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Conceptualising Body Work in Health and Social Care

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

Affiliations:

University of Kent

University of Warwick

University of Surrey

University of York

Abstract

Body work is a central activity in the practice of many workers in the field of health and social care. This article provides an introduction to the concept of body work – paid work on the bodies of others – and demonstrates its importance for understanding the activities of health and social care workers. Providing an overview of existing research on body work, it shows the manifold ways in which this can inform the sociology of health and illness – whether through a micro-social focus on the inter-corporeal aspects of work in health and social care, or through elucidating our understanding of the times and spaces of work, or through highlighting the relationship between mundane body work and the increasingly global movements of bodies, workers and those worked-upon. The article shows how understanding work undertaken on the bodies of others as ‘body work’ provides a mechanism for relating work in the sphere of health and social care to that in other sectors, opening up new avenues for research.

Key words: body, embodiment, work, touch, power, care, division of labour

Address for correspondence: Professor Julia Twigg, School of Social Policy, Sociology and Social Research, University of Kent, Canterbury, Kent, CT2 7NF, UK.

j.m.twigg@kent.ac.uk

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 health care, 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, Jackson and Hausbeck 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 Special Issue of *Sociology of Health and Illness* 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 special issue 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 special issue 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 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 bio-power. 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 the 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 article in this issue shows, are related to their work on other's 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 organized 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 recognizably 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’. But 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 conceptualization 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 health care, 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 health care 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 recognize 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,

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 health care 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 article in this issue 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. 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 health care 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 specialization. This travel is found in health and social care, for example ‘medical tourism’ (Connell, J. 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 insipient 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 rationalize or speed up, as Cohen argues in this volume. 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 organization 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 of 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 volume). 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 time 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 rationalized 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, R. W. 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 sexualized and cloacal ‘nether regions’ of the body, allowing the middle-class lady to maintain the purity essential to her role as society’s heart. In relation to nursing in the nineteenth century, however, as Bashford (1998) shows, it was chaste young, middle class women who were entrusted as part of the sanitary enterprise with the care of bodies. Since then the growing division of labour in health care and the changing social base of nursing have shifted the body work of health care over to less elite workers. Nowadays responsibility for caring for the body, including both children and the elderly, is highly dependent on classed and racialised groups (Neysmith and Aronson 1997, Anderson 2000); and this reinforces the stigma that serving the body carries.

We also need to note the relevance of the social meanings attached to different bodies. Bodily differences may sometimes have a physical dimension, such as the frailty of older bodies. At other times differences are not due to physical power but nonetheless take a bodily form, such as racialised or class markers of social hierarchy. These differences may be rendered more salient, for both worker and recipient, by the close bodily intimacy of body work. Moreover, some bodies may be seen as particularly polluting. For instance, Widding Isaksen, whose account concentrates on elder care, drawing on Kubie and Lawler (1991), argues that the ageing body is seen to carry a ‘piling up of undischarged remnants of a lifetime of eating and drinking...’ and thus perceived as particularly dirty, ‘open, unlimited and unattractive’ (Widding Isaksen 2002b: 802, 792). Contrasts can be drawn here between the stigmatized bodies of many who receive social and health care and the more privileged bodies of those in receipt of the body pampering, body enhancing treatment of the beauty, wellbeing and sex work industries (Black 2004,

Sanders 2004), though these groups of recipients are themselves very varied. The status of the bodies treated has important consequences for the organization of body work and the power dynamics of body care.

The power relations of body work

Focusing on the body work of health and social care highlights the corporeality of power relations between practitioners and patients or clients and the corporeal inter-dependence that characterises their interactions. Generally speaking the power relations of health care tend to advantage the practitioner or worker over against the immediate recipient of his or her attentions (Wolkowitz 2002). This is partly because the practitioner's social class – though also often their gender and age status - is frequently superior to that of the patient. This is especially so in the case of doctors and dentists, but sometimes also in nursing (Chambliss 1996, Abel and Nelson 1990). Practitioners' relative power also rests on forms of expertise and organizational authority that specify how the body is to be treated (Wolkowitz 2011). Studying the body work of health care thus shifts attention to the immediate micropolitics of care, including the ways the institutional power of health care practitioners is embodied through interaction with patients (and occasionally undermined). For instance, the physical postures and positioning of the practitioner and client or patient necessitated by any particular treatment will affect their interaction. Can they look each other in the eye? Will one be standing and the other lying down? Is one dressed for public interactions and the other not? The interaction between body worker and recipient may also be influenced by differences in physical strength and ability, especially in those instances where recipients are relatively frail. Even people who are normally hale and hearty may be rendered physically vulnerable through their treatment, at least temporarily.

Body work involves work on both an object body and a subject person, but routinised and standardised health and social care practices construct the recipients of care as tractable and predictable, transforming their bodies into appropriate objects of labour. Looking at health and social care as body work helps to make visible the ways

practitioners achieve this, effecting their institutional power within the interaction. The clearest case of this is surgery, where sedation plays the main role in producing a passive 'patient-body', although, as Moreira (2004:116) suggests, the positioning of the patient starts much earlier, through pre-operative procedures during admissions and on the ward. The interpersonal, emotional work undertaken by health care practitioners to solicit the willing participation of the patient (see Maseide, this volume, Cacchioni and Wolkowitz this volume) also frequently has an 'instrumental' character (Theodosius, 2008), designed to produce a compliant patient or to distract her from pain. Health care practitioners also, wittingly or otherwise, discourage interactions and requests for help from patients through their body language (Halford and Leonard 2003). Practitioners of complementary and alternative medical (CAM) usually articulate a more equalitarian view of practitioner-patient relations than those in allopathic medicine (Oerton 2004, Sointu 2006), but it is not by chance that their health care practices do not generally require the infliction of pain or the immobilization of the patient, so that the micropolitics of their interactions rarely challenge the equalitarian ethos.

Although the dependence of the practitioner on the compliance of the patient provides many opportunities for patients' resistance, in the context of immediate interactions these are rarely acknowledged, never mind encouraged. Hence one is likely to find that expressions of resistance either burst out in unpredictable ways (racial and other forms of verbal abuse that patients inflict on nurses and other carers (Gunaratnam, 2001)); or they take place distant from the immediate encounter, for instance through the organisation of self-help groups or users' support networks. Attempts to empower patients through more patient choice may do little to reduce patients' feelings of vulnerability, since these discourses hardly address the physical vulnerability of patients within body work encounters where they are often naked, prone, weak, subject to the surveillance and control of stronger, clothed staff. The micropolitics of the body work interaction is one reason why the power of patients, even private, fee-paying patients, is limited, as Twigg (2000a) found in her study of the provision of bathing where even wealthy and elite recipients were reduced in power and status by the bodily dynamics of the intervention.

Health care practitioners' relative power vis-a-vis patients is especially striking in comparison to the power relations of consumer services in body work. Where customers are seen as entitled to exercise control (or at least the fiction of consumer sovereignty), as in the beauty and body-building industries, workers try to demonstrate that they put the customer and her/his wishes first (Korczynski 2008, Kang 2003, 2010, George 2008, Gimlin 1996, Cohen 2010). Power relations in these interactions may mirror wider status differentials between the working-class hairdresser, manicurist or personal trainer and the middle-class client, but even here power may have to be tangibly acknowledged. For instance, Black suggests that beauticians develop a 'light and compliant touch' (2004: 119) that emphasises the client's relative power within the interaction. However, the fact that aesthetic workers seek to reassure the client, establish trust, through touch and in other ways (Eayrs 1993), suggests that where body work involves nudity or (even temporary) immobility the potential for the worker's exercise of power over the customer is always present. The exercise of physical power is therefore likely to be characteristic of most body work interactions to some degree at least.

The power relations of care work forms an interesting case, since the worker does not usually have the authority of a doctor, nor does the patient typically have the power conferred by consumer ideology. The care worker is usually a woman, sometimes a migrant worker, holding an ill-paid job, with little social status, and moreover one that is often stigmatized because of the dirty work it involves. Even her employer tends to devalue her contribution (Pfefferie and Weinberg 2008). Patients and clients have the power to 'act up', to refuse treatment or care, or to make it difficult for the worker to perform. However, as Lee-Trewick's (1996) study of residential care suggested, care workers have plenty of opportunities to retaliate, including the withdrawal of emotional support. Nonetheless, as England and Dyck in this volume suggest longstanding care relations often mingle respect and concern with physical care, and this gives both worker and client opportunities to influence the other in ways that are not dissimilar to those of other affective relationships.

The links between body work and wider social and economic change

Although focusing on body work draws particular attention to the close bodily proximity of practitioners and patients, it is important to recognise that its performance is inevitably shaped by wider social and economic forces and demographic trends. The question of whether or not a mutually respectful relationship between worker and recipient can be sustained needs to take account of the three-way relation between the worker or practitioner, their employer, and the client or patient (MacDonald and Sirianni 1996). Moreover, the state plays a major role as a fourth party, funding care provided by private businesses or practitioners, even when not providing it directly through public services, as well as through establishing regulatory care standards and specifying staff-client ratios (Himmelweit 2005).

Two wider shifts in the provision of body work services are now widely recognized. First is the substantial increase in the size of the body work labour force in the global North, with the population of most of these countries ageing, and thus requiring more care. Meanwhile the rise in women's paid employment has left a 'care deficit' in the care of young children and the infirm ageing population that is being filled with paid employees (Hochschild 2003b, Folbre and Nelson 2000). Hence health care and personal support occupations are among the fastest growing occupations (Bureau of Labor Statistics 2003). Cohen (this volume) estimates that at least 10% of the UK labour force is employed in occupations which involve body work, with over half of that figure employed in health and social care. Wolkowitz (2010) estimated that the equivalent figure for the US, even as far back as 2002 was 8 per cent. A labour force of this size is bound to be subject to rationalisation and the development of systems of delivery that abstract from the corporeal relation at its heart.

Secondly, the performance of body work is increasingly dependent on migrant workers or other racialised groups. Immigrant doctors and nurses have played an important role in the provision of health care since the inception of the National Health Service in Britain (see Bornat and colleagues in this volume), but in recent years the domestic care deficit

has been filled by different groups of ‘subordinate-race’ women or other migrants in different parts of the globe, with regional differences within countries (Glenn 2001, Foner 1994, Solari 2006, Lan 2006, Parrenas 2006, Guevarra 2006). Body work is therefore embedded in a global division of reproductive labour that, with the partial exception of doctors and dentists, is feminised and racialised.

However, the performance of body work is linked to, and shaped by, the wider social and economic forces in less obvious ways: body work in health and social care is now deeply integrated into the wider global political economy dominated by forms of capitalist rationality in the management of resources, including labour. As noted above, it has become part of the wider category of services that, because they require co-presence, cannot be off-shored on a large scale (Blinder 2006, Gatta *et al* 2009 McDowell 2009). The financial gains accruing from the provision of high tech expertise to support new body practices such as transplants, assisted reproduction, genomic research, and sex reassignment are legion (Dickenson 2007, Lowe 1995), as is the provision of specialized or high-tech health care services for the ‘lucrative market’ of international patients (Lee and Davis 2004).

Even the more mundane kinds of health and social care have become a source of profit. Public authorities cannot export the processing of bodies overseas to lower wage economies, at least not on a large scale, but they can open up health and social care to private corporations in the expectation that for-profit firms will be better able to organise public services efficiently. However, when health and care are treated just like any other productive services, as is increasingly the case (McDonald and Ruiters 2006, Greer 2008, Player and Lees 2008), the distinctive requirements of body work as a labour process may disappear from the reckoning and the stage be set for disputes over setting standards of care. The transformation of personal care services for the functionally impaired segment of the ageing population is the best demonstration of this trend. Because much of this care is funded by the state, either directly, through national health services or local authorities, or indirectly, through health and social care programmes for the aged or indigent, such as Medicare or Medicaid in the US, the actual provision of care is a

potentially profitable business activity (Diamond 1992, Howes 2004, Gatta *et al* 2009). In the UK, for instance, the proportion of domiciliary care provided by the independent sector, but funded partly by the state, increased from 2 % to 70% between 1992 and 2009, and is now worth some £1.5 billion, with some firms responsible for up to 15,000 care recipients (Snell 2009).

The privatization of residential and domiciliary care services is argued to affect the quality of care along with the relationship between careworker and recipient. Diamond (1992) argues that privatizing nursing homes turns care ‘into a commodity and the residents into manageable units’ (204). Calculation of ‘the bottom line’ becomes possible only when ‘everyday needs and tending to them’ are ‘turned into a countable, accountable logic’ (209). However, the same transformation also takes place when care provided directly by public bodies, or funded by them, has to conform to strict budgeting criteria. Campbell’s (2008) discussion of a Canadian ethnography of domiciliary care suggests that standardised timings inevitably ignore the diverse circumstances in which a bath or other care work is actually done. Building on the work of Dorothy Smith (1988), Campbell argues that embodied clients come to exist only on paper, as the ‘textualised’ creations of bureaucratised systems of service delivery. According to Lopez (2006) time-pressed workers have less latitude to adapt their routines to patients’ wishes, and will need instead to push them through their daily routines. Hence improvements in the treatment of care home residents depend much more on dealing with structured constraints, especially understaffing, than on changing organisational cultures.

In other cases privatization takes the form of turning the client or their relatives into employers; this may enable some care users to feel more empowered, but has mixed or detrimental consequences for workers (Benjamin and Matthias 2004). Several commentators argue that funding arrangements to empower patients have followed the demands of campaigns by disabled younger men and reinforce an ideology of individual independence that is less relevant to other groups of people needing personal assistance (Ungerson 1993, Watson *et al* 2004). There may also be a more fundamental problem with measures that maintain the disabled person’s sense of personal independence at the

cost of the self-effacement, or relative disempowerment of the workers' status (Ungerson 1999, Rivas 2003). As Razavi (2007) suggests, the links between service quality and working conditions needs to be better publicized. Following from this campaigns to empower patients and clients may be most effective when practitioners and patients (or their relatives) form coalitions that defend workers' rights, pay and conditions (Boris and Klein 2006, Lopez 2006).

Conclusion

In this introductory article we have tried to identify some of characteristics of body work, its links with existing areas of research interest, and the new insights it can promote. Conceptualising body work means paying attention to the proximate character of frontline work in health and social care, including the implications of the physicality of the body and constructions of its meanings for workers in health and social care, the emotional demands such work makes and the ways in which the interactions between clients and patients are experienced through and in the body. We suggest that the concept of body work, with its the explicit focus on the interaction of practitioners with patients' and clients' bodies and how these are understood, helps to explain the status hierarchies in health and social care and their intersection with gender, 'race' and ethnicity. Because of its capacity to bridge the gap between large-scale planning and practitioner-patient interactions, the concept of body work is germane to a number of policy issues. Body work needs to be studied within and across health care regimes, so that one can trace the tangible effects of changes in the organization of services, funding, and other 'external' constraints on how body work is structured, measured, monitored and experienced. The concept of body work is especially useful in capturing the variability and timeliness of human needs for care and the costs for patients and workers of failing to allow for this, and therefore the contradictions inherent in the provision of care guided by measures of efficiency and standardized protocols.

In the articles that follow, a range of scholars explore the significance of body work across a variety of settings and professions. Rachel Lara Cohen opens the debate with a wide ranging analysis of the labour process of body work, laying out the constraints

imposed by the nature of bodies. Contrasting health and care with other service sectors, she highlights the labour intensity of body work, showing how it is difficult to concentrate or standardise spatially or temporally because the unpredictable nature of the body and its needs. She points to the way in which attempts to generate efficiency savings in health and social care are costly for workers and for the bodies that are worked upon.

Kim England and Isabel Dyck deepen the analysis ethnographically with their exploration of the distinctive negotiations that structure the body work of care in the home environment. Drawing on qualitative data from Ontario, Canada, they highlight the negotiated nature of the work, showing how successfully caring for the body in the home environment inevitably involves the formation of both a division of labour *and* strong, co-operative relationships between family caregivers, care workers and care receivers.

Emma Wainwright, Elodie Marandet and Sadaf Rizvi turn the lens of their analysis on to training, providing insights into the ways in which working class mothers are made into body workers. Drawing on qualitative interviews with mothers training for a range of body work occupations (child care, carework, nursing, massage reflexology, aromatherapy and beauty work) they show that becoming a body worker requires extensive disciplining of one's own body. Perhaps surprisingly, given the gendered nature of body work, this disciplinary process, which they term 'body training', is partly focused on eliminating overt displays of femininity, especially female sexuality.

Continuing the theme of training, Nicola Gale draws on an ethnographic study of trainee practitioners of osteopathy and homeopathy, analysing their experiences of learning their craft and the ways this involves understanding how to communicate and touch the patient's body. In making sense of the activities and practices of these complementary and alternative practitioners, she introduces two novel concepts: 'listening to body talk' and 'body stories'. Listening to body talk encapsulates the contribution of the active patient. Patients here, unlike in the situation analysed by Maseide (this volume), do not have to be technically competent but do need a degree of communicative competency to

articulate their symptoms. This in turn relates to the ‘body stories’ whereby the interactional ability of both practitioner and patient give rise to an effective narration of the symptoms and concerns that require attention.

Jennifer Tarr in her article focuses upon what she sees as irresolvable tensions between biomedicine and Alexander Technique. She contends that the discursive claims and strategies pursued by practitioners of the Technique hinder any reconciliation or acceptance of their practice by mainstream medicine. In particular, and drawing on ethnographic data, she maintains that proponents and practitioners emphasise that they work upon the ‘self’ and the conscious body. The integration of the mind and body is crucial; any attempt to alter the physical body alone would be unsuccessful. Thus she concludes an incompatibility lies in the discursive frameworks which privilege the integration of the mind/self and body over the objective body in contrast those of the objective body of biomedicine.

Thea Cacchioni and Carol Wolkowitz’s article turns to medicine and the intimate body work that doctors and physiotherapists may offer women seeking treatment for pelvic pain disorders. Their interviews and observations in Vancouver suggest that successful treatment depends on engaging with the cultural meanings of the vagina. The careful negotiation of touch formed part of the treatment, and is not simply a way of negotiating access to the patient’s sexual organs. These practitioners engagement with both bodily and social dimensions of women’s perceived sexual difficulties runs counter to the polarization of physiological and social factors that has characterised debate on the medicalisation of sex.

Patrick Brown, Andy Alaszewski, Trish Swift and Andy Nordin continue the theme of intimacy and touch in their article on gynae-oncological encounters. They reflect on the element of trust in the medical encounter, focusing in particular on the embodied quality of interactions on which trust is based. They show how trust is embodied in and through body work, and how seemingly detached forms of body work are connected with the emotion work of care and the craft work of body work as touch.

Drawing on his observational study of respiratory physiological clinics in Norway, Per Maseide again explores the nature of medical examination, though in this case the ‘body work’ involves no direct hands-on work or touching of the patients’ body, as the examination process is mediated by technology used to measure the patient’s physiological status. The ‘correct’ use of the equipment requires effective communication between the doctor and patient, with the former working to ensure compliance on the part of the latter, so that the body work entails the constitution of an active, able and compliant patient. Maseide argues that the examination represents a mutually constitutive process between bodies and bodily modes; their agency and objectification are evident throughout the medical assessment.

Anna Harris shows how looking at doctors’ body work sheds light on challenges facing migrant doctors that are often obscured by the more usual concentration on formal qualifications. Her auto-ethnography of her experience as an overseas doctor beginning to practice in the UK concentrates on the ‘moment of mismatch’ she experienced when working in an unfamiliar environment, one that made conscious the taken-for-granted embodied, tactile learning medical practice requires.

Parvati Raghuram, Joanna Bornat and Leroi Henry deepen the exploration of the intersections between the bodies of workers and of patient/clients by once again focusing on migrant doctors, this time those caring for frail older people. Drawing on oral history interviews with South Asian geriatricians who worked in the UK, they trace the complex interplay between the stigmatised bodies of older people in the health care system and the racialised bodies of the migrant doctors assigned to care for them.

Finally Chris Shilling uses his *Afterward* to reflect upon the contribution of classical sociological theory to the conceptualisation of the field of body work.

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