The Affective Turn

THEORIZING THE SOCIAL

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MORE THAN A JOB: MEANING, AFFECT, AND TRAINING HEALTH CARE WORKERS

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> Neither love nor hatred of work is inherent in man, or inherent in any given line of work. For work has no intrinsic meaning.
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> —C. Wright Mills, *White Collar: The American Middle Classes*

E-mail still seems to me like a mode of communication most valuable for conveying new and urgent matters, though apparently not everyone agrees. I recently received in my inbox a "summary brief" on trends in career development, in which it was reported that "nearly 50% of all those working in the United States would choose a new type of work if they had the chance." This *Wall Street Journal*/ABC News poll result hardly seemed to qualify as breaking news. The pollsters' explanation of the finding, however, was startling; they concluded that such apparently high levels of dissatisfaction with work are evidence that "we live in an age" in which work has become "more personal than ever—when who you are is what you do—a deeper source of personal satisfaction than ever." The authors of the summary brief offered a thankfully more cautious explanation, though one that sounded strangely like an admonition: "Many are reexamining their careers in light of the growing realization that work should be more than a job."

The proposition that Americans are seeking or should seek work that is "more than a job" implies that the work—more precisely, the waged labor—many, if not most, people already do is devoid of meaning and satisfaction beyond the wages earned; it is a simplistic proposition, one that silently privileges unspecified kinds of work. Likewise, the hidden suggestion that work that is more than a job subordinates or transcends its status as waged labor constitutes a bourgeois fantasy. But it appears positively surreal that the fact that 50 percent of the people working in the United States would choose a new type of work is interpreted as a sign of growing engagement with work, rather

than alienation from it; that the statement "who you are is what you do" is delivered without irony in the context of an economy defined by the relentless creation of low-wage, dead-end jobs. These interpretations are like mantras: perhaps saying that work offers a deeper source of personal satisfaction than ever before will make it so.

Drawing on interviews with allied health care workers in New York City (nursing assistants, technicians, and other paraprofessional workers) and administrators in the training industry in which they participate, in what follows I examine how the imperative for work to be more than a job is created and deployed through training and education programs in the health care sector.[1] Surely there is no other kind of work more likely to be more than a job than that of providing care. Surely it is in providing care that the need to earn a wage can and should be transcended. But in the health care sector, the backbone of the service economy, workers who provide care are well aware of the latent function of the injunction that their work should be more than a job: the rationalization of their low wages. And even though they feel that their work is important, health care workers are nonetheless subjected, like the rest of us, to the creeping effects of the constant message that work should be more than a job. When Marie, a talented and compassionate nursing assistant, is asked by her neighbors what she does, she tells them she is a "professional butt cleaner" to—in her words—remind her of where she is at and where she hopes to be. "Don't get me wrong, I like my job," she added, "but it's just that it's the same thing repetitively, and I'm not growing." Juan, a registrar and physical therapy assistant, said about his work at a hospital: "I feel that I'm wasting here."

In the health care industry in New York City, such dissatisfaction with work has been channeled into a vast training and education apparatus. For many health care workers, continuing training and education is the most obvious way to satisfy their desire to grow, to change, to improve. Not surprisingly, the training industry in New York City that supports and fuels the ambitions of allied health care workers prospers in an era that invests great psychic, cultural, and material resources in the promise of work that is more than a job. In fact, federal and state governments have allotted hundreds of millions of dollars to hospitals and to training health care workers in New York State since the mid-1990s, on the premise that the workforce is woefully unprepared for the effects of competition and managed care in health care.[2] The influx of training funds into the health care sector in New York City spawned a cottage industry of health care workforce specialists, including individual entrepreneurs, consulting firms, community colleges, universities, and for-profit and not-for-

profit vocational schools. These individuals and organizations often design and implement training in partnership with labor unions and employers. Leading the way is the City University of New York (CUNY)—the largest urban institution of higher education in the country, comprising seventeen public undergraduate institutions and enrolling more than 450,000 students—which has become a major developer of workforce training programs, including those in health care. The latest in a series of reports on the issue found that nearly half of CUNY's 2003 enrollment was in continuing education and workforce programming (adult education courses; employment and welfare-to-work programs; and business contract training).[3]

The interest in training health care workers is not surprising, given that the health care sector is New York City's single largest employer, employing nearly one out of eight workers in 2002.[4] Employment in the health care industry grew by 14.1 percent from 1990 to 2000 and is projected to continue to grow, making it a buffer against more volatile industries. The northeastern corridor stretching from Baltimore to Boston has become the "nation's health epicenter," adding 50,000 jobs between 2000 and 2002, while in the same period all other industries combined shed 220,000.[5] Training and educating health care workers constitutes yet another extension of the medical-pharmaceutical complex into the region's economy.

The possibility of such a large industry to train health care workers is based, in part, on the nature of the health care labor process and occupational structure: health care organizations continually tweak the division of labor in response to fiscal constraint and new technologies, often necessitating training. Regulatory agencies require training and continuing education as part of the licensing of professionals and organizations. In addition, while some corporations or public bureaucracies offer career ladders internal to the organization, the dominance of professions in the health care industry means that specific organizations can create only limited career ladders; career progression requires significant external education and often entails a switch in employer.

The training and education industry in this case, however, is also a specific product of the efforts of 1199 Service Employees International Union (SEIU), the largest health care workers' union in the country, which represents over 230,000 health care workers in New York State, to ensure its own institutional well-being, as well as that of the hospitals where the majority of its members are employed. The union's president, Dennis Rivera, was the mastermind behind the negotiation of a number of aid packages to New York's health care system, many of which specifically allocated funds for worker retraining. Most

of these aid packages were negotiated in the mid-1990s, when New York City hospitals predicted they would undergo massive restructuring as a result of market-based reforms.

Here, I am focusing only on what the training and education industry has become, rather than whether it fulfills the expectations of the various stakeholders and powerbrokers who brought the industry into being. Regardless of the logic by which training funds were rationalized or the political interests served by them, the training and education industry for health care workers is something more and other than what an evaluation of its outcomes would reveal. The training industry contributes to the affect economy, an economy increasingly central to the production of value in a services-based, capitalist society. Focusing on the education and training industry in terms of its relation to affect necessitates a shift away from thinking about education and training in terms of its success at providing skills, knowledge, or upward mobility. Education and training are in fact valued and valuable apart from such traditional outcomes. Likewise, the nature and growth of this education and training industry cannot be solely explained by the individual's needs and the employer's demands which it supposedly fulfills. Instead, I am drawing attention to the unanticipated and less visible flows of value in the training and education industry for allied health care workers.

The concept of affect as I use it refers to a different register of phenomena than the concept of emotions, at least as the latter term is typically used in sociology. The necessity of holding to a distinction between emotions and affect is supported by research and thought in a number of fields such as philosophy, neuroscience, and communication studies. The neuroscientist Antonio Damasio recently proposed a distinction between emotions and feelings, though I propose to call the same distinction that between affect and emotions. For Damasio, when an organism encounters a stimulus capable of triggering an emotion, the emotion consists of the actual physical response of the organism as it is mapped and modified by the brain. This is a process that can become, but does not necessarily become, conscious. Emotionally competent stimuli in fact can be detected while bypassing attention and thought. Often—but again, not always—attention and thought are subsequently turned on these stimuli, but emotions are modifications of the body that are autonomous from conscious thought and attention. Feelings, on the other hand, are "largely constituted by the perception of a certain body state" or "the perception of the body state forms the essence of a feeling."[9] Feelings require a level of awareness and attention, awareness that is based on mental maps of the body's physical

state. Emotions are changes in the state of the body, which the brain maps and which can then become the basis for feelings.

Damasio furthermore suggests that the relationship between an emotionally competent stimulus and the feeling that may emerge is not linear. The process encounters numerous types of interference. For instance, the physiological response of the body is not only a reaction to the stimulus but can also be informed by memories of the stimulus and prior reactions to it by oneself and others. Similarly the reaction to stimulus is by no means determined or hardwired into the brain; as a result of socialization the reaction to and selection of stimuli to which to react may change over time. In addition, there may be gaps in the brain's map of the body that forms the basis of feelings—the brain may not create a true "representation" of all physiological properties. Many of these relays between the body and the brain furthermore happen almost simultaneously.

The reason for using the term *affect* for the nonconscious aspect of emotion that Damasio describes is that in the social sciences, *emotion* is a term most often used as an equivalent of feelings. Literature on emotional labor and emotional management, in particular,[7] focuses on essentially cognitive adjustments—feelings—to the objects that cause emotions. In Arlie Hochschild's now classic work, flight attendants were asked in training seminars to manage their feelings so as to produce an experience airline passengers would want to buy. Damasio recognizes that we may consciously evaluate the objects that cause emotions: "One of the key purposes of our educational development is to interpose a nonautomatic evaluative step between causative objects and emotional responses."[8] We may attempt to consciously evaluate certain kinds of objects and produce socially acceptable (or even commercially acceptable) emotions about them. But I suggest that the training programs studied here are aimed in addition to intervene in affect, which shadows but is independent of consciously modified emotions or feelings. As such, the potential effects of the training considered here are rather different: automatic, noncognitive modulations of bodies in reaction to certain objects and environments. The concept of affect is not unknown to sociology, but it is relatively undertheorized as distinct from emotions or feelings since sociology is largely situated in the so-called action frame of reference, the level of expectations, motives, and decisions that has already been filtered out of affective potential.[9]

Instead I am engaging a concept of affect along the lines Brian Massumi has suggested. As he sees it, there are two levels at play in any event: that of intensity, a state of suspense, of potential disruption; and that of semantics and

semiotics, of language, narrative, and expectations. These two levels resonate with one another; their vibrations are sometimes dissonant and at other times harmonious. Affect is "their point of emergence" and "their vanishing point," where the vibrations between the levels either emerge as something actual or fade into the virtual. Affect therefore shadows every event. It is the source of the unexpected, of the unmotivated, of surprise. The level of noncognitive intensity is autonomous from what emerges in consciousness, but it is nonetheless the realm of potential from which any cognitive realizations will be drawn. Cognition—the realm of language and decision making—reduces intensity, converting suspense into expectation.[10] To intervene in affect, therefore, is to attempt to control or regulate how intensity becomes expectation, action, and decision.

Substituting affect for Damasio's term *emotion* also seems appropriate since Damasio, like many theorists considered here, draws on Baruch Spinoza, in whose philosophical system affect also remained distinct from emotions. Antonio Negri, for one, elicits from Spinoza a simple definition of affect as the "power to act."[11] Accordingly, this essay examines how the training and education industry for health care workers attempts to direct the power to act (to engage, to actively participate), or to convert engagement into economic value. Training and education may also teach specific skills and knowledge—including those of emotion management—but these are of no value if they are not also enacted.

The analysis that follows furthermore posits that the power to act is not controllable because there is no linear path between a state of suspension or intensity and its actualization in specific feelings, expectations, or motives. The pressing explanatory gap in neuroscience is that of how the activity of neurons in the brain becomes the phenomenal experience of images, representations, and feelings. Some researchers have therefore turned to the nonlinear dynamics of self-organized systems, or chaos theory, for an answer. The dynamics of self-organized systems "can yield properties of the system that are qualitatively different from any linear combination of its variables."[12] Sociological studies of emotions acknowledge the neurological and physical bases of emotions, but they do not generally conceptualize the relation between them and experience,[13] let alone conceptualize those bases as a self-organizing system that cannot be linked to conscious emotions through linear series or correlations. Of course, none of this prevents those in the training and education industry from *attempting* to control the transformation of intensity into feelings, from making affect a valuable resource in the shifting economy.

This study is complicated by the fact that language only captures what has

emerged from the level of intensity, that affect cannot be exposed through language. The conscious statements by people interviewed in this research are not representations of what has happened in affect, but, rather, indications of the significance for the organism or system of what has happened in affect. The discourse that emerged in these interviews as a particularly charged indication of changes in affect is that of "meaning." The sense that engagement or the power to act must be triggered or controlled, which underlies the injunction for work to be "more than a job," is often expressed as problems or questions of meaning, as the experience of Veronica shows.

Veronica, a nursing assistant,[14] spent two years from 1994 to 1996 in an 1199 GED program (run by its joint labor-management Training and Upgrading Fund), passed the exam on her third attempt, then enrolled in a union-run college preparatory course that helps participants acquire the language and math skills necessary to pass the entrance examination recently established for all four-year CUNY colleges. She passed the entrance exam and as of 2002 had completed four college courses at CUNY, paid for by the union. School had been an ongoing, concurrent activity to her work and home life for close to ten years. She hoped eventually to obtain an associate's degree in nursing.

> Yeah, I figured if you get into the hospital [and the union], I could become an LPN [licensed practical nurse] or something. I always wanted a job that means—you know, it's something, but as a nursing assistant you don't get no respect—I mean you get treated—it should be an important job, because you take care of people, you listen to their problems, you console them, and yet you get treated as if you're nobody. Especially by the nurses.

Veronica started to say that she had always wanted a job that means something, like an LPN. But she corrected herself, reminding herself that her job as a nursing assistant did, in fact, mean something, was an important job. Yet the problem was that it was not treated as an important job and that those who did it were not treated with respect. Nonetheless, she had begun to think of the work of licensed or registered nurses as meaningful in comparison to her own work. Veronica was aware that the way a job is perceived is not synonymous with its worth, but meaning was the discourse most ready to hand to explain her desire to have a job that would be valued and respected.

Hospitals and their management consultants also turn to this discourse of meaning when faced with the reality that many health care workers are unhappy and feel fundamentally unappreciated and underpaid. A recent report by the American Hospital Association (AHA) Commission on Workforce for Hospitals and Health Systems titled "In Our Hands: How Hospital Leaders

Can Build a Thriving Workforce" argued that fostering meaningful work is one of five keys to solving the "workforce crisis" in health care: "People enter health careers to make a difference in the lives of others. But hospital work is also demanding, hard, and exacting, requiring skill, focus, and attention to detail. As the demands on each caregiver and support workers have increased, the work has become less meaningful and more tedious."[15] The wish that hospital work would be once again meaningful is another expression of the imperative for work to be more than a job. This discourse of meaning is essential to understanding the investment in training and educating health care workers. However meaning is ascertained—as an objective measure of particular jobs or as a product of the way the jobs are socially regarded and valued—is increasingly not relevant except in relationship to the development of an affect economy, in relationship to the shift in capital accumulation to the domain of affect. The heath care industry and its training/education component is one important site for the development of techniques to intervene in affect and transform it into value. The search for meaning plays its part in the development of this economy: if meaningfulness is the measure of particular jobs, then the education and training industry, particularly in health care, creates credentials that confirm the presence of meaning and proceeds to credential people—for a fee. If the problem of meaning is that of how jobs are regarded, then education and training becomes a vehicle for elevating the status of some occupations or compensating for a lack that is ascribed to people in supposedly nonmeaningful jobs—for a fee.

Defining meaningful work only through implication, the AHA report is striking because it takes as given that health care work is not (or is no longer) meaningful. The link between meaning and caring is and can only be made by resorting to a romantic myth that one-on-one caring constitutes the true heart of hospital work: "Today, many in direct patient care feel tired and burned-out . . . with little or no time to experience the one-on-one caring that should be the heart of hospital employment."[16] One need only read a few histories of hospitals to come to the conclusion that one-on-one caring has never been the heart of hospital employment;[17] yet the report reinforces the notion that hospital work can and should transcend its status of wage labor, as does the statement that people enter health care work to make a difference in the lives of others. Both statements imply somehow that it is impossible to be a good caregiver and to be concerned about wages.[18] The fact that many of these workers do not have more lucrative options in the labor market, given their education and work histories, does not fully explain why people commit to the field of health care, particularly at entry-level, low-wage direct-care jobs. Many

of the health care workers I have interviewed attested to their enjoyment in taking care of people, their sense of a calling to this kind of work and its rewards. But they were also concerned about their wages. Moreover, feelings of growth, of being challenged (intellectually, physically, or emotionally), and o autonomy do not automatically accompany the provision of care. Caring work is still work, and as such it has no intrinsic meaning, only the meaning that is assigned to it and represented in such things as wages and working conditions. Many nursing assistants are among those Americans who would choose a new type of work if they had the chance.

Meaning figures prominently in the discourses of health care workers, employers, trainers, and consultants, and the reason it is impossible to pin meaning down, to identify what constitutes meaningful work and declare when it is achieved, is because it is a free-floating engine of growth and production. The channeling and directing of the desire for meaning is the bread-and-butter business of an affect economy. The training and education industry can offer itself as a vehicle for achieving meaning while the industry's existence—in fact, its regeneration and growth—depends on the fact that meaning perpetually vanishes. The difficulty of Veronica's situation is that although she desires meaningful work, the desire for meaning is conditioned on the fact that meaning can never be found. Continual education and training is predicated on the limitless postponement of meaningful work. The education and training industry takes advantage of Veronica's desire for work that means something, but it does not provide such work. One can see how meaning might become perpetually deferred, but the engagement that the desire for meaning produces —affect—is continually reinforced.

Veronica expresses a desire for meaningful work and education and training takes advantage of this expressed desire, attempting to direct her engagement, her power to act, to direct affect. But it would be simplistic to interpret how Veronica describes her experience as evidence that the training and education industry is driven simply by the desires or needs of individual workers who demand it. Such an interpretation assumes that the power to act is located within individuals and outside history and society. Similarly, saying that workers have a growing realization that work should be more than a job fails to consider the political and economic conditions that make such a realization possible and probable. Wanda's experience, by contrast, shows that an individual's demand might not be necessary at all. In fact, the education and training industry is a productive apparatus that takes advantage of the desires it encounters, but it also modulates affect independent of the professed needs of individual workers or employers.

"I'm not comfortable just working like that. I wanted to be a nurse," Wanda said by way of explaining her most recent return to school to a registered nurse prep program at the age of forty-five. By "just working like that" she meant working without also going to school or pursuing other interests and passions. "I wanted to continue my education because I started it at home [Trinidad] . . . but I never finished. So I said, well, if I'm here, this is the place that they say is the land of opportunities, I'm going back to school." In Wanda's story, the way in which the education and training industry is organized has played a crucial role in coconstructing her pattern of mobility, as well as the relationship of that mobility to fulfillment and meaning. Wanda entered an industry with opportunities rare for a worker of her color and background,[19] and she gained access to an adjunct educational complex similarly uncommon in the world of low-wage service work. As soon as Wanda landed her first union (1199) job as a nursing assistant—a year after emigrating from Trinidad in 1987—she obtained her GED through a union-funded program. She obtained her LPN certificate in 1995 after attending a part-time, union-funded program for two years.

After obtaining her LPN certificate, she stopped going to school for a while, but said, "I shouldn't have done that because I got my [LPN] certificate in 1995, and if I had continued, I would have been finished by now [with the registered nurse, RN, degree]." I asked her why she took a break from school.

> Well, at that time, when I graduated, they were not hiring RNs anymore. They were laying off the RNs. So I said, what's the point, you know? And I just kept on working as an LPN. And then the union also stopped giving the course, or paying for the course for RNs because it [the RN shortage] was not so extreme then. And until it was . . . we got some flyers saying that they had started paying for the RN course. So I said look, I'll take the opportunity.

Wanda said she would have continued with school without union support, but there is little doubt that the union education programs dictated, to a greater or lesser extent, the course of her career. The short-lived and ill-founded predictions of a registered nurse surplus in the mid-1990s eliminated nurse training programs so that health care workforce experts were caught off guard by the substantial, nationwide nursing shortage apparent only five years later. The joint labor-management Training and Upgrading Fund had only recently restarted several programs in response to the shortage, for which Wanda hoped to qualify.

But what is of particular interest about Wanda's story is not only that her career movements were not entirely a matter of individual choice but that they were also not dictated by a personal quest for meaning, respect, or fulfillment.

After obtaining her LPN certificate in 1995, she worked as a nursing assistant for three years, waiting for a job to open up at the hospital where she worked, from which she lived only one block in a hospital-owned apartment building. Our conversation shows how Wanda was taken up by, and asked to respond to, a process of perpetual modulation:

Ariel: *In that period when you were an LPN but you were still working as a nursing assistant, did that change how you did your job as a nursing assistant?*

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

Why did you first go to the OR?

They were downsizing one year, and they closed one of my floors, and I was floating, working different floors until I got the appointment in the OR.

How did you feel about that transition?

I felt good about it. Because I think I needed a change. Because I welcomed the change, the work was different. . . . Learning different—learning, learning, learning. I learned how to set the trays for the different operations. I did that until I got the appointment to be an LPN.

So you left the OR when you got the LPN position?

Yes. I went to the ER [emergency room] then. [laughs] That was another thing, whew!

How did you feel about that *change?*

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

Why?

I don't know. We got new administrators; I don't know what took place. And that is how I came to be working in Peds [pediatrics]. The union took up the cause, because we would call that displacement, and then we had a meeting, and they asked me where I wanted to work, and I said I think I want to work in Peds, with the children. So that's where I went. It's nice working with the children.

Wanda found aspects of her work that engaged her and surprised her in the various jobs she has held. She became very animated when discussing her interactions with the mothers in the pediatrics unit in particular; but she also lit up when describing working with the operating room instruments. Wanda both sought out and was exposed to numerous training and education experiences. The course of her career had been steered by her personal and practical needs, but, just as importantly, by the availability of training and education, and the vicissitudes of the health care industry. A survey questionnaire might reveal that she was first a nursing assistant and then an LPN, *not* the variety of units on which she worked or the fact that she received two months training on the pediatrics floor, or that when she worked in the general medical/surgery unit on the fifth floor, the entire unit was sent to a mandatory communication class because of patient complaints, or that she took a computer class while working in the OR for her own edification. "Learning, learning, learning" animates her occupational history. Wanda did not embark on an explicit journey to track down meaningful work; she stepped into the circuits of an affect economy in which perpetual engagement is produced. For both Veronica and Wanda, the outcomes commonly attributed to education and training—a new job, better pay, knowledge—did not follow in an immediate or straightforward manner. Three years passed before Wanda put her LPN degree to use, and when she did, her eighteen-dollar-an-hour salary was only two dollars more than what she had been making on the evening shift as a nursing assistant. She waited to go on in school until industry predictions of a nurse surplus passed. She went into the OR and into pediatrics because of hospital downsizing and/or work reorganization. Wanda did not demand these changes, but she found that the learning each change entailed sustained her over the years in these jobs.

An affect economy cultivates engagement and generates energy, which are both before and other than meaning. Any technique for cultivating engagement and the power to act is potentially quite valuable economically. Antonio Negri goes so far as to argue that "*value* is now an *investment of desire*."[20] One of the features of this affect economy is the struggle over this value: Who will benefit from its production? For many employers and trainers, the hope is that the training and education industry will channel engagement into hard work, into the attitude that "work is more than a job" and therefore requires commitment regardless of the conditions of that work.

For instance, one nonprofit organization dedicated to improving the quality of direct-care services has developed an initiative, in response to some of the new grants and funds available, to encourage workers (i.e., home care

workers) to enroll in college courses. Participating workers can receive a nominal bonus and a specialized certificate after completing a noncredit college preparatory course and four specially designed for-credit college courses focusing on areas such as psychology, behavior management, disabilities, and therapeutic recreation. The mission of the organization is to improve the quality of care. Since one of the major barriers to quality care in settings such as home care is the substantial rate of worker turnover, due to the low wages, the organization's director hopes that increased worker training will serve not only to make these workers better caregivers but also as the grounds for negotiating better wages and working conditions. The organization's strategy recognizes that a central way to improve care is to improve the lives of those who provide it.

It seems possible, however, that training and educating direct-care workers will undermine the organization's goal of developing a more skilled, more committed workforce; after all, such workers are likely to leave their jobs as soon as they have enough education and credentials to do so. The certificate program had not yet translated into better wages, and the chances that the wages and working conditions of direct-care workers will soon improve enough to keep them in their jobs is slim. The director noted that this was a potential problem in principle more than in practice:

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

There are, as the director reminded me, thousands of workers across the city pursuing college degrees this way—one course at a time, while working and, in most cases, managing a family. The certificate program the organization has developed, consisting of four courses, does not move these workers substantially toward a college degree. Nor is it a certificate that qualifies participants for a specific, better job. But, apparently, what it *can* do is engage the workers, give them a sense of accomplishment, and place the work within a context of more academic knowledge, all of which potentially improves the quality of care by improving the relations and exchanges between patients and caregivers. The director's implication is that workers in the certificate pro-

gram might have a sense that they are moving forward and this may keep them in their jobs and improve their attitude and feelings about their jobs. Clearly the most direct way the training and education programs might improve care is to reduce turnover, regardless of any changes in the conditions and terms of work.

This is why education *and* training can be appropriately discussed as if they were synonymous. Doubtless there is a difference between in-service training for a new medical device and union-funded or bonus-carrying college courses. Presumably college credits establish a base for these health care workers to pursue an economically meaningful degree. Nonetheless, since it takes a working person—most of the health care workers I have interviewed—many years to prepare for college, let alone obtain a BA, employers and training program planners not only judge their programs in terms of traditional outcomes like a new job or significant wage increases but also consider how education and training affects the worker's relationship to his or her (con)current job. College credits are an important currency, but they do not show the dividends of a degree for many years, if ever. In the apparently widespread, but not surprising, situation that work fails to produce satisfaction and fulfillment, both training and education have been positioned as potential ways to compensate for that failure, in addition to (or rather than) serving to prepare workers for better work or to provide knowledge for its own sake. Most educational programs funded in this particular health care industry are furthermore a benefit of employment rather than a social right, so workers must continue to work while pursuing an education, extending the time it takes to earn a degree or credential.[21] While in some analytical contexts the difference between education and training is great, as is the difference between the potential earnings of a college graduate and a high school graduate, the reality for workers entangled in the education and training industry can be, and most likely will be, a matter of the perpetual deferment of typical outcomes.

Michel Foucault famously likened the school to the hospital to the prison to the factory as spaces of enclosure and discipline where bodies are classified and subjectivities molded to fit the needs of a modern society.[22] Gilles Deleuze has argued, however, that discipline, as a mode of arranging power, has given way to control (and that this is a transformation recognized and predicted by Foucault). In a control society, "just as the corporation replaces the factory, *perpetual training* tends to replace the *school*, and continuous control to replace the examination." In a control society, power is exercised through "limitless postponements" and continual modulations of life and relations that makes it increasingly less useful (in terms of politics or theory) to think of institutions

(such as school, work, home) as distinct, with separate functions and distinct methods.[23] The attempt of hospital administrators and trainers to (re)claim work as the terrain of meaning, of subjective investment and fulfillment, betrays the impulse to control, as Deleuze has identified.

Phenomenological analyses, which suggest that interaction is performative and constructed, assume that no matter how fleeting, meaning construction is an act of consciousness, an activity that sets apart humans from other organisms and the inorganic. What the training and education industry allows us to see, what it exemplifies, is that the desire for meaning is immanent to an affect economy. The desire for meaning emerges from confluences of nonhuman (institutions, objects) and human actors, confluences not necessarily expressed in the motives or intentions of human actors. This immanent desire constitutes a protean bundle of energy, a force. While Veronica's story, her narrative, clearly shows how an individual's expressed desire for meaning might be taken up by the education and training industry, Wanda's story shows how the desire for meaning is constituted beside and beyond the conscious intentions and motives of actors. Learning is produced in surplus as Wanda moves through various jobs and training programs, and there are many directions in which such learning might be channeled.

Beyond phenomenological analysis lies an ontological revision of thought about the body, including the laboring/learning body. As Luciana Parisi and Tiziana Terranova have pointed out, bodies might best be viewed as compositions of fluids, forces, and affects preceding the phenomenological self.[24] A body, furthermore, is not synonymous with the human organism, but refers to material bits that can be drawn together or apart by forces, reorganized according to changes in these forces. A body, for Spinoza, is defined by its capacity of affecting and being affected. The education and training industry might be thought of as one system (among many) for controlling the flows of energy, in particular that generated by the desire for meaningful work. In so doing, it attempts to direct affect, the power to act. The training and education industry perpetuates the endless reconstruction of bodies and capacities, the limitless reconfiguration of desire and its investment. This is exemplified by Wanda's reaction to each of her job changes, that is, the way in which she ricochets between events that powerfully and momentarily engage her. It is also exemplified in the ways some trainers spoke about their programs.

At a large community-based training organization, I interviewed the former director of allied health programs. Her office was in the corner of a sunny warehouse loft, with windows facing a skyline recently emptied of the World Trade Center. She had just taken the newly created position overseeing work-

force development projects, which had been implemented in the wake of the economic downturn exacerbated—but not caused—by the events of September 11, 2001. The loft had just been vacated by a dot.com gone bust, and the spatial transition from new media to training for entry-level health care jobs embodied the economic state of the city. Reflecting on her work as a trainer and, earlier, as a nurse, she said: "There has to be an administrative decision to constantly nurture the workforce. If I had my way, there would be all kinds of continuing opportunities for self-exploration and personal fulfillment. I think that those are linked to helping people to cope better with the kinds of jobs that they have in their lives, which are very rigorous and exhausting, emotionally and physically." In the particular setting of this interview, which pointed to a number of insecurities facing the city and its workers, it was not surprising that nurturance constituted the paramount concern of training. Moreover, it seemed politically and ethically important to demand nurturance, to expect it even from training courses on very narrow occupational and skill-based topics. This workforce expert went on to describe how nurturance could be implemented in short courses and in-services on topics like nutrition, stress reduction, body mechanics, and the health care worker's own health problems (which often stem from the physical demands of the work).

Like the credit-bearing certificate program described above, such courses would encourage workers to rearrange their relationship to their work. The implication is not that workers will be able to cope with their work and the brute necessity of waged labor because the experiences outside of work are richer, but because education and training will refashion work itself as an object or arena of stimulation and engagement. In this second case, the focus on the actual bodies and energies of the workforce proves significant; the trainer recognizes that the basic way in which workers are out of tune with their work is embodied, so that a more direct route to adjust their experience of work might be through their bodies, or through the noncognitive level that in fact conditions which emotions or attitudes can even be expressed.

Having identified this controlling impulse among trainers, as well as their incipient recognition that affect might be the source of economic value, one of the important features of affect to which it is necessary to return is its autonomy and its continual escape from capture by language or tools of assessment. There is indeterminacy in how affect is channeled into value and for whom. The trainers I have interviewed suggest that one of the potential benefits of their programs is that they take the desire to be engaged among health care workers and turn it into investment in, and identification with, the employing organization and/or the job, which could become measurable as (among other things)

job satisfaction and lower turnover rates. Knowing that trainers harbor this hope, I asked Veronica during our interview several times whether "going to school has had any effect on how you feel or behave at work." Firmly, and without hesitation, she said no each time. Veronica said that she kept work and school separate; only one or two people at her place of employment even knew that she was trying to get a nursing degree. Veronica was concerned that if others at work found out, particularly supervisors and nurses, it would exacerbate their suspicions that she did not respect authority or defer to those above her.

Then, near the end of the interview, Veronica mentioned that she talked about the books she was reading in her classes with patients at her hospital (a private, nonprofit on the tony Upper East Side of Manhattan). Going over to a bookshelf, she pulled out a folder full of handwritten notes, essentially reading lists, from patients. One note included Howard Zinn's *People's History of the United States* and Noam Chomsky's *Understanding Power.Com.* Another note, written by a teacher, comprised three full pages of books. Veronica had read some of these books and referred to the lists when she was choosing what to read next. Employers who provide and fund training are banking on the fact that employees who are going to school make better workers—they bring what they are learning to the workplace, they are more engaged when they can see a future. Although Veronica told me that she did not see any connection between her work as a nursing assistant and the content of her college courses, the patients with whom she discussed books probably experienced a connection. Likewise, her employer, the hospital, benefited indirectly from what was undoubtedly a pleasurable interaction for both Veronica and her patients, even if none of her coworkers or supervisors knew she was going to school. Nonetheless the value of affect, the expression of Veronica's engagement, cannot be easily calculated by the hospital nor (so far) accounted for in its measures of productivity. It is as if Veronica's folder of notes from her patients forms the center of a body that holds Veronica together with her patients, the hospital, and her teacher—a more powerful body. This particular ripple in and between bodies coming together as organisms, individuals, forces, and institutions is potentially valuable.

Negri has argued that in the global market of postmodernity there is no possibility of measuring the value of labor and, furthermore, the "problem of measure itself cannot be located." Labor is neither outside capital (as it was under the conditions of primitive accumulation) nor is it inside capital, since money (exchange) no longer represents a specific quantity of labor nor does the reproduction of labor determine the value of goods. It follows that there can be no real correspondence between a wage and the value or productivity of

work. Negri argues that "the more the measure of value becomes ineffectual, the more the value of labor-power becomes determinant in production. . . . In this paradoxical way, labor becomes affect, or better, labor finds its value in affect, if affect is defined as the 'power to act.'"[25] Accordingly, the value of Veronica's labor lies in those moments of engagement wherein her capacity for affecting others and being affected by others is expanded. And those moments of engagement are "determinant in production," in other words, they are necessary to the very functioning of the hospital.

What is being produced and traded in Veronica's encounter with education is not just technical skills per se, or knowledge, but affect. It sustains Veronica, personally, in a way the explicit tasks of her job do not, since in the immediate course of her daily life she uses her education to create interactions based on respect and sharing, in contrast to the disrespect she usually feels. But training and education cannot easily or solely funnel affect into the confines of waged labor—that is, these effects do not necessarily make her actual job more meaningful and more satisfying. Veronica did not, for instance, identify more closely with the hospital or become more satisfied with her job—her work did not become "more than a job"—but her education had overtones in her current job that were valuable—perhaps not capturable and measurable, but productive. And of course education is not without potential economic value to Veronica, who may in the long term acquire a college degree. The cumulative value of an economy of affect is considerable when we consider the vast size of this training industry and the fact that traditional ends of training and education—skills, a better job, more pay—may be perpetually delayed.

The affect economy in which the education and training industry for health care workers participates is embedded within capitalist relations of production. Such relations of production are directed toward the creation of a surplus of affective capacities via the promotion of the desire for meaningful work and in maintaining inequity in the distribution of the wealth created by these capacities. The desire of health care workers to change jobs is not so much a product of the fact that their work (waged labor) is or is not inherently meaningful, but a product of the fact that their jobs are undervalued compared to other kinds of technical and knowledge-based work that are consistently privileged, not least by social scientists when evaluating and ranking occupations. Health care workers, particularly those who do hands-on care work, know that it is so-called knowledge work or technical and creative occupations that are referenced in the notion that work should be more than a job. The cultivation of engagement in a capitalist economy is no doubt always oriented toward

disguising these inequities in the value assigned to certain bodies and certain kinds of work while turning that engagement into even greater value, appropriated by a few.

Interventions in affect, which can bring some bodies together into more powerful and stable constellations than others, are not free from ethical and political implications. From a Deleuzian perspective on control, the training and education industry constitutes part of a historically specific formation of power that relates "to different levels of matter/energy through an intensification of perception and experimentation."[26] In the training and education industry there is an intensification of attention to meaning, in addition to skills, knowledge, or credentials. In these terms, the training and education programs might be understood as elements of a new system of domination—that of control—and therefore as experimental responses by capital to the problem of value creation. But the unpredictability that characterizes how the power to act is enacted means that education and training programs cannot guarantee that workers' engagement will emerge as the commitment to being more productive workers, at least by any traditional measure.[27] Because the education and training industry is to some extent self-perpetuating and capable of perpetually reconfiguring meaning, just as bodies and desires (e.g., for meaning) are capable of perpetual modulation, education and training are not merely or exactly tools of capitalist interests.

It is important to examine the specific ways in which the desire for fulfillment, satisfaction, and meaning gets taken up and channeled into productive, valuable circuits. The concept of an affect economy serves to identify and specify a register of production and exchange in which the political stakes of a control society may be rooted. The ways in which an affect economy is in fact consistent with a capitalist political economy, and therefore the extent to which transactions in the affect economy further specifically capitalist forms of domination and organizing work, are, however, unfolding. Power in an affect economy resonates as modulations and limitless postponements, but the question of the ability of capitalism to take advantage of that kind of power is not already foreclosed. Jonathan Beller has argued that "from here on, the development of capital will be unthinkable without the simultaneous development of technologies for the modulation of affect and the capturing of attention."[28] Doubtless this is true, but the case of the training and education industry for allied health care workers would suggest that affect is not subject to the usual forms of measurement and analysis, so that the political responses its modulation calls forth are emergent and unpredictable.

NOTES

1. This essay is based on in-depth interviews and observations conducted as part of my dissertation research. I interviewed forty-four health care workers and trainers, educators, and planners participating in New York City health care training organizations and programs between 2000 and 2002. The health care workers interviewed were largely allied health care workers in the sub-baccalaureate labor market, where occupations require at least a high school degree and probably some sort of postsecondary training, credential, or degree, but not a baccalaureate degree. See W. Norton Grubb, *Working in the Middle* (San Francisco: Jossey-Bass, 1996). At least one-third of those people working in health care in New York City are employed at this level. Some of the occupations that the people I interviewed held or were in training for included nuclear medicine technologists, licensed practical nurses, certified nursing assistants, respiratory therapists, and registrars or unit clerks. Most of the workers I interviewed were women, about half were black or Hispanic, and many were immigrants. The majority of health care workers I interviewed were 1199 members.

2. Barbara Benson, "Funds Aim to Retrain Health Workers: Union Gets Millions to Help Employees; Many Lack Basic Skills for New Jobs," *Crain's New York Business*, August 4, 1997, 1; Commission on the Public's Health System, "CHCCDP: Are We Getting Our Money's Worth?" April 2003, 1–63; Karen Pallarito, "Cashing in on Connections: N.Y.C. Hospitals' Funding Deal Angers Upstate Rivals," *Modern Healthcare*, August 4, 1997, 20; and from the three press releases from New York State, Office of the Governor, "Governor Opens Bronx Health Training and Childcare Center," October 22, 2002; "Governor Pataki Announces $250 Million in Aid for Hospitals," June 14, 1999; and "Governor: $80 Million for Health Care Workforce Training" October 25, 2001.

3. Center for an Urban Future, "CUNY on the Job: The City's New Workforce Workhorse," April 2004; "Putting CUNY to Work," June 1999; "Rebuilding Job Training from the Ground Up: Workforce System Reform after 9/11," August 2002.

4. Center for Health Workforce Studies, *The Health Care Workforce in New York City, 2002* (Albany: Center for Health Workforce Studies, School of Public Health, State University of New York at Albany, 2002).

5. David Leonhardt, "Growing Health Care Economy Gives Northeast a Needed Boost," *New York Times*, December 30, 2002.

6. Antonio Damasio, *Looking for Spinoza: Joy, Sorrow, and the Feeling Brain* (New York: Harcourt, 2003), 55, 89.

7. See, for example, Arlie Russell Hochschild, *The Managed Heart: Commercialization of Human Feeling* (Berkeley: University of California Press, 1983); John Van Maanen and Gideon Kunda, "'Real Feelings': Emotional Expression and Organizational Culture," *Research in Organizational Behavior* 11 (1989): 43–103, esp. 53.

8. Damasio, *Looking for Spinoza*, 54.

9. A suggestive point of contact between sociological theory and the concept of affect is Randall Collins's formulation of "emotional energy." See his "Emotional Energy as the Common Denominator of Rational Action," *Rationality and Society* 5.2 (1993): 203–30; "On the Microfoundations of Macrosociology," *American Journal of Sociology* 86.5 (1981): 984–1014; and "Stratification, Emotional Energy, and the Transient Emo-

tions," in *Research Agendas in the Sociology of Emotions*, ed. Theodore Kemper (Albany: State University of New York Press, 1990), 27–57.

10. Brian Massumi, *Parables for the Virtual: Movement, Affect, Sensation* (Durham, NC: Duke University Press, 2002), 26–27, 32–33.

11. Antonio Negri, "Value and Affect," *Boundary 2* 26.2 (1999): 77–87.

12. Nicholas Georgalis, "Mind, Brain, and Chaos," in *The Caldron of Consciousness*, ed. Ralph D. Ellis and Natika Newton (Philadelphia: John Benjamins, 2000), 179–204.

13. For instance, Jonathan H. Turner, "Toward a General Sociological Theory of Emotions," *Journal for the Theory of Social Behavior*, 29.2 (1999): 133–61.

14. In the section that follows, readers unfamiliar with the world of health care work will find it useful to know that nursing work in most health care facilities is divided between several hierarchically arranged occupations: nursing assistants, registered nurses (RNs), and licensed practical nurses (LPNs). Nursing assistants (often called nurse aides) are the front-line workers responsible for the general physical and hands-on care of patients (washing and dressing them, feeding them). Their training ranges from a few weeks to a few months, although in New York most are now "certified" after completing a training program with at least one hundred hours of classroom instruction and a standard examination. Licensed practical nurses work under RNs and are permitted to carry out many of the same tasks as RNs (such as dispensing medication), though their clinical and legal responsibilities are much more limited. Licensed practical nurses are generally trained in one-year nondegree programs. Registered nurses are legally and ethically responsible for all nursing work in a unit. They also implement and delegate physicians' orders, though their autonomy and tasks vary greatly by setting and by their education. Registered nurses may have diplomas, but increasingly they have at least an associate's degree and frequently a bachelor's degree.

15. American Hospital Association, "In Our Hands: How Hospital Leaders Can Build a Thriving Workforce" (Report of the American Hospital Association Commission on Workforce for Hospitals and Health Systems), April 2002, 13.

16. Ibid., 8.

17. See, for example, Susan Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850–1945* (Cambridge: Cambridge University Press, 1987); and David Rosner, *A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885–1915* (Cambridge: Cambridge University Press, 1982).

18. This is what Viviana A. Zelizer calls the oversimplified "hostile-worlds" view, in which commodified relations are seen as incompatible with intimate, caring relations. See her "Intimate Transactions," in *The New Economic Sociology: Developments in an Emerging Field*, ed. Mauro F. Guillén et al. (New York: Russell Sage Foundation, 2002), 274–300.

19. One of the most remarkable accomplishments of 1199, notwithstanding obtaining the legal right to organize health care in the first place, was its simultaneous commitment to workers' rights and civil rights during its organizing heyday in New York City (the 1960s and 1970s). See Leon Fink and Brian Greenberg, *Upheaval in the Quiet Zone: A History of Hospital Workers' Union, Local 1199* (Urbana: University of Illinois Press, 1989). Though I believe the problem of the devaluation of care work is fundamentally about gender inequality and the politics of how education is organized is fundamentally

about class inequality, in New York City, both are also shaped by racial inequality. Particularly in the health care world, occupational hierarchies sometimes align with racial and cultural difference (though hospitals do not make available the hard data to confirm this), exacerbating the experience of injustice. So when Veronica said that she was treated like a nobody by nurses, it was clear from our conversation that "nurses" sometimes meant "white nurses." The tendency for registered nurses to see nursing assistants as ancillary or nonprofessional personnel often dovetails with powerful cultural and racial prejudices. Therefore, while the Training and Upgrading Fund makes unparalleled opportunities available to allied health care workers and to women in health care, in New York City it also makes unparalleled opportunities available to immigrants and people of color who experience multiple forms of personal and institutional discrimination.

20. Negri, "Value and Affect," 87.

21. The question of release time—allowing workers to be released from work with pay while in a training or education program—makes for a contested issue between unions and employers. Those at the 1199 Training and Upgrading Fund have created more and more training programs offering release time, mostly because the training industry is currently so well funded and hospitals do not have to pay for training or replacement employees out of their bottom line. Nonetheless, as long as education remains an occupational benefit, both its content and form are largely shaped in response to the preferences of employers, not of employees.

22. Michel Foucault, *Discipline and Punish: the Birth of the Prison*, trans. Alana Sheridan (New York: Vintage, 1977).

23. Gilles Deleuze, "Postscript on the Societies of Control," *October* 59 (1992): 5.

24. Luciana Parisi and Tiziana Terranova, "Heat-Death: Emergence and Control in Genetic Engineering and Artificial Life," *CTheory* (2000), www.ctheory.net/text_file.asp?pick=127.

25. Negri, "Value and Affect," 78, 79.

26. Parisi and Terranova, "Heat-Death."

27. And it might make them less productive by traditional measures since talking to patients, as Veronica does, is an activity not included in the job description of nursing assistants and not usually counted as an essential part of their job. See Timothy Diamond, *Making Gray Gold: Narratives of Nursing Home Care* (Chicago: University of Chicago Press, 1992).

28. Jonathan Beller, "Capital/Cinema," in *Deleuze and Guattari: New Mappings in Politics, Philosophy, and Culture*, ed. Eleanor Kaufman and Kevin Jon Heller (Minneapolis: University of Minnesota Press, 1998), 91.