Body Work in Health and Social Care

Critical Themes, New Agendas

Edited by
Julia Twigg
Carol Wolkowitz
Rachel Lara Cohen
Sarah Nettleton

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Body Work in Health and Social Care

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Conceptualising body work in health and social care

Julia Twigg, Carol Wolkowitz, Rachel Lara Cohen and Sarah Nettleton

Introduction

Body work is work that focuses directly on the bodies of others: assessing, diagnosing, handling, treating, manipulating, and monitoring bodies, that thus become the object of the worker's labour. It is a component part of a wide range of occupations. It is a central part of healthcare, through the work of doctors, nurses, dentists, hygienists, paramedics and physiotherapists. It is a fundamental part of social care, particularly for older people in the form of personal care and the work of care assistants (Twigg 2000a). Body work is also a central theme in alternative medicine (Sointu 2006). It is at the heart of the body pleasing, body pampering trades such as hairdressing, beauty work, massage, and tattooing (Black 2004, Sweetman 1999), and it extends to other, more stigmatised occupations, such as sex workers (Sanders 2004, Brents *et al*. 2010) and undertakers (Howarth 1996). The contexts within which these practitioners operate, the knowledge systems they draw on, and the status hierarchies in which they are embedded, vary greatly; however, as we have argued elsewhere (Twigg 2000b, 2006, Wolkowitz 2002, 2006), there are certain commonalities that can be traced across these contexts that make the concept of body work sociologically useful.

This book explores the relevance of the concept of body work for the field of health and social care. The Call for Abstracts followed from a research seminar series organised by the authors in 2007–9 entitled 'Body Work: Critical Issues, Future Agendas' funded by the UK Economic and Social Research Council. The seminars were not confined to the field of health and social care, but brought together social scientists interested in exploring the social relations of body work across a range of occupations that focus on the human body, many of which are far from the conventional areas of health or social care. The series demonstrated how a concept of body work is useful for exploring commonalities and differences in workers' dilemmas and strategies in what are otherwise widely disparate occupations, in ways that highlight, rather than ignore, the particularities of their work. The concept also provided a vehicle for the collaboration of researchers associated with different specialisms, not only those concerned with health and social care, but also scholars of work and employment, gender, ethnicity and migration, and social policy and sociology. The crossovers and commonalities between these fields were among the most fruitful aspects of the seminars. It is very much in the spirit of these wider collaborations that we approach this

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book on body work in health and social care. Indeed, one of the gains of the concept for health and social care is its capacity to link these subjects with wider social structures and discourses.

This introduction to the book seeks to elaborate the concept of body work and to specify some of the gains from adopting it as a focus in health and social care. We begin by highlighting the boundaries and intersections between our conceptualisation of body work and that of parallel and different usages, particularly in relation to emotion, work and the body. We argue that one of the benefits of our definition is to foreground the constraints care of the body must deal with, especially as regards the use of time and space. We suggest that by acknowledging the particular character of body work, we are better able to understand the micro-political relations between practitioners and patients and clients, how difficult these are to alter, and how these are shaped by the wider social and economic context. We are arguing, therefore, that the concept not only makes visible aspects of health and social care too often neglected, but also highlights critical dimensions on which comparative research is needed.

Body work, as we have noted, involves direct, hands-on activities, handling, assessing and manipulating bodies. It is often ambivalent work that may violate the norms of the management of the body, particularly in terms of touch, smell or sight. It is sometimes a form of dirty work in both the literal and sociological senses (Emerson and Pollner 1976) as workers have to negotiate the boundaries of the body and deal with 'matter out of place' (Douglas 1966). Body work also lies on the borders of the erotic, its interventions paralleling and mimicking those of sexuality; and this further reinforces its ambiguous character. It is gendered work, differentially performed by men and women (Widding Isaksen 2002a). It is practised on both an object and a subject and, as such, involves both a knowledge of the materiality of the body and an awareness of the personhood that is present in that body. It can be linked to pleasure and emotional rapport as well as to abuse and discipline. It is ambivalently positioned in relation to power, caught in dynamics that can tip either way, presenting the worker as either a demeaned body servant or an exerciser of Foucauldian biopower. It can treat the body as a unity, or in terms of discrete body parts, and this has implications for how it is organised and experienced. Whether the work takes place on bodily surfaces, or penetrates the body, whether it involves inflicting pain or producing pleasure, whether it deals with the head or the 'nether regions', or appendages rather than the torso may all have implications for the social relations of body work. Body work therefore invokes ontological questions in terms of how the human body is read or known, and how it may be handled, transformed and understood.

Boundaries and intersections

The relations between the body and work have increasingly been the focus of sociological interest (Wolkowitz 2006, Shilling 2005, Gimlin 2007, McDowell 2009). As a result, the term body work has been used in wide and varying ways. It is helpful therefore to clarify what we are and are not including under the terminology, and how our concept of body work relates to other, parallel, conceptualisations. In order to identify a distinct set of social relations, we define 'body work' relatively narrowly. For us, body work involves work that focuses directly on the bodies of others, who thereby become the object of the worker's labour. For reasons of analytic clarity we omit certain areas. Thus work undertaken by individuals on their own bodies, though interesting and increasingly significant, is not included. We omit debates around the self-disciplining of the body as part of the Foucauldian

technologies of the self (Foucault 1997), as a requirement for work (Witz *et al.* 2003) or as a project in High Modernity (Shilling 1993), particularly in relation to norms of appearance and control (Bordo 1993, Gimlin 2002, Davis 1995), though we are, of course, interested in the body work of those who are employed to help others meet those expectations, or whose work practices on their own bodies, as Wainwright's chapter in this book shows, are related to their work on others' bodies. We also lay aside the current focus within public health on the requirement for citizens to promote their own health through regimes of bodily activity and control. Again this represents a form of working on the self, not others' bodies. We also exclude the work-transfer occurring in health systems whereby patients take on technology-related activities on their bodies previously performed by staff.

We are also excluding from our concept 'work' that takes place outside the employment nexus, typically in informal, family-based relationships, such as child care or care for frail or elderly relatives, though such activity frequently involves work on the body. Some theorists of care (Ungerson 1997) have argued for the importance of treating it as a unified sector across the public/private divide. Others (Lee Treweek 1996, Twigg 2000a), however, have argued that the distinctive nature of the social relations in which informal care is embedded, and its uncommodified character, mean that it is better analysed apart. For similar reasons we only include voluntary sector body work if organised in ways that mimic paid work. In practice body work tends to be bifurcated in its provision, located either in the informal, family sector or in paid employment. Body work as part of volunteering is an unstable category: too intimate for passing friendship, lacking either the neutrality of paid work or the intimacy and compulsory quality of family relations.

We also exclude work on fragmented bodies and parts of bodies, such as tissue samples or bodily organs. Our focus is on bodies that are whole, and recognisably so. Because of our interest in intersubjectivity, we concentrate on bodies that are alive and, typically, awake to some degree; but we do not exclude work on the dead body, and would include tasks such as laying out the body on the ward, or the work of undertakers in managing and presenting the deceased. In both cases, though the body is dead, the social person is still present in the corpse.

The boundaries of body work are inevitably fluid, and we may on occasion want to work across these boundaries in order to find out when and why they are established and breached in practice. For instance, Rapp (1999) found that when laboratory technicians examining fetal cells found an adverse result they related the sample back to the woman from whom it was taken. We should also note new technologies that enable body work to be conducted 'at a distance'. Laying out these boundaries is helpful in sharpening our concept and clarifying how it is distinctive.

Our use of body work overlaps with that of other theorists. McDowell (2009) adopts the term body work as a shorthand for all the embodied, interactive work in the consumer service sector that requires co-presence. She includes workers' management of their own bodies and bodily performances, not only their attentions to the bodies of patients, clients and customers. McDowell's use of the term is part of her case for bringing the embodied character of many frontline service sector interactions to the fore, and is thus much to be welcomed. In recognising the importance of embodiment in all consumer services encounters she does not, however, adequately distinguish between cases in which workers' focus on the bodies of the clients/customers is a defining and essential feature of the job and other forms of interactive work where the presence of an embodied worker simply adds extra value, pleasure or authority to the interaction (something that has elsewhere been conceptualised as 'aesthetic labour' (Witz *et al.* 2003)). As it happens, many of McDowell's (2009) case studies are examples of body work in our sense, presumably because they best illustrate

the usefulness of looking at the corporeality of interactions in the construction of jobs and occupational identities. However, we think that occupations that require touching the patient or client's body (or at least close proximity or inspection) are characterised by particular challenges and dilemmas and that these are analysed more sharply by confining the term to those situations.

'Body work' also overlaps, empirically and theoretically, with the alternative conceptualisation of 'intimate labour' (Boris and Parreñas 2010), a concept rooted in discussions of the increasing commercialisation of intimacy (Hochschild 2003a, Zelizer 2005). This concept, however, is as much concerned with the transformation of the social experiences of consumers as providers; and this has meant that domestic labour, much of which does not involve intimate touch, is included, as it occurs within the intimacy of the consumer's home. We suggest that our concept of body work has a key advantage over 'intimate labour', in that the focus on intimacy can elide the bodily nature of the work. If working closely with bodies is simply associated with 'intimacy', it becomes essentially an intense form of emotional labour (Hochschild 1983), implying a difference of degree rather than kind. This is not to say that emotional and body work are not closely intertwined, but that the bodily aspects of the work need to be analytically distinguished.

As we have noted, body work inevitably involves an interplay of inter-subjectivities. There has already been much written about emotional labour (Hochschild 1983, Bolton and Boyd 2003, Kang 2003) and this literature needs to be incorporated in the conceptualisation of body work. Although the concept of 'emotional labour' was initially developed within the commercial service sectors, sociologists of health and illness have also recognised and demonstrated that working with, for and on bodies in health and social care settings is emotionally draining, laborious and demanding (James 1989, 1992). 'Emotional labour' maps neatly on to the gendered occupational hierarchies of healthcare, with the privileged, predominantly male professions relegating the emotional work, along with the other 'dirty work', to those lower down the pecking order. There is empirical evidence to support this; though it is important to note that those in the upper echelons of the healthcare division of labour are not immune from emotional 'wear and tear' (Graham 2006, Nettleton *et al.* 2008). Feelings, both physical and emotional, potentially involve vulnerability, and since the whole edifice of biomedical science, and attendant evidence-based practice, presupposes a form of 'disembedded' expertise (Giddens 1990), the viable scope for emotions becomes awkward, and much emotional work involves the suppression, rather than expression, of emotion. Thus, while emotional sensitivity and expressivity are desired and necessary characteristics of medical work, they must be circumscribed lest they are conceived of as 'unprofessional' and a threat to the abstract system of medicine (Nettleton *et al.* 2008).

It is important to recognise that not all the emotional aspects of body work are negative. Emotion can also make body work worthwhile, meaningful and rewarding. It is double-edged: a source of satisfaction and frustration. For many, the affective aspects of work constitute an important motivation and are a welcome counter to the encroachments of bureaucratic tasks (Bolton 2005, Cohen 2010). Body workers are likely to experience empathy and sympathy, not least in settings where the women, men, boys and girls with whom, and on whom, they work are facing profound life events or death. But they are also exposed to hurt by those on whom they practice. As we discuss further, below, the power relations are not unilateral and, when dealing with people, practitioners can experience sexism, racism, and other forms of abuse. The emotional component of body work has thus to be managed as part of the job. It also transcends and permeates boundaries between formal paid employment and the lives beyond, for emotions generated through body work

are not easily shed or cast off when the worker leaves the workplace, especially when the workplace is a health and social care setting.

Making body work visible

Though the body is central to the activities of health and social care, this fact is often obscured in accounts of the sector. The reasons for this are complex and relate to both the ontological and sociological status of the body and work on it, and to features specific to the construction and analysis of health and social care work. Medicine, for example, is marked by a 'dematerialising tendency' (Dunlop 1986: 664) whereby status is marked by distance from the body, so that when high status professions like doctors do engage in body work they do so in ways whereby the body element is closely framed, with the potentially demeaning aspects of it bracketed off, either symbolically through the use of distancing techniques, like the drama of the ward round or pre-surgical cloaking, or transferred across to lesser status, ancillary, and frequently gendered, occupations like nursing (Twigg 2000a). Similar processes operate within nursing, where status is once again marked by distance from the body. Nursing has often been oddly coy about the reality of frontline bed and body work which has been rarely articulated in nursing texts or discourse (Lawler 1991, 1997). Nurses, as they progress up the occupational hierarchy, move away from the basic – from 'dirty' work on bodies to 'clean' work on machines – and eventually to work, like management or teaching, that involves little or no body work at all. This retreat from body work has been reinforced by the growing division of labour within nursing through the use of skill mix, allied to the long-running desire of nursing to establish its professional status. Social care has similarly avoided thinking of itself in terms of body work. Social care is traditionally constituted in the discourses of social work and managerialism, neither of which emphasise the bodily (Twigg 2006). Social work in particular has traditionally defined its role as 'not the body', handing that territory over to medicine (Diamond 1992). But social care is in fact centrally about body care, which forms the main activity of residential and home care.

The methods used to explore this territory in health and social care research also tend to downplay the bodily. Empirical research is dominated by interviews, in which the experiences of workers and patients are translated into words, with the inevitable bias towards abstraction and bleaching out of the corporeal. There is paucity of observational work. Partly this is because access to the private world of body care is not easy to negotiate: care acts take place in private spaces; and staff act to protect the dignity of patients and, significantly, themselves, for as Lawler (1991) showed in her classic account of nursing, nurses go 'behind the screens' not only to protect the dignity of patients but also of themselves as caring, 'clean' professionals. As Lawton (2003) argues there is a need for novel methodological approaches. Significantly it is ethnographic and observational studies, particularly those like Diamond (1992) and Lee-Treweek (1994, 1996, 1998) based on participant observation, that have cast most light on the embedded and embodied nature of body work. Fields like carework that involve 'unskilled' labour can allow for participant observation by researchers, whereas healthcare interventions, though they take place in more public settings, may not be open to researchers in the same way, and this may obscure our embodied knowledge of them. Harris's chapter in this book is thus particularly welcome for its first-hand reflection on embodied practice by a doctor. The increasingly stringent ethical guidelines that regulate social research particularly in relation to privacy and consent (Boden *et al.* 2009) may also militate against such techniques.

Time, space and place

The spatial and temporal ordering of body work is central to its provision. Body work requires co-presence. Workers and the bodies they work upon must be in the same place. Moreover, they must be in the same place at the same time. This makes the times and places of body work relatively inflexible. It also has a series of other consequences. First, technological innovations notwithstanding, it is unlikely that body work will ever be comprehensively off-shored, that is, exported overseas to lower wage economies. Since the bodies in need of work – patients, clients or customers – remain geographically dispersed, both within and across countries, so does demand for body work. This does not however mean that paid body work is evenly spread geographically. A second consequence is that since the resources required to pay for bodily needs, whether these are for healthcare or personal adornment, are unevenly distributed, so too is paid body work, with a greater concentration of body workers in rich countries and regions. This in turn generates a further consequence in the demand for and immigration of workers, many of whom come from countries with less developed paid body work economies, producing what have become known as 'global care chains' (Hochschild 2003b, Yeates 2004). Within countries, however, the spatial dispersal can also reflect longer established patterns of living arrangements and employment, with coastal and other retirement areas populated by low-income, frail older people, and with economies of care that draw on unskilled local labour.

In addition to workers' spatial mobility, the global market for body work increasingly depends on the ability of bodies (patients or customers) to travel to sites of regional specialisation. This travel is found in health and social care, for example 'medical tourism' (Connell 2006), but also in other types of body work, for example, 'sex tourism' (O'Connell Davidson 1996) or even the search for obscure and culturally 'authentic' tattoo design (DeMello 2000: 14). 'Tourism' tags notwithstanding, some travel for body work results in permanent relocation, either locally, into long-stay nursing homes or further afield, as in the case of the steady stream of retirees moving to Spain, Florida and other sunbelt regions (Katz 2005, Wolkowitz 2010b). The permanent relocation of people who are particularly needy in terms of their demands for body work reinforces incipient spatial variation in body work demand and its corollary, patterns of global labour migration.

In order to achieve the co-presence necessary for body work in health and social care, workers must make themselves available not just in the right region but in the specific places and at the times that the bodies of patients, clients or service users are ready to be worked on. This may be difficult to manage within capitalist wage-labour relations. Body time fits poorly with 'clock time' (Simmonds 2002). Whereas clock time, the commodity against which capitalist wage-labour is reckoned (Adam 1993), is abstract, accountable and exchangeable, bodily rhythms are individual and variable, the times and duration of bodily need unpredictable and expansive, as Davies (1994) showed in her account of what she terms the 'process time' of care. The dependence of the body work labour process on bodily needs makes it difficult to rationalise or speed up, as Cohen argues in this book. Since many bodily needs are difficult to constrain to 'working hours', body work is potentially 24 hours a day 365 days a year, requiring flexible bodies and flexible workers (Martin 1994). Moreover, the unpredictable nature of body work means that demand spikes are inevitable. When these occur, unless staffing levels are 'unprofitably' high, a decreasing likelihood given the dominance of the profit-motive in the social organisation of body work, some demand is likely to go unmet; patients, clients or service users left waiting, as Diamond's (1992) account of for-profit care homes showed.

The site where body work takes place is also significant. Body work can take place both within and outside designated workplaces, with the same task taking on very different

features depending on where it occurs. For example, a care assistant who washes the body of an older person in a residential care home will be subject to the institution's schedule, conscious of the other bodies awaiting attention and perhaps subject to direct surveillance by a manager or to intervening demands from other residents (Diamond 1992, Lopez 2006). The same tasks may be performed in a private home and may be similarly rushed, with the timetable determined by the minutes allotted to each visit, but the spaces and times of work are here produced and managed not only by an external manager but in direct relationship with the person being washed, and the family or friends who form their social network (as England and Dyck explore in this book). Body work that takes place in domestic spaces can thus both extend commodification, whilst simultaneously removing waged labour from direct managerial control and embedding it within extra-economic social spatial and temporal relationships.

Much of the meaning of these relationships derives from the fact that these activities take place in a distinctive and special space, that of home (Rubenstein 1989, Sixsmith 1990, Allen and Crow 1987, Gurney and Means 1993). The coming of care, particularly intimate body care, into this ordered space disrupts its meanings, challenges its privacies, and redistributes its spaces, as Twigg (1999) and Angus and colleagues (2005) showed in their analyses of home care. There is interplay between the body and its structured privacy and that of the spatial ordering of the home. The provision of bodily care also interacts with the temporal ordering of the home, intruding into its structured round of privacy and intimacy, at times presenting disjunctive social experiences in which the body is dressed, undressed, washed and bathed at 'meaningless' times that conflict with normal social ordering, and that impose on it the rationalised clock-based time of bureaucratic provision (Twigg 2000a).

Divisions of labour

Paying attention to the social meanings of body work also helps to explain why the social division of labour in health and social care is so resistant to change. Resonating through the provision of body work are a series of assumptions about gender, class, race and age that shape the pattern of provision and its social evaluation. The mind-body binary is a strongly gendered construction, with the body identified with women and the mind identified with men (Grosz 1994). Ungerson (1983) and Widding Isaksen (2002b) argue that women's much greater involvement in bodily care rests on normative associations in relation to gender, bodies, spatial regulations – and dirt. Widding Isaksen (2002a) argues that 'masculine dignity' is much more dependent on fantasies of the body as closed and bounded, and consequently men find care work psychically challenging and fearful. Many of the positive cultural associations of body work, including touch as comforting or healing, are also seen as feminine, drawing on deeply entrenched patterns in relation to motherhood. Body work, as we have noted, also borders on the ambiguous territory of sexuality. Hegemonic masculinity constructs men as potentially sexually predatory (Connell 1995), and this means that limits are often placed on their access to bodies, both female and male; women by contrast are accorded greater freedom, their intervention being interpreted as sexually neutral or safe. As a result, many patients and clients, both male and female, display a preference for receiving care from women. This further underpins the gendered character of body care, with women greatly overrepresented in both paid and unpaid care work; and with further repercussions for the gender segmentation of the labour market as a whole.

The Cartesian division of responsibilities of brain and body is classed and raced, as well as gendered. In Britain, the Victorians gave working-class women responsibility for the