


# Care Work gender labor and the Welfare State

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## Caring by the Book

Caring comes from the private world of love, intimacy, families, and friendship, but much of it is now done in the public world of work, organizations, markets, and governments. Just as farm and craft labor were once wrenched out of the family and brought into a system of work controlled from outside (Polanyi 1944), caring work is increasingly separated from the personal relationships in which it naturally arises and is performed instead in a system of managed and waged labor. Caring work is still overwhelmingly done informally by female relatives, but to a significant degree it is transforming into jobs with formal task descriptions and occupations with formal training and certification requirements. Much caring is now "produced" by organizations that manage workforces, clientele, and the "delivery" of care. In these organizations, care is measured, allocated, and monitored by accounting systems, which fragment it into countable components.

This change in the organization of caring work represents a shift from the private to the public sphere. By public sphere, I do not mean "government" or "public sector." Rather, I use the terms *public caring* or *caring in the public sphere* to denote three conditions that make this newer caregiving politically different from its traditional private context. First, the relationship of care involves others in addition to the caregiver and care recipient. These others might include payers, such as insurance companies and government programs; for-profit firms or not-for-profit organizations that provide caregiving services; or government agencies that oversee government-funded services. Second, these external parties



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are at least initially strangers instead of intimate acquaintances or relatives; third, and most important, these external parties have some authority over what happens in the caregiving relationship.

In the private sphere, caring is done informally and spontaneously, mostly by relatives and friends, and it is mostly unremunerated, though not necessarily. People make up the rules as they go along, negotiating with each other about what sorts of tasks will get done. In the public sphere, caring is more formal and done by people who care for others as their primary occupation and source of livelihood. Caregivers often are, and think of themselves as, professionals or paraprofessionals instead of as ordinary friends and relatives, though a significant amount of caring work is done by women who are nominally hired as maids and housekeepers but who are asked to mind children or care for adults while they are cleaning. Unlike caring work in the private sphere, public caring work is controlled by organizations, professional associations, private firms, nonprofit agencies, and government programs, and it is regulated by rules about which caregivers and care recipients have little say. This shift from private to public sphere is especially true for care of people deemed dependent—children, the frail elderly, the disabled, and chronically ill.

When care “goes public,” worlds clash. The values, feelings, and interactions that make up the relational essence of care in the private sphere are sometimes devalued, discouraged, and even forbidden in the public world. Caregivers and the people they care for are pressured by the norms, rules, and policies of the public world to make care conform to the image of work that predominates in the public world. At the same time, they struggle to sustain the meaning and value of care as they know it in their more intimate relations.

The feminist discussion about caring work has focused on three issues. First, how can caring work be rendered more visible, so that it is appreciated as a learned skill and hard work, and so that people who do it can be properly recognized and rewarded (Waring 1988; England and Folbre 1999; Steinberg and Walter 1992; Steinberg 1999)? Second, if caring work is brought into the market economy and if people receive pay for doing it, will money change the motivations of the people who do it or the character of the care they provide (Evers, Pijl, and Ungerson 1994; Waerness 1996; Folbre and Weisskopf 1998; Radin 1996; Himmelweit 1999)? And third, how can more care be shifted to the public sphere, so that women do not have to bear the extraordinary burdens of doing it alone and invisibly (Hochschild 1990; Harrington 1999)?

Recognizing that a huge part of caring work already operates in the public world and is already part of the money economy, this chapter asks a different question: what happens when care is recast in the image of work as we know it? Rather than focusing on money as somehow corrupting care, I focus on ways that professional, business, civic, and bureaucratic cultures clash with the understandings of good care held by most caregivers themselves. I suggest that the

norms, ideas, and rules about care in the public world are in some ways incompatible with the norms, ideas, and rules about care in the private world. Abel and Nelson (1990:12) trenchantly articulated this theme as “the conflict between the universalism of bureaucracies and the particularism of caregiving.”

This is not to argue that private, family, or informal care is always better than public, formal care. We do need more care in the public sphere, because the burdens in the private sphere are too high, and the needs are too great. But when we move in that direction, we must know how to preserve what is valuable about care in the private sphere. We need to make care public in ways that do not destroy its value. We need to make the essence of caring work visible, not so much in order to make it countable and rewardable, but rather, in order to render clear what it is that we want to provide in the public sphere.

### Methods

To show how the norms and rules of public care might conflict with caregivers' ideals of good care, I use interview studies of people in caregiving jobs to learn how they define good care and its components. I then use this same material to listen for the ways they feel tensions and conflicts between their ideals and their practices, and between their concepts of good care and the requirements of their jobs. The first section of this paper describes the broad components of good care from caregivers' point of view. Subsequent sections explore the tensions between caregivers' more particular concepts of good care and public-sphere rules and norms. I have identified six tensions: 1) love versus detachment; 2) specialness versus fairness; 3) patience versus schedules; 4) family relations versus work relations; and 5) relationships versus rules. There is some overlap among these categories, but separating out particular elements of the concept of good care highlights how particular aspects of public caring conflict with ideals of good care.

In this chapter, I am avowedly a “lumper” rather than a “splitter.” I aim to describe the elements of good care that are common to many types of caregiving, and to reveal the kinds of tensions that arise between public care and private ideals in a variety of contexts. Thus, I include examples from mothering, family day care, child care centers, family health care at home, formal home health care, nursing homes, chronic disease and rehabilitation hospitals, group homes, and psychiatric hospitals. I include private-sphere caring in families and public-sphere caring at varying levels of “organizedness” from in-home, one-on-one care to care in large institutions.

There are, of course, important differences in caregiving among different types of clientele (especially, differences that arise from varying degrees of dependence and cognitive function); different types of institutions (for example, care

provided in individual homes versus that provided in small institutions and large institutions); and different types of labor arrangements (for example, private informal—sometimes underground—arrangements, private contracts, full-time and part-time work, agency employees, employees of large institutions). I ignore these differences, however, because I want to illuminate the commonalities, not the differences. My goal is to articulate a theory of how care “works” from the point of view of people who do it—what is essential about it and what are its meaning and value to those who care and those who are cared for?—and to illustrate how the content and values of private care sometimes clash with those of public care.

I make use of several sources of interviews with caregivers. First, there are numerous published studies by sociologists, anthropologists, public health researchers, and others who have conducted in-depth qualitative interviews. By no means have I found or used them all, but they are a rich source of quasi-ethnographic data to learn how caregivers in all types of caring work think about what they do.

Second, I have been studying how policy changes in home health care are affecting actual care at the bedside. As part of my study, I interviewed 24 direct caregivers: home health aides (7), home health nurses (9), physical and occupational therapists (5), a social worker, and two case managers. Nineteen of these people are affiliated with one not-for-profit visiting nurse association in New England, which also allowed me to observe team case conferences where clients’ progress and problems are discussed. This agency is located in a small town and serves about fifteen other towns in its semirural, virtually all-white area. The other five are people I learned about through word of mouth, and they work in a large metropolitan area. I am expanding my study to interview caregivers in a large urban area so that I can capture the views of immigrant and minority women, who constitute the backbone of home health care in most big cities. So far, all of my interviewees are women, and all but one (from the metropolitan area) are white. In the text that follows, any quotations without attribution to a publication are from my own interviews.

Third, the Picker Institute in Boston, Massachusetts, graciously allowed me to use an unpublished transcript of a focus group with ten home health aides. The group was conducted in 1995 by Lisa Leroy, a Ph.D. candidate at Brandeis University, and the discussion centered on aides’ concepts of good care as well as their views of what factors contribute to or hinder good care. Quotations from this material are cited as “Picker Institute.”

This kind of enterprise runs the risk of mistaking people’s resigned acceptance of the status quo for their ideals. By looking at care as it is currently done and at caregivers as they currently are, one is liable to hear what they think is possible or even only actual, rather than what they think would be ideal. Their very ideals are constrained by their socialization and by the power relationships

in their jobs. In studying caregiving, there is a special danger that one might find a gendered image of care without realizing that it is gendered, simply because most caring work has been and still is done by women.

Although some writers on both the left and the right have argued that compassion itself is a distinctly “feminine” virtue (Ruddick 1984; O’Sullivan 1999), the ideals of good care as I perceive them from the data are not gender-specific. There are few male caregivers in the published studies, and none in my own study of home health care, so my sample is small. Nevertheless, there is a lot of similarity between the ideals expressed by men and women who do work in caregiving (see especially Diamond 1990; Harris 1998). This similarity may arise from the fact that because men are a tiny minority in paid caregiving work, they are socialized into accepting the female standards that dominate. But even if there is some disparity between men’s and women’s concepts of good care (something I do not believe has ever been documented), I suspect that the disparity between the ideals of the private and public worlds of caring is far greater than any distance between the ideals of men and women. The tension between public and private modes of caregiving is by far the more serious problem.

Last, a note about why I use the term *caregiver* instead of *care worker*, putting me out of step with the conventions of this volume. This chapter is about the transformation of caregiving from a personal and relational activity to a more routinized, managed, impersonal activity. The term *care worker* suggests the modern industrial and bureaucratic concepts that I am contrasting with the relational and personal concepts of care I believe caregivers hold. None of the women I interviewed in my home care study ever referred to herself as a “worker.” They talked about themselves and each other as aides (or “girls”), nurses, and “PTs” (physical therapists). They talked about their jobs and their work, to be sure, but I think applying the term “worker” to them misrepresents how they think of themselves. I sense that the same is true for most of the caregivers interviewed in the literature I cite, though of course I cannot be sure. It may well be that in fields and regions where paid caregivers are unionized (such as home care aides in parts of California and New York), the women do think of themselves as workers in the modern, industrial sense. On the whole, however, I think most caregivers, and especially professionals with college degrees, would feel demeaned by the term.

### *Finding Ideals of Care*

Caregivers frequently say that good care or the care they aspire to give is the kind of care they would give their own relatives. “I would like to think I would take care of my mother the way I would take care of my patients,” says a home care aide, talking about what she considers good care (Picker Institute 1995:15). “My example of good care is when my mother took care of my grand-

mother," said another. "The way she took care of her, gave her attention. You know, she still made her feel like she was young and alive and us being around growing up and my grandmother see us grow up around her" (Plicker Institute 1995:17). An aide in a long-term hospital for the chronically ill explained: "You have to be human and understand that these people are like your father and mother. They are the same. And you have to treat them exactly the same. You have to think at every moment that this is your mother, this is your father" (Glouberman 1990:35).<sup>1</sup> Family day-care providers consistently say that they try to treat their client children the same as their own: "I try to give them the experiences I gave to my own children" (Nelson 1995:28). The Golden Rule of caring work seems to be "Do unto others as you would do unto your own kin."

For every kind of caring work in the public sphere, there is an analogue in the private sphere that hovers around as a kind of inspirational doppelgänger. Children's day care operates in the shadow of motherhood. (One wants to say parenthood, but in fact, day-care providers are almost all women, and they do use motherhood as their standard of comparison [Nelson 1995].) Home health care operates in the shadow of family caregiving. Group homes for retarded adults operate in the shadow of families and apartments housing roommates. Caregivers and care recipients seem to carry images of this other sphere and use them to compare and judge caring in the public sphere.

People in public caring jobs frequently compare themselves, usually favorably, to the even more public, more centralized analogues of their field. Family day-care providers use day-care centers as their invidious comparison. Home health workers use nursing homes. Group home staff use mental hospitals and institutions. Even people who provide care in institutions, the most public of public care settings, also frequently make invidious comparisons between institutions and more private care. They, too, seem to use the private-sphere analogues as points of reference. "It is better if they can be kept with their families, or have family care," says a nurse in a psychiatric hospital (Glouberman 1990:49). "I wouldn't put a mentally handicapped child of mine in an institution," declares a teacher in an institution for mentally handicapped children, who portrays herself as much more competent than the mother of her favorite patient (Glouberman 1990:27). "It's true that it's more natural to die at home outside an institution," asserts an aide in a long-term hospital for the chronically ill, all of whom eventually die in the institution (Glouberman 1990:39). Private-sphere caring remains the ideal, something people are willing to give up only when it becomes too burdensome or impossible.

Family caregiving is by no means a bed of roses, however (Abel 1991; Cohen 1996). A significant body of literature documents the high levels of stress, as well as physical and psychological illness, that family caregivers sustain (Abel 1991:62-68 reviews this literature). What has not been much examined are some

of the intense negative *emotional* aspects of family caregiving relationships. As Sholom Glouberman says, "Private caring relationships not only have more love and hugging, they also are more challenging and have more hatred, resentment, irritation, despair and frustration than professional and public ones" (personal correspondence, 1999).

Caregivers in institutions, even while saying that they think family care at home is better, tend to acknowledge that sometimes home care can be worse than care in an institution. "I think that my training gives me some special skills that parents might not have. I don't think that parents really know how to deal with mentally handicapped children," says the teacher in an institution for handicapped children who would never place her own child in an institution (Glouberman 1990:27). "People can be badly treated at home as well as in an institution," allows the chronic-care hospital aide who thinks it's more natural to die at home. "For some of them, it's better to be in an institution," he adds (Glouberman 1990:39).

Nevertheless, it seems very clear that for people in all fields of caring work and at all levels of "publicness," the standard of good care they carry in their heads is an image of the care given in good family relationships. Public care, care by strangers, care by people who do it as a job rather than as a family connection—that kind of care is regarded as second-best.

Beyond care provided by relatives, at home, what are the elements that distinguish good care from second-best? A home health aide, asked to give an example of what she considers really good care, replies, "It's not always the clean bed, it's not always some food or medication, but it's a smile or I'll get that for you or I'll do that for you, and so many of us tend to forget that aspect of caregiving. I know girls that will go up and do care with not a word spoken, not a remembrance made, not a courtesy. That is not good care" (Plicker Institute 1995:15-16). In every walk of caring, caregivers distinguish between "doing the job" and "caring," between the physical tasks and the emotional relationship, between the technical quality and the moral value of what they do. In fact, they often describe good care by invoking technically good task performance as its opposite. They say that no matter how good the technical care, it is not good care if it does not include other things.

What are those other things? What are those elusive elements of caring work that make the difference between caring and doing a job?

#### *Talk versus Tasks*

A psychiatric hospital nurse describes her work to an interviewer as the most mundane list of scheduled chores. "At 11:30 one staff goes with the patients for lunch and the other stays on the ward. Between 12:30 and 2:00 the rooms are opened for the patients so they can rest" (Glouberman 1990:93). She marches

through her day, hour by hour, ticking off chores mostly in the passive voice—patients are gotten up, patients are given medications, reports are made, the food is brought, patients are escorted here and there, patients are counted, patients are observed, rooms are cleaned, and on and on. Her description of her work sounds like a manager's dream—this woman works by the book, and the patients are manipulated as passive objects.

Nothing in her account suggests any human interaction with the patients, and in fact, she explicitly says she avoids any real involvement. "If you become so seriously involved with the patients, you have to put so much of yourself into them that it's impossible. If you're so emotional and so sympathetic to them you can go crazy." Yet immediately she adds, "Actually, really I am so close to our patients. I always sit down with them, talk to them and everything. I think just two people sitting down and conversing normally is how you have to get through to them to gain their confidence" (Glouberman 1990:96).

Just two people sitting down and conversing normally. You will not find that as part of the job description in any caring occupation, but it is the basic structure for every kind of caregiving. The whole time they are doing something to, for, or with a client, caregivers are talking and listening. Often they take this part of caring work so much for granted that they do not even see it as part of caring. It is so unconscious that it becomes invisible, even in the private sphere of caring within families (DeVault 1991).

Invisible and unconscious as this aspect may be, talking and listening are the elements that caregivers consider *instrumental* in creating care. This is as true for caring work in the private sphere as in the public. A mother explaining what it means to make a family meal, says: "If you have a real discussion at the dinner table, like we used to when I was a kid, you can give a person a chance to let you in on their life. What they were doing all day when they weren't with you. You can find out more about that person. . . . It's a time when you can show that you really care about that person in more than just a caretaking role. I mean, I'm their mother, so I attend to certain needs for them. But that doesn't mean I really know them" (DeVault 1991:53–54).

Talking and listening seem to be the background, the time fillers, the incidental accompaniment to the performance of tasks, but to caregivers they are the engine, the tool, the vital force that creates care out of physical tasks. "Listen to them, it will do them some good," says a male aide in a long-term hospital, succinctly stating the therapeutic value of listening (Glouberman 1990:35). No matter how much drudge work, medical work, or education caregivers do, and no matter how strongly their employer emphasizes the performance of specific tasks, they think the important stuff happens in the talking and listening.

One home health aide says meetings with "the other girls," even just casual conversations, are extremely helpful. Asked what she gains from these meetings, she says, "Someone might have a good idea, or tell us about a problem they faced

the day before, and will give us a little tip. If a man doesn't want to talk about something, a certain subject, make sure you don't mention that. That sort of information, I find it helps." What first comes to mind when this woman thinks of helpful collegial advice is tips about topics of conversation, not information about the skilled bodily care that is officially the heart of her job.

A day-care center aide says that before she came to work in the center, she thought the job would involve things like changing diapers and potty training. Then she took some training in early childhood education, which taught her that she could help toddlers to learn. "The classes I took helped me. They taught me how to talk to them [the children]" (Strober and Gerlach-Downie 1995:109). Implicit in what she says is her belief that talking to children is a learned skill, and it is the skill that enables her to accomplish the goal of child care, helping toddlers learn.

Wordless care is not care in the minds of caregivers, or for that matter, in the minds of most people. It is the archetypal horror story. "At the Kindercare infant room, there was more than an hour and a half on a recent Thursday morning when no one said a word to 13-month-old LaRhonda," reported the *New York Times* to illustrate a story on poor-quality day care (Lewin 1998). An academic critique of day-care centers uses similar vignettes for its "data": "Lena" (5 months) was sitting on the floor playing with some toys. The caregiver decided to change her diaper and approached Lena from behind, abruptly and wordlessly picked her up, and laid her on the changing table. . . . The caregiver did not talk to Lena. . . . A few times Lena gurgled and cooed. The caregiver did not respond. . . . When finished with the task, she put Lena back down on the floor, also without a word" (Leavitt 1995:7).

If doing tasks without words is quintessentially bad care, caregivers who work with clients who have trouble communicating think a crucial part of their job is to help them find words and to learn to understand them. "You have to figure it out sometimes for yourself," says a teacher in a hospital for handicapped children. "Some of them will make some kind of sign and then you know. But for the ones who really don't, it's a really hard thing. They all have things they want to communicate, even the ones that don't seem to know what they want" (Glouberman 1990:25). Nonverbal communication becomes as important as verbal. Like the day-care aide who learned how to talk to children, people who work with nonverbal clients consider nonverbal language a genuine skill. A nurse's aide in a geriatric care unit explains why nonverbal communication requires personal relationships: "They all have ways of communicating. . . . Sometimes it's with their eyes or a certain move. They have their ways. If you know the patients, you can communicate" (Glouberman 1990:102).

Nonverbal communication is important even when clients are perfectly able to talk. That is why, as Suzanne Gordon shows in her close observational study of nurses, face-to-face talking can elicit much more information than written

questionnaires. For example, a typical question asked to find out if home health care patients need help with activities of daily living is "Do you have help with shopping?" A home care nurse explains why verbal answers are not enough: "The patient might answer, 'Yes. My son helps me.' The nurse might think, oh great, there's no problem here. But in a face-to-face conversation, the patient's hesitancy in answering a question or his body language might convey hints that he really has difficulty getting his son to do his shopping" (Gordon 1997:133-34). Here is another way caregivers find that talking, simple talking, is a tool of their trade.

But seemingly simple talking, "just two people sitting down and conversing normally," entails highly skilled, attentive listening and watching. People who do caring work are often oblivious to the real skill involved. Like the nurse who called her conversations with patients "just two people sitting down and conversing normally," sometimes caregivers are not aware of how they have learned several idiosyncratic languages to communicate with each of their clients, how they have learned to decipher sounds, facial expressions, gestures, and other body language, in order to carry on that "normal conversation."

In the public world, where people are paid for caring, the payers care about how their money is spent. The managers of caring work want proof that they are providing *something*, and often, proof that they are providing something of high quality as well. So they want everything documented. And measured. "You can't manage what you can't measure" is the mantra of management. Managers want something to *show* for their money and their efforts. Tasks show. Talk does not (Smith 1974; Diamond 1990).

Thus, for example, the agency I studied uses a "service plan" for home health aides. It is a paper that serves as the aides' "work order" and lists some 50 possible tasks a nurse might check off for the aides to do. Not one of them is talking or listening. This contrast between the formal job description and the actual practice highlights how, when care becomes public, something essential is squeezed out. Timothy Diamond, a sociologist who worked for two years in nursing homes as a nurse's aide, illustrates how tasks drive out talk with this story: "I stopped to sit with Mary Karney, a seventy-seven year old resident, who was crying on her bed. Before I could find out why she was crying, I was interrupted by my supervisor who scolded me for sitting with Mary, reminding me that I had more vitals to do before bed check. My job priorities did not include sitting with Mary Karney. . . . In this instance, the routine taking and recording of blood pressures not only took precedence, but in effect precluded, tending to Mary Karney's sadness" (Diamond 1990:176).

A home care physical therapist I interviewed worries that soon she will be required to document her time by 15-minute increments, as she already must do when she practices in a clinic. "Did you do gait training? Did you do therapeutic exercise? Did you do, you know, just PT stuff? And you don't get time for, you know—I let [someone] cry on my shoulder for 15 minutes because things aren't

going as well as she wishes they were . . . or she has some concerns . . . or she's worried about whether her husband's going to be able to take care of her and can she stay here [at home]?" This kind of thing "may be social work," the physical therapist says, "but right now I'm there, and she needs me to listen. I need to know when to refer this on [to a social worker], but sometimes I'm just there to listen."

Thus, in the public world, caregivers learn that talk is not considered work. The same male aide in the chronic care hospital who advised that listening to people "will do them so much good" went on to say, "If you're with them here you will have to do your work, and you can't stop. But they want your complete attention and at times you don't have time to talk" (Glouberman 1990:37). Here is the danger of caring work in the public world: When care becomes formal work, talk is no longer a legitimate part of it. Talking is not "doing your work." Not that talk is forbidden or that lots of talk does not happen despite the pressure to "do your work"—but talk is no longer valued for its own sake.

#### *Love versus Detachment*

In the Western dichotomy between reason and emotion, work is viewed as belonging to the realm of rationality. Its purpose is to get things done, to produce something useful or desirable to somebody else, and to meet specific goals. The emotional and spiritual parts of work—caring for one another, attending to emotions and personal dignity, maintaining bonds of loyalty, and finding and expressing meaning—are left to the realm of family and personal life. In the work world, anything that smacks of feelings, emotions, personal relationships, dating, family concerns, and most especially love is thought to disrupt the workplace and interfere with rational judgment and productivity.

Caregivers in every walk say that their training, their employers, and their professional norms all discourage "getting too close," "getting too attached," or "getting too emotionally involved" with the people they care for. Sometimes the "too" is left out, and caregivers perceive that any kind of closeness is discouraged. "Sometimes . . . we, the home health aide, are the only people they come in contact with, that they call their friend, that they talk to, telling you their personal problems. Sometimes it gets too much for you, it weighs heavy. Because they tell you, don't get involved, but how can you not get involved with a client?" (Glasser and Brecher 1997:117). As one physical therapist put it, "If you're human, you do." Clients, patients, and children get attached for their part, too. "Of course they bond," another physical therapist told me when I asked about attachment. "I mean, if you see a patient two to three hours a week, that's more than my mother sees me."

At some point, almost all caregivers use the word "love" to describe their feelings toward some or all of their clients. "I love them. That's all, you can't help it. They give you hugs and kisses and tell you how much they appreciate it. You are

not supposed to take them home but you do, in your hearts you take them home" (Karner 1998:79). The deep affection that is almost taboo in the formal rules of caregiving organizations is both unavoidable and essential to caregivers. "Oh Rose, I love you, I would say," a home health aide tells a journalist about her relationship with an elderly woman, as she gestures how she would embrace her client and the client would hug her back (Conover 1997:132).

Love is often a way that caregivers distinguish good care from mere technical care. Speaking about the chronic disease hospital where he works, an aide says, "Here they love all the patients. If it weren't like that I would have left, because I couldn't stand that. There are hospitals with all the equipment. They're well set up, they have everything, but they don't treat the patients well" (Glouberman 1990:38). One type of "bad" day care happens when "love fails to emerge," to use the phrase of sociologist Margaret Nelson. A family day-care provider told Nelson she had once had a boy who "wasn't lovable and I couldn't hold him and hug him. . . . I don't think there's anything wrong with having personality clashes. The thing is with a kid you don't want to hurt their feelings. I wouldn't want my kid in a home where he wasn't at least liked, let alone loved" (Nelson 1995:38). For this woman, and for many caregivers, the work of caring is similar to the world of dating or friendship, where personality clashes and special attractions are legitimate bases for deciding whether to go deeper into a relationship. Just as this woman probably would not marry someone she did not love, she thinks she ought not enter into a contractual relationship to provide day care for a child she cannot love.

The love that develops between carer and cared for is perceived as both inevitable and good. Yet caregivers are sometimes ambivalent about the love in their work. They talk about the pain of losing people they have cared for and loved. And some talk about how too much closeness can undermine their therapeutic effectiveness (personal interviews and case conference observations). Much of their ambivalence, though, comes from the clash of norms between the private sphere and the public sphere and from public caregivers' perceptions and training that attachment is wrong. There is a striking defensiveness in these caregivers' professions of love: "You can't help it," "You just do," "How can you not get involved?"

Because professional training and workplace culture emphasize the importance of detachment, caregivers sometimes feel badly about their strong emotional attachments. They come to see themselves as emotionally immature, professionally incompetent, and sometimes even guilty of transgressing the rules of good care. Thus, for example, a family liaison officer in a long-term hospital describes her own path toward emotional detachment as if it were a process of maturation: "I used to become very attached to patients and became quite upset when they died. Now I don't let it happen. I haven't closed myself to the patients. . . . I really love some of them—I run over and give them a hug but I think it's part of my own

maturation. How long can you go on climbing over everyone you meet?" (Glouberman 1990:60). This woman seems quite conflicted about her own attachments. She says she no longer "lets it happen," then she says, in so many words, that she still does let it happen, then she makes fun of her own attachment, calling it "climbing over everyone you meet," as if her hugs and warmth were an adolescent excess.

One home health aide, when I ask about attachment, tells me that she finds it very hard when a patient is dying and that she "would never be good at" hospice care. I ask her if she has any tricks to protect herself a little from getting too attached. "That's one of my downfalls," she answers, as if not being able to stay detached is a professional failing. She says, "That's the way I am. I have always been like that all my life. . . . You know, 'cause that's one of the things on—when we do our yearly evaluations or our six months. They will ask a goal, and I've taken hospice courses through the agency and I've read books and I still, I cannot do anything to overcome how I feel. That's just the person I am, I guess."

One can understand how it would be very useful for caregivers to be less affected by the sadness of their clients' lives. At the same time, this woman's struggle captures one of the deep conflicts in caring work, the conflict between "the person I am" and the ideal work personality that professional norms seem to require.

### *Specialness versus Fairness*

Love means special attraction, preference for some people more than others, stronger loyalty to some people than others, simply making someone else special. But specialness is taboo in the public world of caring, where fairness and equal treatment are the governing norms. In the world of work, even the words for these special bonds are decidedly pejorative—favoritism, nepotism, cronyism, and in recent political times, preference. Many caregivers talk about having "favorites," as if it is normal. "She is my favorite. . . . I consider her like a relative—like my daughter," says a teacher of a 17-year-old girl in her hospital, before she mentions her own 8-year-old daughter (Glouberman 1990:21). Others talk about having a favorite as something of a professional failing. A nurse in a psychiatric hospital says, "I try not to get too involved with the patients so that they become dependent on me." And then, as if confessing a weakness or a professional slip, "I do have a favorite patient. I guess old Martha. Other than that, no one" (Glouberman 1990:50).

Here is still another way that private norms of caring clash with public norms. Employers, supervisors, and the formal culture of workplaces discourage emotional attachment and the "favoritism" it sometimes spawns. A nurse in a psychiatric hospital, having absorbed these norms, denies any favoritism and explains to an interviewer why favoritism is wrong: "We don't have any favorites here. If we did and one client noticed it, it would be bad" (Glouberman 1990:97).

In the public sphere, caregivers are caught between the natural human experience of special attachments and the civic and professional norms of equal treatment. The norms of equal treatment are extremely strong, and certainly a forceful part of professional socialization. Caregivers often tell interviewers, "I treat all my clients the same" while they are in the midst of discussing their different feelings toward clients. When Margaret Nelson asked family day-care providers whether they feel differently about their own children and the other children in their care, "the answer [she] almost uniformly received was, 'I treat them all the same'" (Nelson 1995:33). When I ask home health workers whether their work and their relationships with clients are affected by the length of time they expect to be working with the client, they, too, are quick to deny differences in their treatment. "No, because I just give everybody the same care. I think I do my best and I give everybody the same care," says one aide. "You know I feel like I'm still treating them the same as I treat any patient, whether I'm going to be there for two days or whether I'm going to be there for a year. I feel like that I give the same whether or not the time is the same." Nelson (1995) says day-care providers' insistence on equal treatment is "a form of denial" that their feelings for different children *do* differ, and that the women deny such feelings because their standard of good care—motherhood—requires loving all children equally. But these proclamations of equal treatment also indicate caregivers' outward acceptance of the larger cultural norms of fairness, even when these equal-treatment norms conflict with their own strong sense that each child or client is unique and deserves *different* treatment.

Caregiving requires individual caregivers to reconcile these two conflicting norms. One norm holds that each person is unique and should be cared for uniquely. The other holds that all people should be treated alike. Caregivers in the public world are thus caught in a moral double bind. They cannot give good care by their own standards if they do not love their clients, if they do not allow themselves to let strong attachments develop, and if they do not treat each client uniquely. But they cannot be good professionals, good workers, or good citizens if they violate the norms of impartiality and equal treatment that govern public life and that have been drummed into them since kindergarten civics and before. Individual caregivers are left to reconcile these conflicting moral imperatives.

#### *Patience versus Schedules*

Every caregiver agrees that to do this job, "You've got to have a lot of patience." For starters, it takes time to build up a relationship with people before they trust you to take care of them. If somebody does not want a bath, a home health aide tells me, "If it's somebody that really says, 'No, no, no,' I say, 'Well, how about we just soak your feet?' That's not too intrusive, that's not too intimate. So we

start with soaking the feet. I might be just soaking the feet for months. . . . So sometimes it's a bit of gentle persuasion, or gradually working that whole trust factor in and the person begins to feel more comfortable with you."

Caregivers see building trust as a prerequisite to everything else, so to them, it is more important to spend time building trust than doing any particular task of caring. Insofar as building trust takes time, it is often time in which the more physical and countable tasks do not get done. But while individual caregivers may have the patience for this long, slow buildup of trust, organizations usually do not. They have work to get done, they pay people to do that work, and time is money to them.

One home health aide tells me she is sometimes criticized by supervisors for taking too long with a client. For example, she says, if the aides are going into a home only to put elastic stockings on someone's legs, a supervisor might say, "Well, that should only take you 10 minutes to do, and why are you there for a half-hour or 45 minutes?" The aide then tells me: "You know, you can't just go in and get out. I'm sorry. You know, my grandmother had people taking care of her. It's like I wouldn't want them to do the same—you know, just come in and wash her up and leave. You know, they have to have some kind of relationship going." The time it takes to "get that relationship going" is essential time to caregivers and their clients; it is wasted time to organizations.

Patience is essential to good care in other ways in addition to its role in building a trusting relationship. Many caregivers define patience not in terms of time but rather as responding to individuals' needs. "Patience is understanding the individuality of all of these children," according to a family day-care provider. "I could have another 18 [children] and each one of them would be different again. There's no two that need the same amount of loving or need the same amount of reprimanding. Each one needs a little extra something of some sort which is fun finding with that individual" (Nelson 1995:32–33).

Patience is in this sense the opposite of standardization. To claim this kind of patience as part of caregiving is to claim the authority to discern clients' idiosyncratic and unique needs, in opposition to the general determination of client needs asserted by an employer or a payer. Moreover, to insist on exercising this kind of patience is to grant greater legitimacy to these unique needs than to needs as defined by a superior or an organization. Thus, for example, a nursing home might see clients as having a need for their medications at certain times during the day and night. Nurses' jobs are then defined as dispensing medications according to a schedule. But nurses typically see the patients' need for pills as part of a larger set of needs, including the need for a relationship. "I have to give medications to 50 patients on my shift, sometimes three times a shift," says a licensed nurse who works in a nursing home. "You can't just go and put the pill in the person as if they were a machine. These are human beings. They need to talk to you. They need to know what's new. They need a little conversation" (Eaton 1995:22–23).



To claim this kind of patience as essential to caregiving is also to claim a different standard of distributive justice. While an organization typically allows each client a fixed amount of time for medications, dressing, or bathing, caregivers use a concept of "to each according to his need." Caregivers' resistance to schedules is in part asserting their own authority to enact their vision of justice. One home health aide, explaining why she prefers home care, described nursing homes this way: "They're always short-handed, they only hire the very minimum of help, and I felt like these people were assembly line. We'd have anywhere from seven to nine people to take care of in an eight-hour shift. Plus answer call bells, plus do the other things, give two baths. And I felt like I was cheating these people because I could not effectively give them the care they deserved to have that I felt that they were paying for."

In a public context, caregivers' awareness that each client is only one of many clients changes the way caregivers and clients experience time. Spending time is the major means by which caregivers can show they care about someone and the major way that they can make someone feel valued. The obvious time rationing required in most caring jobs undermines the illusion caregivers try to create that each client is special. A home health aide tells me how she deals with a client's request that she stay longer than the time she can allot to that client: "I'll say, 'Well, you know I can't. Such-and-such is waiting for his lunch, too.' And I say, 'You know how important it is.' I say, 'You're important and my next person is just as important as you are.'" The aide negotiates demands on her time by making the client feel important, and she gains the client's assent to ending the visit by getting her to identify with the next client. I ask the aide if clients accept this explanation. "Usually, if they have everything upstairs, they can be reasonable," she says. "And if they don't have everything upstairs?" I ask. She laughs. "Yeah, it is a little hard to explain to them that you have to get going. And I will just leave. I'll just say, 'I'll see you tomorrow.' And I'll go."

Not having enough time to do what you think the client needs is a source of stress and guilt for caregivers. Being unable to slow down to the client's time ("They aren't made to be rushed," one home health aide says) highlights both the client's neediness and the caregiver's inadequacy. A nurse tells of a patient with a brain tumor who has a hard time talking. "She knows what she wants to say but she has a hard time getting it out and she gets very frustrated. Sometimes you try to wait. But sometimes you sort of help her along and it makes you feel kind of bad. But you have to because you don't have the time to wait. And at times she's grateful for your help. But she's always sorry. . . . And she's sorry that she has taken so long to get things out. And you feel guilty because you can't spend the time with her that you really should" (Glouberman 1990:104).

Not having enough time is a fact of life, caregiving aside. Even in the most private of caregiving settings, the family, people have to divide their time and cannot "give" it all to one person. But time rationing becomes a more acute prob-

lem the more organized the caregiving setting. When caregivers describe their work in moderately public settings—such as family day care and home health care—they usually criticize the insufficient staffing and time rationing required in their more institutional counterparts—day-care centers and nursing homes. Good care, it seems, requires some sense of being able to allocate time according to individual needs and some sense of freedom from the control of a schedule.

#### *Family Relations versus Work Relations*

Caring for a parent, child, or grandparent, with all the love that entails, sets the standard of care for many caregivers in the public realm. If family caregiving serves as a model, the metaphor often also becomes emotional reality. When people care for strangers as jobs, they say over and over that the people they care for are "like my own family," "like a second mom," "like my own children." They often say they are treated like a member of the care recipient's family. They love and feel loved just as if these strangers were kin. They become what Tracy Karner (1998) calls "fictive kin." "We get close, very close," says a home health aide. "You are just as much a member of their family as their children or their grandchildren. They spend more time with their homemakers than they actually do with their families a lot of the time" (Karner 1998:77).

Sometimes the metaphor of kinship becomes more than just emotional reality. Caregivers begin to integrate their own families and their clients in little ways. A teacher in a hospital for handicapped children talks about bringing some of the children home to her house, and bringing her own little girl to the hospital (Glouberman 1990:23). A home health aide tells me how, on her day off, she helped a client get ready for her rooth birthday party, then later picked up her daughters from school, brought them to the party, and proudly took their picture with the woman. I ask her if her girls had ever met this client before. "Yes, in fact, one time on my vacation I took a day and I made a picnic, and we came up and had a little lunch with this lady."

In the public world of caring, this erasure of the boundaries between real family and work associates is discouraged. A real mother would have her daughter's phone number and feel free to call, but agencies and organizations discourage, sometimes even prohibit, their workers from giving out their home phone numbers. John Herrmann, a sociologist at the University of Virginia who has been researching volunteer-based hospices, asked volunteers why they do not seek Medicare certification and funding (which would enable them to be paid). Among other reasons, "they note that volunteers in certified programs are discouraged from giving out their home phone numbers, and are otherwise proscribed from treating the patients like family, which is what they think they do" (personal communication 1999). Several home health aides tell me that though they are not supposed to give out their home numbers, they do it selectively, or they tell a client, "I can't give you

my number, but if you want to call me it's in the book." They are also quick to tell me they do not mind that clients call them and they do not think clients ever abuse the access. When I ask what kinds of things clients call about, the aides make clear they think every call is legitimate. Someone calls to say she needs to change her appointment, or she would like the aide to come early to get her ready for a visitor, or he would like the aide to bring some milk or bread when she comes, or she wants to warn the aide that her driveway has not been plowed yet.

Aides feel that giving their clients their phone numbers contributes to good care, but it also clearly violates the rules of their employer. They understand why the agency has this rule. They usually say that the rule is to protect them from excessive demands by clients and to keep their caregiving job within the bounds of a job. But they are not sure they *want* to keep their relationship within the bounds of the job as defined by the agency, or that the agency's boundaries permit them to do the job right. They want to have discretion. "You know, we are not allowed to give our phone numbers out. Well, that should be our choice, if we want to do that, you know, we should be able to do that," one aide tells me. In the absence of discretionary authority, they simply take it. They use the phone as a way of making their client and themselves more like family.

Even agencies whose mission is to re-create home and family life for their clients find themselves operating under rules that prohibit development of familylike relationships. David Schwartz, former director of the Pennsylvania Developmental Disabilities Council, had been active in the deinstitutionalization movement and in developing group homes in the community for retarded citizens. He eagerly "developed lots of procedures and systems," while "working hard to achieve structure and organization." Then one day he got a call from a staff member in a group home. She had made friends with one of the residents and wanted to invite her home on Sundays to go to church and spend the day together. The rules, however, prevented such a breakdown of the staff-client relationship. Because the staff person was off duty on weekends, she could not take a client home and not get paid without violating federal labor law. But the agency did not want to pay her overtime (Schwartz 1997:33-34).

The problem here is that when caring goes public, when it is done as work instead of as private family or friendship relationships, it suddenly gets new and smaller boundaries. Now, everything in the relationship must be defined as part of the work. If client and caregiver spend time together, it is work time and must be compensated and regulated like the rest of work time. But people's relationships jump the boundaries. Their feelings for one other do not stay precisely modulated according to the norms of a professional or employment relationship.

### *Relationship versus Rules*

No matter what goals and purposes they talk about, whether it is providing personal assistance, medical care, education, safety, or life experience, caregivers do

what they do by making relationships with their clients. They become like family and friends, yet they are professionals or employees or both—roles that limit their ability to act as friends.

Caregivers often believe that what clients need more than anything is a relationship. When clients are elderly or disabled, they need company, they need a friend, they need simple human contact. Caregivers are acutely aware of the isolation and loneliness of their clients: "A lot of [home care clients], they have family that stop in, but they don't have just friends—people that they can tell things that they wouldn't tell their family" (Karnar 1998:76). An aide in a long-term hospital says, "People sit in a chair here all day, waiting for someone to just come over and talk to them, to wash them, to give them their food. . . . They have to sit and wait for everything in this hospital. They have to wait for the world to come to them" (Glouberman 1990:35). When the clients are children, they need mothering, affection, someone who cares for them. Nelson found that family day-care providers tend to think intellectual stimulation and learning activities are secondary goals and emphasize instead goals having to do with relationships: "I'm trying to give the children a sense of family," or "I'm offering closeness and security—my motherhood" (Nelson 1995:28-29).

Company is a goal in and of itself for clients and caregivers, but it is almost never the goal of a caregiving agency or program.<sup>2</sup> In the public sphere, company is a by-product of other tasks that happen to involve two people being in the same room, but it is not what programs usually pay for or what agencies instruct their employees to do with their time. This conflict is evident in how home care workers and their supervisors talk about the work. A supervisor says, "A lot of [clients] see [home care workers] as a friend—somebody to talk to and they are the ones that see them everyday. We have a rule. I know it is real hard to stick with the rules, a lot of them have a very hard time as far as not talking about your personal life and not getting into the client's personal life" (Karnar 1998:77). By contrast, a home care worker says, "I don't like to make them feel that I am a worker for them. I like to make them feel like I am their worker and their friend, too" (Karnar 1998:76).

Why do caregivers feel so strongly about the legitimacy of providing company and friendship while formal programs and firms consider them only secondary? Caregivers see social contact as the most essential human need. Some are fulfilling their own need for social contact by caring for others. One home care aide says her patients "make me feel so good. I don't know, because I lost my husband almost two years ago and the patients is my family now" (Picker Institute 1995:44). Perhaps their own loneliness makes them especially attuned to others' needs for contact. Some see company as the essence of the therapeutic process, though they cannot express the idea in such professional terms: "It's very difficult for me to say how a kid really improves. I think there is a bond that grows between two people—that sort of thing," a rehabilitation hospital aide tells Glouberman (1990:86).

Some caregivers see their main job as preserving a client's dignity and identity, and they use company and friendship as tools to that end. For example, an

oncology nurse deliberately gets an elderly doctor reminiscing about his career while the chemotherapy is dripping. She actively listens and asks pertinent questions. "When I take fifteen minutes to talk about his work," she explains, "it affirms the validity of his life. He is not just a person with cancer, he is a person who has an identity that extends beyond his illness, even beyond his death" (Gordon 1997:210-11). A hospital nurse asks a patient how he is getting along with his urinary catheter and invites a leisurely description of his daily routine for inserting the tube and cleaning the bag. "I bet you do it really quickly," she comments, triggering another round of conversation in which the man expresses great pride in his agility with a task that is otherwise a source of shame and embarrassment. In this ordinary conversation, which the man's doctor apparently deems beyond the bounds of medical care because he doesn't even ask about it, the nurse manages to rescue and reinforce the patient's dignity (Gordon 1997:67).

Caregivers typically feel that providing company is a legitimate, necessary, and therapeutic activity, but they feel constrained by agency rules and professional norms. One home health aide reveals the high value she puts on company when I ask her for an example of a time she felt really successful: "It always makes you feel good when somebody says, 'I'm really glad to see you. I haven't seen anybody all day.' And you know, OK, you're bringing a little spark into them." Later in the interview, she unwittingly betrays what's in it for the agency, in contrast to what the client wants and what she enjoys providing. If the client does not want any type of bodily care, such as a shower or shampoo or a fingernail cutting, she says, "I try to coax them into something, because I am there—in order for the agency to get paid, to pay me—I have to do some type of hands-on [care]."

Tangled in client requests, agency rules, and their own sense of what is right, caregivers often act on their conscience, but at the cost of feeling guilty and afraid of being found out. The issue of "merely" providing company is one area where caregivers' sense of what is required in a human friendship conflicts with what is required of them by their employer. One aide tells me: "A lot of these people [home care clients], they will tell you to sit down, have a cup of tea or something. What are you going to do? Tell them no? And you do, and they will keep asking you."

Gift giving is another aspect of caring relationships where private and public standards clash. Reciprocity is a strong cultural norm. Clients in all kinds of caring relationships are eager to do things for and give things to their caregivers, no matter how poor or how dependent they are. Children bestow gifts of drawings, found objects, and trinkets on their teachers and day-care providers. A home care patient greets his nurse with a shopping handout from Toys-"R"-Us and a news clipping he thinks she will like. She understands that these are his efforts at reciprocity, and acknowledges them by telling him she missed the paper yesterday and will use these items (Gordon 1997:103). Gift giving is prohibited by some home care agencies, though clients and caregivers do it anyway. Nurses sometimes bring flowers, home-baked food, or small items they know a client can

use. One aide told me she is supposed to refuse any gift from a client, and she told of times when a client tried to give her a gift through the agency and the agency refused the gifts, telling the client that the aide could not accept them.

Sharing stories of one's personal life is another element of friendship that is usually discouraged in formal caring jobs. One nurse recalled how she had described her own first childbirth to a patient in labor and was then reprimanded by her nursing instructor: "You should never give any personal information to a patient. Nursing is a professional relationship" (Gordon 1997:86). Describing her conversations with an elderly client, a home health aide explains to me the rationale behind the rule that aides are not supposed to talk about their personal lives: "I try not to give her *too* much information about my family, 'cause we're not supposed to, because some of these, like I said, they take everything to heart, and you don't want to bring up family problems, because pretty soon this lady, *she's* having this problem, she's taking over your problems, and it's something that you *don't* do."

Nevertheless, home care workers do share information about their personal lives, because you cannot carry on a conversation without reciprocating. But they come to feel that they are "not professional" when they do. A physical therapist tells me that with two of her long-term clients, she really felt like she had "maybe"—she lingers nervously on the "maybe"—"gone over the bounds of being just a professional and actually become a friend. In other words, they would share their personal feelings. They would feel comfortable to cry, to complain, to show themselves, and got to know me and my family." Her idea that "showing oneself" and "getting to know" one another are beyond the bounds of professionalism highlights the profound tension of caring work when it goes public.

Touching is a complicated issue in caregiving. For home health aides, some kind of touching is the core of the job—in fact, they typically use the phrase "hands-on" as a noun to name the type of care they are supposed to perform. They cannot be paid unless they have their hands on the patient in certain defined ways. A hug or a pat does not count, but a sponge bath or a hair brushing does.

For most caregivers outside the realm of health care, physical touching is often expressly forbidden. Since the 1970s, when sexual and physical abuse by caregivers became recognized as a serious problem, institutions have developed regulations and policies to protect vulnerable populations. Partly out of this desire to protect and partly out of fear of litigation should their employees abuse a client, agencies tend to use hard-and-fast rules against touching or to define acceptable and unacceptable forms of touching. In many group homes, the residence counselors are not allowed to give so much as a reassuring arm around the shoulder (personal interview with a residence counselor). Teachers' unions are increasingly urging and training teachers to avoid physical contact with children. The Ohio chapter of the National Education Association teaches its members "how to give a non-hug . . . a sweeping motion where you put your arm

around a shoulder without really touching" (Kronholz 1998). Student volunteers in Harvard University's large community service program are instructed not to touch the people they work with—no hugs or encouraging pats for immigrants they tutor, and certainly no hugs for children. "If a child asks 'Can I hug you?' or 'Can I sit in your lap and you read me a story?', we are supposed to say, 'How about if you sit down here next to me, and I'll read you a story'" (personal interview with Harvard undergraduate).

Even health care workers, who are supposed to have hands-on contact with patients, are subtly restricted in the kinds of touching they can do. Even they sometimes feel they are not permitted to touch simply to express reassurance or affection or security. A private-duty home health aide tells a reporter how she crawled into an elderly woman's bed one night to calm her during a terrified screaming fit: "Normally they train you to be so cautious, to wear gloves all the time. That didn't seem right in this situation. You want to stop the baby from crying, so you hug it, you just do it." She tells how she lay down next to Rose with her arms around her, and they both fell asleep (Conover 1997:132).

In all these ways, the standards of behavior in caring jobs conflict with the essential friendship that constitutes the caring relationship. Being with a client only for the sake of providing company is not allowed, or paid for. Gift giving is discouraged. So is sharing information about one's personal life. Touching is restricted or forbidden. Yet caring jobs encourage and stimulate the intimacy of the private sphere. Workers cannot simply turn off their feelings or their standards of human conduct. So in order to be good workers, they constantly skirt the boundaries of the permissible, sometimes crossing over.

### *Conclusion*

The conflict between the public and private worlds of caring is not simple to diagnose. There are no easy enemies. Private ideals are protean and are shaped in part by norms of the public realm, especially those of fairness and professionalism. Public standards, rules, norms, and goals come from a variety of sources. The culture of professionalism, civic ideals of fairness, workplace culture in general, and realities of organizational and business survival all promote disengagement, distance, and impartiality. Not getting involved, however, is impossible in caring relationships as they are conceived and practiced by people who give care.

The essential elements of care can be squeezed out by the norms and rules of work in the public world. Talk gets displaced by tasks and is no longer a fully legitimate part of care. Love is taboo; detachment is correct. The idea of a client being special is wrong in the moral culture that defines fairness as treating everyone the same. Patience, the sense of devoting as much time as a person needs, is impossible when care becomes systematized and caregivers work on schedule.

Familylike relationships are forbidden in a culture that replaces real family with paid workers. And simple human relationships are hindered, discouraged, and even condemned by rules against getting close, giving gifts, touching, and sharing of oneself. In all these ways, organization, management, professionalization, and commercialization undermine good care.

Yet, when we look closely, we see that people maintain their ideals, even in the face of the most restrictive rules, the most deadening chores, and the most despairing situations of human suffering, debility, and death. They not only hang on to their ideals, they act on them in many small ways. They violate rules, professional standards, their own better judgment and self-protective impulses, all in order to provide the kind of care they think others need and deserve. They turn strangers into kin (Karrner 1998; Stone 1999).

This conflict between private ideals and public practices is part of the stress that is so endemic to caring jobs. Maintaining one's own sense of human decency and rightness takes constant work—not only emotional work but moral work as well. People who must constantly violate rules, standards, and norms in order to do what they think is right must also work to fend off feelings of guilt and fears of getting caught, of losing their jobs, and of hurting their clients. In studies of burnout and high turnover among caregivers, fear and guilt management do not get much attention. The usual policy responses to burnout and turnover are to give more training to caregivers and to offer support groups. These responses miss the mark, for they do not address, or even acknowledge, the underlying moral conflicts of caring work.

The policy problem for the future is how the ideals and practices of good care can be preserved in the face of pressures from professional, civic, workplace, organizational, and business cultures. To make caring better, we need to learn from the ideals of caregivers and from their underground behavior—the ways they follow the spirit rather than the letter of their job descriptions. We need to learn from good caregivers how to provide good care and how organized, public caring work undermines good care. If we want people to enter and stay in caring jobs, we need to face up to the moral conflicts of caring work and not wish them away with training and support groups.

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## Chapter 8

I wish to thank the family day-care workers who participated in the Gender, Citizenship Conference in November 1997, and Deborah Stone for her assistance in this work.

1. I use the term "race ethnicity" in order to emphasize the histories that shape group identity, rather than the term race, which is based on purported biological characteristics. While race is a principle of social relationships, it is the social definition and have historically shaped the cultural identities and experiences.
2. The analysis of conflicts within family child-care work presents of a larger research project, the findings of which are published in Lewin (1997, 1998).
3. Karen refers to the child-care needs of parents enrolled in state search, or educational programs. Karen was interviewed prior to the repeal of AFDC (Aid to Families with Dependent Children), which was a program, while not widespread, were more readily available than to Needy Families.
4. Family child-care workers in middle-class neighborhoods frequently ingress to care for children through state-subsidized programs. The state's policy of paying less than market rates for child care (