich 1976), but as the pension and training funds become political entities in their own rights, commanding billions of dollars in investments and grants, it is easy to see 1199—particularly from within—as benefits administrator rather than a force for social and racial justice.

In the entanglement of health care employers, labor unions, and educational providers that makes up the training and education industry for allied health care workers, there are few formally sanctioned spaces for politicized engagement. And time is increasingly scarce—the culture of lifelong learning requires days that are crammed from dawn to dusk with work and school. Though I asked most of the health care workers I interviewed what they did in their "free time," few answered the question without laughing—most claimed they could not remember or never knew what free time was.

APPENDIX: DESCRIPTIVE TABLES

I: Demographics of Health Care Workers Interviewed (n=23)

Age	Age range	21-55
	Average	37
Gender	Women	18
	Men	5
Race	Hispanic	6
	White	4
	Mixed	2
	Black	11
Highest level of formal schooling	High school diploma	8
	Some college/post secondary credential	6
	Associate's degree	5
	Bachelor's degree	4
Children	Yes	19
	No	4
Marital Status	Never married	8
	Married or partnered	9
	Divorced or separated	5
	Widowed	1
Place of Birth	United States	9
	Dominican Republic	4
	Trinidad	3
	Romania	1
	Canada	1
	Jamaica	2
	Ghana	1
	St. Vincent's	1
	Barbados	1

II: Occupations Held by Health Care Workers Interviewed (N=23)

	# in position at time of interview[39]	# ever held position
Health Care		
Housekeeper	-	1
Dietary/Kitchen Aide	1	3
Home Health Aide	-	3
Certified Nursing Assistant (aide)	4	7
Security Officer	-	2
Registrar/Clerk	7	8
Surgical Technologist	2	3
Respiratory Technician	1	2
Ophthalmology Technician	2	2
Nuclear Medicine Technologist	3	3
EMT/Paramedic	1	1
Physical/Occupational Therapy	2	2
Licensed Practical or Registered Nurse	1	2
Physicians' Assistant	1	1
Teacher/Supervisor	2	2
Non-health care:		
Retail	-	5
Office Work	-	3
Nanny/Domestic Work	1	2
Construction/Manufacturing	-	2
Restaurant/Food Service	-	1
Security	-	2
Education	-	1

[39] Column total is greater than 23 because it includes cases where workers were in training for the position and because some workers held more than one job at the time of the interview.

III: Affiliations of Trainers, Educators and Workforce Planners (N=21)

Organizational Affiliation	# at time of interview	# ever
Independent training consultant	1	4
Hospital- or health care-organization	5	6
College or university	5	5
Labor union	5	5
Community- or nonacademic training	3	4
Policy and workforce planning organization	2	2

IV: Median Hourly Wages for Selected Health Care Occupations in New York City and the United States, 2001[40]

	NYC	U.S.	Ratio
Personal and Home Care Aides[41]	$7.93	$7.76	1.02
Home Health Aides	$8.18	$8.46	0.97
Pharmacy Aides	$8.63	$8.66	1.00
Physical Therapist Aides	$11.02	$9.76	1.13
Pharmacy Technicians	$12.90	$10.40	1.24
Nursing Aides, Orderlies, and Attendants	$13.06	$9.27	1.41
Medical Assistants	$13.25	$11.35	1.17
Dietetic Technicians	$13.78	$10.48	1.31
Surgical Technologists	$13.82	$14.47	0.96
Occupational Therapist Aides	$14.57	$10.37	1.41
EMTs and Paramedics	$15.56	$11.14	1.40
Medical Records and Health Information Technicians	$16.12	$11.31	1.43
Licensed Practical Nurses	$16.69	$14.75	1.13
Medical and Clinical Laboratory Technicians	$17.15	$13.85	1.24
Respiratory Therapy Technicians	$17.70	$16.27	1.09
Occupational Therapist Assistants	$19.12	$17.23	1.11
Cardiovascular Technologists and Technicians	$19.78	$16.83	1.18
Physical Therapist Assistants	$20.48	$16.96	1.21
Dietitians and Nutritionists	$21.34	$19.43	1.10
Medical and Clinical Laboratory Technologists	$22.27	$20.31	1.10
Radiologic Technologists and Technicians	$23.19	$18.12	1.28
Diagnostic Medical Sonographers	$24.38	$22.59	1.08
Nuclear Medicine Technologists	$24.48	$22.79	1.07
Occupational Therapists	$25.37	$24.70	1.03
Registered Nurses	$28.20	$22.44	1.26
Physical Therapists	$29.92	$27.20	1.10
Physician Assistants	$33.73	$30.75	1.10
Pharmacists	$34.17	$36.00	0.95

[40] Source: U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics (OES). This data is for health care workers in all health-care settings.

[41] Occupation titles in bold are occupations which at least one respondent in this study held at one time or was employed in/in training for that occupation at the time of the interview. Unfortunately, wage data by occupation *and* place of employment is not available for New York City, which would have allowed me to show the wage differences between nursing aides (nursing assistants) in hospitals and nursing homes, for instance, in New York City and the United States. Such data would more clearly show a "union wage premium" since the hospital sector in New York City is more thoroughly unionized than other health care sectors. Nursing aides have one of the highest ratios of salary between New York City and the United States, which is likely the result of particularly strong success at unionizing that group of workers and their relatively high wages in hospitals.

V: Characteristics of Selected Allied Health Care Training Programs[42]

	% of Accredited Programs Responding to Survey	# of Graduates from Accredited Programs[43]	% Female Graduates from Accredited Programs	Average Salary	Avg. Program Length, in months	Most Common Sponsoring Institution of Accredited Programs
EMT Paramedic	37.8%	3,440	21%	$30,400 (1997)	15.1	Community College 58.8%
Health Information Technician	46.9%	1,506	93%	$40,000 (1997)	20.6	Community College 74.3%
Medical Assistant	38.0%	10,605	94%	$21,247 (1998)	15.4	Vocational School 44.9% Community College 43.3%
Nuclear Medicine Technologist	91.3%	642	56%	$56,000 (2001)	20.0	Community College 26.1%
Ophthalmic Medical Technician	55.6%	52	65%	$41,000 (2000)	-	Academic Health Center 33.3%
Physical Therapy Assistant	33.2%	2,975	72%	$26,000 (1997)	21.3	Community College 73.4%
Physical Therapist	34.0%	5,893	66%	$56,500 (2000)	32.6	4-year college 72.8%
Physician Assistant	42.1%	3,636	59%	$71,046 (2001)	27.6	4-year college 57.9%
Respiratory Therapist[44]	59.7%	3,110	69%	$40,809 (2000)	22.8	Community College 62.2%
Surgical Technologist	33.7%	4,049	75%	$30,180 (2002)	13.7	Community College 47.1% Vocational School 35.9%

[42] Compiled from the *AMA Health Professions Education Data Book*, 2003-2004. Based on a national survey of health professions' educational programs accredited by major accrediting organizations. All data from 2001-2002 academic year, except average salary, for which year of data is listed.
[43] Useful to assess relative size only. Figure represents only graduates from accredited institutions responding to AMA survey.
[44] All data for Respiratory Therapist based on advanced-level credential, except salary for which level is not specified by the AMA data.

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