REGULATING AFFECTIVE LABOR: COMMUNICATION SKILLS TRAINING IN THE HEALTH CARE INDUSTRY

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ABSTRACT

This paper assesses the significance of a communication skills training program at a hospital in New York City. Qualitative data – including interviews and observations – are taken from an evaluation of the training program. Rather than focus on outcomes, we analyze the political and economic context that produced this course and how the instructor, curriculum, and participants enacted and transformed it. The course took ubiquitous training strategies – such as flexibility, responsibility, and teamwork – and applied them to the specific process of health care work; a process that our evidence suggests is better understood using the concept of affective labor, as opposed to skills, knowledge work, or emotional labor. The course was, we conclude, an attempt to regulate affective labor, in the sense that regulation simultaneously responds to and produces instability.

INTRODUCTION

This paper emerged out of an evaluation of a communication skills training program in a New York City hospital. During our fieldwork, it quickly became apparent that the course was significant because of its unusual nature: it was addressed to

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allied health care workers – not doctors and not primarily nurses – who were also, atypically, unionized; it was organized in anticipation of increased competition in an industry ostensibly oriented toward the provision of care and public good – an orientation that has been held in some influential quarters to be irreconcilable with market forces (e.g. Arrow, 1963; Parsons, 1951); and its messages were conflicting and ambiguous, such that it could not be fully understood with concepts – such as skill or emotional labor – readily available in sociological literature. In this paper we first describe in detail the political and economic forces that produced this course and the circumstances of our initial evaluation and data collection. In the central, ethnographic sections, we describe how the messages of this course were constructed in the classroom and on the hospital floors (rather than assess whether they were implemented). We conclude that the strategies used in the course are the tools of an *affective* labor process, a concept that we argue captures the nature of service work – at least in this case – more fully than those of skill, knowledge work, or emotional labor. While this course can be understood as a technique for regulating affective labor, it also reached beyond the expected boundaries of on-the-job training and opened up a space for workers to confront the structural causes of poor working conditions.

THE POLITICAL ECONOMY OF HEALTH CARE AND TRAINING

In a now classic work, David Harvey argues that capitalism is dominated – since the political and economic crisis of the early 1970s – by a "flexible regime of accumulation" entailing highly flexible labor processes and markets, heightened geographical mobility of capital, rapid shifts in consumptive practices, a surge in the service sector, increased competition, and the withdrawal of the welfare state (1990, pp. 141–172). This period has also been called "post-Fordist" (Amin, 1994; Jessop, 1994) because of the widespread consensus that it was preceded by a distinct era of "Fordism" (Aglietta, 1976; Gramsci, 1971, Ch. 3) that was driven by the production of durable goods and mass consumption. Harvey points out that the contemporary period is characterized by shifts in industrial organization in which the self-contained corporation is transformed into a network of entities for a higher degree of flexibility. With an accelerated pace of product (including service) innovation, corporations are now able to produce greater variety in order to meet demand at any given moment, thus increasing market competition as well as risk. Anthropologist Emily Martin suggests that ideals of the American corporation resonate with emergent cultural and scientific understandings of bodies and biology as complex and interdependent systems: "The organization is a fleeting,

fluid network of alliances, a highly decoupled and dynamic form with great organizational flexibility" (1994, p. 209). That said, Harvey also points out that there are continuities between Fordism and a flexible regime of accumulation as well as significant variation in the extent to which a flexible regime of accumulation is manifested in organizations, occupations, or employment conditions. As Steven Vallas has suggested (1999), "flexible regime of accumulation" is a potentially rich paradigm for understanding the diversity of workplace responses to political and economic change.

Although the resurgence of the commodification of care and the corporatization of the American health care system correspond to the portrait of a flexible regime of accumulation, changes in this industry have been, not surprisingly, inconsistent; reasoned observers conclude that the entire industry is in a state of "hyperturbulence" (Shortell et al., 1995, p. 131). This is due in part to the fact that this industry never entirely fit the *Fordist* model because of the nature of its product and the historical dominance of professionals (Freidson, 1970; Starr, 1982). The contours of a new political economy are nonetheless evident in the core institution of health care: the hospital. The costs of sending everyone who is sick to institutions with extensive technology, highly paid specialists, and vast ancillary services are not ones that the state or private employers are willing to bear. Hospitals are responding by establishing economies of scale *and* scope to retain their market power, decentralizing the provision of non-acute care to less costly settings, and developing highly-specialized, technology-intensive acute service niches (see discussion in Snail & Robinson, 1998). In New York State, legislation even made it possible for non-profit, voluntary hospitals to own and operate for-profit subsidiaries (McLafferty, 1989).

These changes stem in large part from the government's encouragement of competition – particularly via managed care – as an attempt to control escalating health care costs. Most recently, the federal 1997 Balanced Budget Act (BBA) contained several measures to reduce Medicare reimbursement levels to health care providers and to encourage Medicare patients to enroll in managed care plans. Similarly, under Federal Waiver 1115, New York State received approval in May 1999 to begin mandatory enrollment of 1.5 million New York City Medicaid recipients in managed care plans (State of New York DOH, 1999). New York State also deregulated hospital rates as part of the 1996 Health Care Reform Act (HCRA), allowing private health care insurers to directly negotiate rates with hospitals. New York City has seen a flurry of mergers in reaction to these policy changes, as provider entities uneasily transform themselves into "systems" with the services and bargaining power to effectively negotiate rates with managed care plans (Prinz et al., 2000). The hospital where we conducted our research has increasingly invested in developing ambulatory and outpatient clinics, anticipating

shifts in reimbursement (by state, federal, and private insurers) away from acute and emergency care toward preventive and ambulatory services.

Recent research has shown, however, that evidence regarding managed care's impact on costs is inconclusive (Sullivan, 2001) while only a few mergers among major providers in New York City have actually materialized. The mandatory enrollment of Medicaid patients into managed care was marred by marketing scandals and the withdrawal of commercial insurance plans when the introduction of competitive bidding significantly lowered reimbursement rates (Haslanger et al., 2000; Sparer & Brown, 1999). Meanwhile, Medicaid enrollments declined in the wake of welfare reform (this population joining the ranks of the under – and uninsured) and social safety-net institutions (such as the city's public hospital network) bear the largest share of decreased revenues (Prinz et al., 2000). Thus, the evolution of the health care industry in relation to neo-liberal, pro-market principles is fraught with difficulties.

The role of the state in health care is more complicated than the hollowing out (Jessop, 1994) or chipping away (Pinch, 1997) of the state predicted in discussions of neo-liberal, post-Fordist, capitalism. The enactment of Medicare and Medicaid in 1965 – an encroachment of the state into services and transactions that were once conducted almost entirely under the purview of proprietary providers (Starr, 1982) – made the government the largest single purchaser of health care and guaranteed payment for services (initially at levels controlled by providers). This also created financial conditions hospitable to private development in sectors like health maintenance organizations, pharmaceuticals and technology, and hospitals (Bohland & Knox, 1989). Ensuing attempts by recent administrations to divest the state from its role in health care and turn the provision of health services over to the competitive market have *further entrenched* the state in the everyday affairs of health care operations, e.g. attempts to merely reduce costs have turned, perforce, into the determination of treatment practices (Ruggie, 1992). Clearly, however, the neoliberal state becomes entrenched only when its contradictions necessitate – recent administrations have made no plausible attempts to solve the problem of almost forty million uninsured Americans (NCHS, 2002). The overall lesson from this industry may not be that the state will find it impossible to disengage from the provision of health care, but rather, that distinctions between "public" and "private," which may have been more concrete in the Fordist era, are increasingly nebulous.

This paper examines the role of a workplace training program, in this case communication skills training, in articulating contemporary political and economic changes in the health care industry. This training is also connected to broader changes in universities, community colleges, and proprietary schools. The wholesale transformation of community colleges from transfer to vocational

institutions in the late 1960s and early 1970s corresponds with the timeline of flexible accumulation. This transformation has been criticized for diverting students toward the study of practical skills and attitudinal "resources" rather than transfer courses and a college degree (Brint & Karabel, 1989; Dougherty, 1994). Federal policy since the Nixon administration has routinely focused on reducing the "skills gap" through job training, despite evidence that formal education is not related to productivity (Berg, 1970) and job training is not related to individual mobility (Lafer, 2002). "Lifelong learning" and continuous (re)training have arguably become a cultural and ideological norm, rather than a mere instrumental outcome of economic and industrial needs (see Jansen & Wildemeersch, 1998) and we suspect that the communication skills training we observed is of apiece with these trends.

SETTING AND METHODS

Under the 1996 HCRA New York State legislation, $100 million dollars were allocated for hospital worker retraining over the course of several years (Benson, 1997; Lipowicz, 1996). More recent amendments to the Act have provided additional funding for training. Under Federal Waiver 1115, the federal government approved $1.25 billion dollars in assistance to New York State – of which about a quarter, or $300 million, was earmarked for hospital worker training – to be paid over the course of five years (Lipowicz, 1999). Both sources of funding came with restrictions,[1] but their general purpose was to retrain workers who had either lost their jobs or who would experience changes in the nature of their jobs due to the influence of managed care and increasing competition in the health care industry. The 1199 Service Employees International Union – whose training arm funded our initial evaluation and today represents 210,000 health care workers in New York State – was responsible in large part for negotiating these monies from state and federal officials (Pallarito, 1997) and became both a recipient of these grants as well as the administrator of funds for voluntary hospitals employing 1199 members in the New York City area. This was an unprecedented influx of training funds, and the training departments of hospitals receiving these monies were presented a tremendous opportunity. They also faced significant constraint insofar as courses were to be organized in anticipation of changes entailed by managed care and an accompanying degree of organizational adjustment that, as we discussed, had not necessarily occurred.

The data in this paper were collected for an evaluation of a communication skills training program at a medium-size (about five hundred bed) voluntary hospital in New York City. In addition to providing communication skills training, the hospital

we studied used the influx of funds to provide courses such as computer skills, medical terminology, and foreign language training, as well as support individual workers in formal upgrading and education programs. We observed seven sessions of the on-site hospital training program in communication skills and conducted follow-up semi-structured interviews within six months of the training with twenty-one randomly selected unit clerks, nursing assistants, and nurse managers who had attended the course. In addition, we conducted over fifty hours of observation on several units in the hospital.[2] The course, taught by a former nurse and administrator who retired to establish her own consulting company, was divided into four sub-sections: Anger Management, Team Building, Essentials for Success, and the Power of Attitudes and Professionalism. Registered nurses and nurse managers were given a one-day version of the communication skills course, while two-day training was required of ancillary nursing personnel, housekeepers, maintenance workers, and unit clerks/secretaries. Most of the participants/workers in these classes were minorities and immigrants: 90% of the staff we interviewed for the evaluation identified themselves as black or Hispanic, including respondents born in the U.S. as well as Nigeria, Jamaica, Barbados, and Haiti. The course participants were almost exclusively female and our interview respondents were all women.

The hospital environment and health care industry, in general, is based on a hierarchical arrangement of occupations working under both professional and bureaucratic controls. In this hospital, nursing assistants handle much of the direct care tasks, including changing bedding, cleaning and dressing patients, and responding immediately to patients. Unit clerks have a clerical function vital to the unit; they pass orders between different units and staff, and document unit activities for hospital statistics and analysis. Nurses supervise nursing assistants and manage the care plans for their patients, and filling out paperwork and dispensing medication dominate much of their time. Nurse managers direct the staffing levels, budgets, and quality of care for entire units. In this paper, we focus on the data collected from nursing assistants and unit clerks – by far the largest group attending the communication skills course and the first line of contact with patients on most units. In many studies of the health care industry at the level of policy or organizations, providers and workers are absent, or are assumed to straightforwardly convey institutional and organizational changes to patients. When the effects of organizational changes on the delivery of care or the labor process *are* considered, physicians are usually the primary focus.[3] The qualitative, "bottom-up" nature of our study reveals, however, that "ancillary" caregivers – predominantly nursing assistants and unit clerks – are more than conduits of organizational mandates. Rather, they oftentimes transform organizational messages and directives. Our work is indebted to recent qualitative studies on similar semi-professional health workers, which demonstrate these workers' pivotal role in the administration

of patient care and the functioning of the health care industry as a whole (e.g. Diamond, 1992; Foner, 1994; Henderson, 1995).

The goals of the communication skills course we observed, as identified by trainers and administrators at both the union and hospital, were: facilitate team building; teach staff members how to manage their anger; empower staff and facilitate among them a general sense of their importance to the organization; enhance interpersonal relations among staff and between them and their families; and enhance customer relations. Given these rich and extensive goals, we aimed for the spirit of thick description in the evaluation and described the dynamics in which communication skills training was situated; we did not attempt to strictly isolate the effects of this training program. Our major finding was that absent reform at the levels of organization and industry, the effects of this training on actual work processes and relationships were severely constrained. Nonetheless, we also found that participants enjoyed the course and uniformly expressed respect for the instructor. In addition to understanding the intricacies of health care work because of her experience as a nurse, she is a woman of color and an immigrant with whom many participants could identify and seek to emulate. When the instructor listed her own degrees as an example of success she was greeted in one session by spontaneous applause. It was clear that the course was a break from the pressures of work and allowed the participants the space to express and vent, in a collective manner, their frustrations and difficulties.

COMMUNICATION SKILLS *IN SITU*: RESPONDING TO HEALTH CARE WORK

What follows is not a report of our evaluation; rather, we draw upon the evidence collected (course and worksite observations, interviews) to analyze how this training influences and reflects larger social and economic trends. We concur with Miller and Rose (1990) that "evaluation . . . is something internal to the phenomena we wish to investigate" (p. 4), since evaluation defines success in terms of the criteria of its stakeholders. Rather than assess whether teamwork, for example, was an outcome of the training program, we examine how the meaning of "Teamwork" was shaped by this specific course and setting. First, we describe series of key strategies presented in the course for effective communication and management of workplace problems: flexibility, responsibility, teamwork, and self-management. These strategies, clearly derived from the discourses and practices of a flexible regime of accumulation (exemplified in Martin, 1994 and summarized by Smith, 1997), were given new, specific life in the setting of this particular course and industry. More exactly, we propose that the course was an attempt to adapt these

strategies, or refine them, for the conditions of health care work, specifically the performance of affective labor. We suggest that the course can be understood as a mechanism to regulate affective labor, and use the term regulation in the sense intended by the "Regulation School."[4] We then draw attention to the possible implications of this case for other industries and for training and education as a whole.

Responsibility and Teamwork: Responses to Shortage

Responsibility and Teamwork occupied a central role in the communication skills course. The training instructor started the first day of class, at 8:00 a.m. in a windowless room adjacent to the training department, by positing herself as a role model of success. This was evinced by the flexible character of her everyday work life as a consultant: she exercised control over her work process and had discretion in managing her time. The instructor presented management of one's self and time as dimensions of taking responsibility. Addressing the class, the instructor asked 'do I have more time than you do?' One of students replied 'maybe' – astutely sensing the question was a set-up. 'No,' replied the instructor, 'we're all given the same amount of time – twenty-four hours a day, seven days a week. It's a matter of maximizing time efficiently and effectively.' From the first moments of the training, general principles such as efficiency and responsibility were countered by the most vocal course participants with concrete experiences: examples demonstrating the impossibility of adhering to such principles within the context of their resource-poor work environment. In this case, a participant responded by raising the intractable problem of "shorting," (i.e. understaffing on the hospital floors). The instructor replied colloquially: 'you got to learn to deal with it, girl, or you won't be able to work anywhere!' – indicating that since cost-cutting and reduced staffing levels were universal in the industry, her best choice was to use communication skills as a tool to deal with it.

In another instance, a nursing assistant named Carmen[5] asked: 'what if we don't have supplies? I use my time and dollars to buy supplies!' The instructor replied that Carmen's behavior was sending a 'negative' message: 'you're more than ready to blame management, but usually you're asking to be managed.' In her defense, Carmen argued that if she does not buy supplies on her own, the job does not get done: 'How can we have a grooming[6] without grooming supplies? What should we do, twiddle our thumbs?' The instructor responded 'yes, twiddle your thumbs. That's your choice – behavior that is rewarded is repeated.' The instructor was making a complicated point: by complaining about the lack of supplies rather than making the most out what was available, Carmen was "asking to be managed," yet by buying the supplies, she would be contributing to her own exploitation. In the context of the course, self-management was defined as 'achieving goals based on a sound value system.' In this light, Carmen's willingness to buy supplies for her patients might be viewed as commendable: rather than asking to be managed, she was taking ultimate responsibility for the problems of both the patients and the organization. Instead of praising Carmen, however, the instructor said that her best course of action was, essentially, to let the situation remain unresolved.

The instructor was trying to create some sort of compromise among competing factors: the importance of self-management and assuming responsibility, her understanding of complaining as asking to be managed, and the real problem of limited resources. Yet, at what point do limited resources actually infringe upon carrying out a job responsibly and according to a system of "sound values?" The suggestion that the worker "twiddle her thumbs" positioned her between a rock and a hard place because, most importantly, it potentially compromised the care of the patients. Some workers even reported emotional costs of not having enough supplies. During a unit observation, for example, one nurse clearly felt remorse when she had to refuse patients items that were no longer available – such as dietetic ice cream, slippers, and multiple menu selections – especially when administering care to homeless patients and those without personal resources. Further, it did not improve worker morale that in this relatively non-automated hospital, one of the newest technological investments had been in looming, computerized supply cabinets that dispense supplies only when an employee punches in their identification number, digitally tracking the use of supplies by every single employee on the floor. The communication skills instructor was not able to pose any viable solution to the apparent contradiction between the messages of the course and the material consequences of cost-cutting that pervaded the hospital setting, nor could she be expected to do so, given that the program had been situated by the policies and institutions that created it as a response to change (the invasion of managed care), rather than a venue for identifying and solving organizational problems.

A separate session of the course was devoted to "Teamwork." Communication Skills were presented in this segment as the tools workers use to navigate an increasingly interdependent work environment. Martin describes a flexible worker as someone able to "...risk the unknown and tolerate fear, willing to explore unknown territories but simultaneously able to accept their dependence on the help and support of their coworkers" (1994, p. 214). Echoing Martin, the instructor informed the workers that 'the person who risks nothing, does nothing, has nothing, is nothing. He cannot learn, feel change, grow, love and live. Only a person who risks is free.' But risking the unknown and interdependence coexist uneasily with the occupational stratification and hierarchy in health care organizations: the organization of the working day for most health care workers

follows a highly regimented schema in which hours are proscribed in shifts, with a specified list of tasks that must be completed within that time frame. Workers must adhere to a highly hierarchical employment structure and strict job descriptions that are established by professional organizations, state regulations, and in this particular case, reinforced by the collective bargaining agreements of employers and a powerful union. Staff, particularly lower-level staff, not only had to adhere to such job descriptions but they saw them as their best protection against being over-worked and exploited. In one unit we observed, nursing assistants conducted hearing tests on infants, even though this task was part of the nurses' job descriptions and the nursing assistants had never been formally trained on the equipment. Nursing assistants felt deserted by their union in this situation and the imperative to "come out of description" was a focal point of conflict and passions. In addition, such situations tend to produce mistrust and feelings of resentment among those who already feel "dumped on" at the bottom. Stories of being disrespected by nurses and doctors were constant among the nursing assistants and unit clerks – in the training class, during interviews, and during observations. For them, teamwork was a loaded term since they could not imagine that nurses and doctors would start changing bedpans or coming out of *their* descriptions.

Not only were teamwork and responsibility problematic when considered independently, but in addition, the communication skills course, perhaps unwittingly, presented these two strategies as incompatible. For instance, the course stressed the need for all workers to take responsibility for the medical well being of patients, even if the price was sacrificing inter-staff relationships. The instructor told one unit clerk that she was obligated to go over the head of a nurse or doctor if they forgot to follow through on a medical order that she conveyed to them. Another clerk – and student nurse – then told the instructor that she had been reprimanded for correcting a nurse's recording error regarding a patient's medication.

The mixed messages conveyed about the relationship between responsibility or self-management and teamwork are in part the product of the ambiguities of health care work: the medical well-being of patients is a condition for which, while prized above all, there is no uniformly accepted definition, just as there is no firm definition of "quality care." They are also due to the health care industry's fixation on liability. Immediately after the session on teamwork, during the session on "Essentials for Success," a PowerPoint slide revealed the title "Learn to Swim with Sharks." The need to trust and depend on co-workers was now juxtaposed, without commentary, with the message that one must vigilantly guard against co-workers – the vicious sharks. This idea made perfect sense to the participants in the course because they are constantly "covering" and protecting themselves. For example, the instructor discouraged Carmen from buying and providing supplies because she might be liable to accusations of favoritism or discrimination

(i.e. lawsuits), on the basis of disrupting 'prior practice.' Health care workers and organizations feel that they are under constant surveillance, be it from accrediting agencies or nosy family members (see Foner, 1995) and workers are continually aware of their own exposure to personal risk, as when nurses file "protest of assignments" against short staffing to protect themselves from legal liability. In this respect, the course emphasis on individual responsibility simultaneously downplayed the structural causes of resource-poor, stressful work environments while it underpinned the fixation on liability that tends to thwart teamwork.

If there was a consistent message underlying Teamwork and Responsibility, it was that the workers, individually and as a group, were responsible for producing the cooperation necessary for providing quality care. Neither the course curricula nor the nature of the course presentation indicated that the hospital could or should be expected to produce the conditions necessary for cooperation. The participants' proposed solutions to conflict, such as more appropriate fulfillment of supplies or increased staffing, were treated as unrealistic; their complaints about being disrespected by their superiors were portrayed in the training as, if not their own fault, then something that they could change – if they appropriately demonstrated responsibility, teamwork, and self-management.

It All Comes Down to You: Control and Development

As the instructor put it, 'the most fertile area for greater control lies within the self.' In the course sections entitled "Essentials for Success" and "The Power of Attitudes and Professionalism" objectives included developing personal definitions of success; demonstrating increased self-awareness and self-management effectiveness; and discussing the impact of attitude and professionalism on personal, professional and organizational success. In order that the course not be confined to success at work, the definition of success was presented as relative and individual-specific. The message here was not about particular ends, but was focused on the *process* of perpetual growth and the optimization of the individual as a productive member of the hospital workforce as well as society at large.

Once workers established their respective personal goals, the instructor taught that reaching them depended on their ability to control their 'unconscious' or 'subconscious' mind. The conscious mind was defined as one's conscience, i.e. the ability to know right from wrong or 'will power.' The unconscious or subconscious mind was defined as one's 'personal slave': its sole concern is the individual, and it is responsible for creating and reinforcing one's own personal (and thus – presumably – highly subjective) reality. The message here was that control lies in the ability of the conscious mind to will positive thoughts

against its obsequious alter – the quintessential "power of positive thinking." The instructor pointed out that the unconscious mind is likely to be deceptive; as such, she stressed the importance of 'counting to ten' and taking a reflective moment in order to question the basis of one's emotions before translating them into action/reaction. This, the instructor noted, is necessary because people often misperceive events or see conflict where there is none. When faced with questions and counter-examples by attendees that highlighted the contradiction between personal responsibility and organizational limitations, or between flexibility and exploitation, the instructor consistently returned to the theme of the self-fulfilling nature of the unconscious and the importance of positive thinking. One worker objected that it sounded like the instructor was advocating 'self-hypnosis.' In this context, the instructor advanced a possible solution to the problem of supplies mentioned earlier: 'if your positive attitude and professionalism increased, then maybe the hospital's market share and revenue would increase, and then the organization could afford supplies – it all comes down to you.'

Not only did the Communication Skills course address cognitive strategies (in simplified form) to achieve success, it also appealed to the biological benefits of maintaining a low stress level in one's work. This issue was raised during the most time-consuming segment of the course on "Anger Management." The course taught that uncontrolled expressions of anger were harmful to the body system at large, and participants were provided with countless examples of the detrimental effects of stress on the body, including high blood pressure, cancer, heart disease, and other significant health problems. This not only appealed to the workers' sense of wanting to protect their own well-being, but also to their technical knowledge as health care workers. Semi-structured interviews with course attendees (conducted within six months of their training) revealed that the biophysical aspects of stress were among the most well-retained themes. The training also focused on body language as a means of expressing anger and the importance of maintaining control over one's body in order to communicate effectively. The course played on the concerns of workers that *their* health may be jeopardized by the stresses of their work and encouraged them to assume responsibility for and control their anger.

One of the instructor's general cautionary tales about the communicative power of body language stemmed from her own experience when she was a director of nursing. She recounted to the class how an upset nurse had appealed a poor mark on one of her employee evaluations in which her immediate supervisor criticized her for not making eye contact during their interactions. The instructor recalled that she realized the problem was that the nurse was from an 'Asian' country where – as in her own Caribbean country, the instructor asserted – people were 'programmed' not to make eye contact with their superiors. This hospital, like others

in New York City, employs an international workforce, thereby intensifying the potential for conflict and injustice, particularly when race and ethnic differences align with hierarchical ones. Although in this case the nurse's anger was presented as legitimate, the moral of the tale was that people need to be more aware of cultural differences. That is, one's first impulse should be to expect that behavior which may seem offensive and degrading is, in fact, only due to culturally-based misunderstandings. The logic of turning conflict into difference is "totally opposed to employer traditions, to the culture of control, to social relations of labor, to the technical apparatuses inherited from Fordism . . . where an organization of labor based on racism and fragmentation is showing itself to be in contradiction with productivity and quality" (Lipietz, 1988, p. 38). The instructor's anecdote was also linked to the message of self-improvement: part of becoming a good, healthy, and complete person is learning about other cultures and ways of life and adjusting accordingly.

Bringing it Home: The Boundaries of Job Training

Given the conflict-prone nature of this workplace, as well as the potential limitations of communication skills as a response to this conflict, it seemed that in the eyes of the participants, the legitimacy of the course hinged on its relevance to their personal lives and physical/mental well-being. Our data did not allow us to assess whether the participants actually applied lessons from the communication skills class to their personal lives. Nonetheless, a few interviewees said that they discussed the program with their husbands and class participants regularly brought up examples from their personal lives, as did the instructor. During the lunch break of one class, one of us spoke with an nursing assistant who had recently been transferred to a psychiatric unit and was emotionally exhausted from dealing with altered and sometimes abusive patients. She said she had received no particular training in dealing with these patients and that she would come back to the communication skills course again and again if she had the chance. The course was the only space she had been given to pay attention to herself, to recover from the demands of work.

The instructor clearly saw this aspect of the course as one of its selling points. In an interview with the researchers, the instructor indicated that her goal in communication skills training is to empower the staff to self-assess their attitudes and behavior so that change is enacted from within. This pedagogy is informed by her belief that sustainable change requires personal motivation and that good communication skills can be learned. As such, she said her curriculum is not taught in the traditional way, which makes effective communication an obligation to the organization or to another individual; rather, it understands communication

as an expression of one's self. Besides drawing upon examples from her personal life to illustrate various communication techniques, the instructor was explicit about her hopes that the course would be useful at home. During a break she pointed out to a small group of students that work cannot be separated from home because 'disruptions' at home lead to disruptions at work and vice versa. Furthermore, during one session she noted that 'in life, we have jobs that we don't consider jobs,' meaning that the housework, cooking, and cleaning the participants do in their own homes should also be validated as a kind of work.

While not necessarily the main focus of the course, this aspect – that at the level of curriculum and practice, the course was intended to address non-work-related issues – is worth noting, particularly since the logic of the funding behind the course was very narrow: to prepare workers for the organizational changes that would accompany the penetration of managed care. The course depended on its resonance with wider personal relations and portrayed a kind of continuity between the work done on the job and that done at home. One of the nurse managers remarked to us that she asked her nurses to treat patients as family members. This rang hollow, however, because a message of the communication skills course was not to liken patients to family, but to liken family to patients. Indeed, at moments it appeared that the workers were being asked to adopt a general stance toward life that would, almost incidentally, help them at work.

BEYOND SKILL: TRAINING FOR AFFECTIVE LABOR

To understand the significance of this course, we were drawn to two important sociological approaches that immediately appear relevant to the case of communication skills training. The first approach would likely argue that training in soft, emotional skills like "communication" abets the deskilling process, particularly of female workers. The second might see communication skills as an outcome of the change in labor from an economy based on the production of goods to one based on the production of knowledge. We propose that the concept of skills is no longer germane to this kind of training and that theories of a knowledge society or economy fail to fully address affect-based work.

In her well-known study of work and training among airline stewardesses, Arlie Hochschild argues that Harry Braverman's thesis (1974) about the tendency of monopoly capital to separate the conceptual aspects of work from its execution, thereby deskilling manual workers, applies to emotional workers as well (Hochschild, 1983, p. 119). The airlines' programs to train stewardesses to control and produce emotions are a "new development in deskilling. The

'mind' of the emotional worker, the source of ideas about what mental moves are needed to settle down an 'irate,' has moved upstairs in the hierarchy so that the worker is reduced to implementing standard procedures. In the course of offering skills, trainers unwittingly contribute to a system of deskilling" (Hochschild, 1983, p. 120). Like Braverman, she argues that deskilling might produce the specialization and increased skill of a minority of workers (particularly among those who become the trainers), but in the division of labor as a whole most workers are displaced into unskilled jobs.[7] Hochschild also argues that when the airline industry experienced increasing competition after deregulation in the 1970s and needed to decrease costs in order to regain market shares, ticket prices and not service came to distinguish airlines from one another. This prevented the effective practice of emotional labor because of an increased passenger-to-stewardess ratio, enlarged workloads, and subsequent intensification of the work process. As a result, stewardesses grew "detached" from their work and the "transmutation" of private emotional exchange into commodified relationships failed. She is unclear about whether this work speed-up intensifies or neutralizes the possibilities of deskilling.

In our case, deskilling is not so easy to identify and the effects of work intensification point toward the inadequacy of emotional labor as a concept. It is not self-evident that communication skills represents a rationalization and centralization of control over emotional labor (i.e. deskilling). During the communication skills course, a worker reacted negatively to the instructor's use of the word 'proactive' in relation to developing better communication skills. He said it was a 'pet-peeve' of his and that he preferred the word 'creative.' The instructor strongly resisted this amendment. She argued that there was 'no need to create anything' but rather, to 'just impose standards.' The course also emphasized that a professional attitude was a learned behavior. This behaviorist conception of learning, coupled with the (attempted) standardization of communication patterns, suggests a deskilling process. On the other hand, the very existence of courses in communication skills reveals that these kinds of competencies are perceived as necessary elements of staff development because they may mitigate the by-products of cost-cutting such as exposure to lawsuits, angry patients and families, understaffed work sites, and limited resources. Furthermore, the evidence in this particular case suggests that the implementation of communication skills training opens up discussions of workplace problems that derail attempts to standardize emotion and communication.

In the health care industry, at least in New York City, the process of work intensification seems to correspond to an increased emphasis on soft skills – the inverse of what Hochschild describes. Communication Skills training suggests that the need for individuals to take responsibility for managing interactions has

grown because of increased patient contact and pressurized work settings – options for how to manage these interactions have been expanded, not proscribed (see also Wouters, 1989). Furthermore, Hochschild blames the speed-up for a "failure" of emotional transmutation – there is no time for deep acting. This is analogous to arguing that the health care industry's increasing fealty to the business rhetoric of cost/benefit analysis and the intensification of competition are responsible for deterioration in service and an absence of care in this industry. The observation that health care workers may lack time in which to provide care, however, is distinct from the representation of a romanticized past in which female nurses (or stewardesses) had the time to "really" care for patients. The proliferation of training in these kinds of "soft" skills is welcome recognition that managing patient and staff relations is not innate to female workers. Caring, it must be remembered, is both a personal emotion and a construct of historical and social factors. Because the meaning and experience of care mutates, it becomes difficult to pin down the kind of care that has been ostensibly lost and impossible to bring back. We argue that care has not been lost, nor has the transmutation of emotions failed; rather, a new language is needed to characterize what these kinds of workers do and its significance.

The inadequacy of skill (and thus deskilling) as a concept has already been analyzed in relation to knowledge workers in a post-Fordist economy. Aronowitz and DiFazio (1994) argue that the problem with applying Braverman's thesis to contemporary labor processes is that skill has been "decentered": it is increasingly peripheral to the production process. Instead, hierarchies in the labor process now revolve around "knowledge" – "intellectual, abstract (head separated from hand), theoretical, and scientific" (p. 102). Skill, including manual tasks requiring dexterity and tacit knowledge necessary to carry out tasks, is increasingly incorporated into new technologies and automated. The "remaining labor process" is then increasingly based on knowledge of an abstract, scientific character that is – by extension – resistant to automation. That said, should workers who are exposed to "soft" training courses be characterized as knowledge-workers; experts in the complicated arena of emotions, psychology, and the body? Obviously not. The two-day communication skills course we observed is qualitatively different from the abstract, theoretical and scientific work conducted by research doctors, information systems planners, bond traders, and the like. This course drew more directly upon a general culture of self-help and contemporary management ideologies, and although it may be possible to understand and study emotions as an abstract or theoretical subject – indeed this is the basis for much of psychiatry and psychoanalysis – clearly a two-day communication skills course serving an immediate triage function does not incite the sustained examination of emotions and expertise characteristic of knowledge work. In fact, those aspects of a nursing assistants' work that might readily be considered "knowledge"– responding to patients in a medical crisis – were not discussed in the communication skills course. This course did not train workers in a new skill, nor in a body of knowledge, but rather, trained them in affective labor.

Rather than focus on the distinction between emotional labor and manual labor, we suggest that service work – at least as constructed and presented by this Communications Skills class – is *affective*. Michael Hardt defines affective labor as the "constitution of communities and collective subjectivities" (1999), but in our observation, affective labor is directed toward the production of situations and interactions, paying relatively little mind to whether participants in these interactions internalize the definitions and meanings of those interactions. By contrast, the concept 'emotional labor,' like Hardt's definition, connotes the production of internalized states and feelings. In our terms, affect is the substance of interaction and communication; it is a power to modulate bodies and relationships, or, as Antonio Negri has simply defined it: the "power to act" (1999).[8] In this vein, the term 'affective labor' captures the shift to a more superficial and routinized form of work and training, which Hochschild documents with regard to the airline industry (but characterizes as a failure or loss). As a conceptual framework, 'affective labor' incorporates the cognitive *and* corporeal dimensions of acting and managing interactions, which were apparent in the communication skills class, especially when it emphasized the power of conscious will power, "counting to ten," or altering body language. Furthermore, the concept provides an alternative analytical framework to that of care and emotional labor since the latter is limited both by its apparent lack of connection to the kinds of interactions that have been normalized in formal health care settings (which are far from caring) and by its frequent affinity to essentialized notions of gender.

The ideologies and values suggested by the communication skills course drew upon a well-established discourse of self-help and individualism and encouraged participants to locate the greatest possibilities for control and change within the self. However, several aspects of the Communications Skills course indicate newly emerging trends in work and training, especially in contexts in which affect is the main product of the labor process. The course, as we have shown, took values and skills that are indispensable in an intensified, cost-conscious, and stressful labor process and presented them as healthy habits to be carried out in other settings; it assumed a continuity between work and home. Moreover, the course almost exclusively placed the responsibility for producing the cooperation necessary for work in the hands of the workers. This is not a Taylorized workplace, where work is systematically organized and planned by management to generate the highest level of productivity at the lowest cost. Rather, as expressed by this training class, the organization of work is left untouched and fractured, and the

workers are asked to make it productive. Of course in the health care industry there are periodic attempts to re-engineer work as well (which are complicated by the domination of professions) but the communication skills course exhibits a response from another angle to the constant problems of consent and worker productivity.

REGULATING AFFECTIVE LABOR

Although it is possible that this course was an abbreviated instance of a more sophisticated management strategy, the logic of regulation theory as well as that of qualitative research methodology, suggests that specific cases merit analysis, in part because of their capacity to generate social change. Michel Aglietta, the pioneer of the "regulation school," which coined the phrase flexible regime of accumulation and inspired the term post-Fordist (see Jessop, 1990) remarked, "to speak of reproduction is to show the processes which permit what exists to go on existing. In a system whose internal relationships are in course of transformation, not everything does continue to exist . . . When actual social systems are studied, historical experience confirms that *transformation means rupture, qualitative change*" (Aglietta, 1976, p. 12). Such a methodology suggests that an examination of actual social systems and specific events, as we have done here, is interesting not because they are (or are not) representative of larger social processes, but because these seemingly isolated events are in fact the locations of rupture and producers of qualitative change.

For instance, the regulation school was devoted to demonstrating that economic relations do not simply reproduce themselves; capital accumulation occurs in disproportion and conflict (Jessop, 1990, pp. 170–171). Out of this conflict and disproportion are born regulating mechanisms – institutions and procedures – that are necessary to maintain or create stability. These methods of regulation, however, respond to *and create* problems that need regulating such that their impact is undetermined and open-ended. If we think of communication skills training as a method of regulation, as a response intended to minimize workplace strife in a volatile industry in the midst of tremendous change, we see that its reach – into the workers' personal lives, into discussions of supply and personnel shortages, into the problems of respect – may have been excessive from the perspective of merely minimizing workplace conflict. This is evident in the fact that it created a new space for workers to discover and discuss workplace conflicts and grievances, cathect with each other, and consider possible responses to organizational and structural problems. This understanding of the Communication Skills course avoids the perspective of functionalism, from which the Communication Skills

class appears as a mechanism that serves solely and successfully to resolve workplace conflict or as an ideological tool that manufactures consent[9] amidst the contradictions and troubles of the health care system.

Despite valiant attempts, the course instructor was simply unable to resolve the contradiction between the messages of the course and the organization of the labor process; she may even have heightened awareness of such conflicts and generated a new sense of injustice among workers. The message that Carmen should respond to the lack of grooming supplies by twiddling her thumbs, for example, encouraged a subtle form of protest while it also admitted that responsibility and teamwork alone would not solve such problems. Similarly, the message 'it all comes down to you' contains an apparently realistic assessment that the organization of work will not change if left to management and unions. Our observations of the course speak to the potential "informal capacities of hourly employees" to structure their work, which Vallas (1999, p. 95) argues is neglected in much research. The course, in the spontaneous and momentary interaction between instructor, participants and curriculum, offered a set of strategies – for managing the self and interactions with others (i.e. affective labor) – that were intended to compensate for the fractured organization of work. In this sense, it was an attempt to regulate affective labor, but it simultaneously expanded the boundaries of affective labor, introducing new ideas and strategies and opening the door to a collective assessment of the inadequacies of the conditions of work.

Although we understand affective labor to be a significant aspect of a flexible regime of accumulation, many of the mantras of this course (self-control, responsibility, identification with the company, teamwork) are not new. The disciplining of labor power in modern society involves habituation; i.e. broad training – from school to family – to condition workers to the capitalist mode of production. Michel Foucault has argued that the historical moment of the disciplines is "the moment when the art of the human body was born, which was directed not only at the growth of its skills, or at the intensification of its subjection, but at the formation of a relation that in the mechanism itself makes it more obedient as it becomes more useful, and conversely" (Foucault, 1995, pp. 137–138). The valorization of the body and the "distributive management of its forces" occurs through continuous education and training (Foucault, 1990, p. 141). This communication skills class is in part consistent with a history of education and training as discipline. But the communication skills class we observed was not solely a method of creating obedient workers, forcing them to accommodate to conditions of work not in their control: its messages and products were too ambiguous for that.

NOTE ON SELF-IMPROVEMENT AND THE FUTURE OF TRAINING

Affective labor is predicated on the expansion of powers, on the increasing ability to act, modulating bodies and interactions. This course, fittingly, assumed that participants aimed for self-improvement. When during our course observations a participant remarked that she was content with her job and life, the instructor had no response prepared – it undermined the basis of the course. Although this course could not resolve the contradictions between resource-poor work environments and the demand for personal responsibility (raised continually by participants), it did attempt to divert attention from the structural problems that give rise to discontent and channel dissatisfaction into efforts at self-improvement. For example, the course suggested that the conditions in the health care industry might only get worse and that communication skills were necessary to protect the hospital and jobs. After all, these workers' somewhat secure positions as unionized hospital workers – who are well-paid by national industry standards, receive benefits, and above all, have varied levels of job security built into their contracts[10] – produces a level of satisfaction with the status quo and protection from capricious authority. In this way, Communication Skills training can be seen as an ideological subversion of labor power and the security that accompanies it. The unions, who participated in the allotment of funding to this course, may be paradoxically complicit in this subversion. As Harvey has noted, in a flexible regime of accumulation, work is regulated by a system in which Labor and Management compromise to control and manage the workforce (1990, pp. 133–134). It seems to us that training, particularly when it perpetuates feelings of constant precariousness and lack (of qualifications, of skills, of self-control), may be a good basis for control.[11] Given that this compromise over the nature of work exists in New York City's health care industry, the training class could be interpreted as an attempt to secure consent for this arrangement, which it undoubtedly was. But in so doing, it also became the focal point for struggle over and articulation of the responsibility of workers in this hospital and industry. One might say the struggle over work was, in this instance, displaced from the point of production, and found a home in the training course.

Such an observation is important when one of the most visible expressions of a flexible regime of accumulation is the implementation of continual and lifelong education. Training and education have always been regulating mechanisms, but this case may be a harbinger of future training and educational forms and the role they will play in work and organizations. In this case, an influx of training dollars produced an economic niche for trainers – often sub-contracted, self-employed consultants – who produce organization-specific, flexible pedagogical packages.

This educational form can be characterized by a lack of integrated mechanisms to educate the educators, of standard curriculum, of recognized degrees, and of stages that legitimize the accumulation of expertise. The extent to which such forms will persist, even when such specific institutional circumstances as we observed are absent, is an important research question. Furthermore, the effect of this form of regulation on the lives of workers, particularly those in the growing, unstable labor markets of service work, is crucial to disentangle.

NOTES

1. The state funding supported only job-related training, not general education or degree preparation (Benson, 1997); the federal waiver monies were given only to hospitals which derived 20% or more of their annual admissions from Medicaid (Pallarito, 1997).
2. Ten of the interviews were tape-recorded and the remainder of the interviews and observations were recorded in field notes. In this paper, we have placed all quotes from the interviews and field notes in single quotations (").
3. One exception is Brannon (1994). The literatures on physicians and recent political/economic changes in the conditions of their work are too vast to thoroughly cite here: it includes the debates on proletarianization, deprofessionalization, and corporatization (see Light & Levine, 1988 for a review, but Freidson, 1970 set the stage for these debates); studies of medical education (e.g. Mizrahi, 1986), and of course, sociological studies (often historical) of the fundamental dynamics between professions and markets (e.g. Abbott, 1988; Larson, 1977; Starr, 1982).
4. Michel Aglietta in France pioneered "Regulation school theory" with the publication of *A Theory of Capitalist Regulation* (1976). Jessop (1990), in a comprehensive review, identifies seven branches of regulation school theory.
5. A pseudonym.
6. Grooming refers to activities such as combing or styling hair, shaving, brushing teeth, or washing. Nursing assistants are expected to do this for or assist patients with these activities.
7. Although, as Attewell (1987) has contended, the empirical validity of the deskilling thesis depends in large part on the unit of analysis one examines for change – the individual worker, the occupation, an industry, or the economy as a whole.
8. We are indebted to Patricia Clough for first drawing this work to our attention. See Clough (2001) for a discussion of the links between theories of women's work, the cultural studies of science, and contemporary socio-economic transformation. See also Wissinger (2002) for a related analysis of the fashion industry.
9. In Burawoy's classic (1979) study of consent, it is true that consent is generated spontaneously at the point of production and is not imposed from without (by management or some sort of training and indoctrination). Nevertheless, consent is produced. The training we observed seems to be premised on the fact that consent is no longer spontaneously generated at the site of production, but the course itself is also incapable of generating that consent – perhaps because it is not spontaneous.
10. See Fink and Greenberg (1989) for a history of the extraordinary accomplishments of Local 1199 on behalf of workers.

11. See also the critique in Gottschalk (2000, pp. 114–136) of the assumption – shared by most labor and business leaders, she argues – that health care costs present a major threat to the competitiveness of the U.S. economy.

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