

**Finding Dignity in Dirty Work:  
The Constraints and Rewards of Low-Wage Home Care Labour**

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The aging of the population in the U.S. and elsewhere raises important questions about who will provide long-term care for the elderly and disabled. Current projections indicate that home care workers—most of whom are unskilled, untrained and underpaid—will increasingly absorb responsibility for care. While research to-date confirms the demanding aspects of the work and the need for improved working conditions, little is known about how home care workers themselves experience and negotiate their labour on a daily basis. This paper attempts to address this gap by examining how home care workers assign meaning to their “dirty work.” Qualitative interviews suggest that home care workers have conflicted, often contradictory, relationship to their labour. Workers identify constraints that compromise their ability to do a good job or to experience their work as meaningful, but they also report several rewards that come from caring for dependent adults. I suggest workers draw dignity from these rewards, especially workers who enter home care after fleeing an alienating service job, within or outside of the healthcare industry.

## **Finding Dignity in Dirty Work: The Constraints and Rewards of Low-Wage Home Care Labour**

The aging of the “baby boom” generation in the U.S., the UK and other Western countries has spawned a cottage-industry of policy makers, scholars, and activists all concerned about the crisis in long-term care for the elderly (Stone and Weiner 2001). Fueling much of the concern is the question of who will care for the elderly, given that many families no longer live geographically near one another or—if they remain close by—cannot care for a parent or loved one because of pressing demands of career and children (Harrington Meyer 2000).

In the U.S., these realities are expected to translate into an unprecedented growth in the home care industry. The Bureau of Labor Statistics estimates home care aides belong to one of the fastest growing occupational groups (Bureau of Labor Statistics 2004). If past conditions hold, those who enter the occupational field of home care will be unskilled, untrained and underpaid (Crown, Ahlburg and MacAdam 1995, Stone and Weiner 2001).

While research to-date confirms the demanding aspects of the work and the need for improved working conditions (Crown 1994, Hollander Feldman 1994, Stone 2001, Yamada 2002), little is known about how home care workers themselves experience and negotiate their labour on a daily basis. I address this gap by examining how home care workers navigate a job that is emotionally and physically demanding, stigmatized, and offers few material rewards. In short, given the obvious constraints of the job, how do workers themselves assign meaning to their “dirty work?”

Qualitative interviews with 33 home care workers (also known as “aides”) and direct observations of home care labour suggest that workers have a conflicted, often

contradictory, relationship to their work. Predictably, home care aides feel constrained by the high demands and few material rewards associated with their care. Specifically, workers identify three broad work constraints that compromise their ability to do a good job or to experience their work as meaningful: Overwork and added responsibilities; increased risk; and the physical and emotional strain of the job. While these represent significant constraints, workers interviewed also describe clear rewards that come from caring for another person. Rewards stem from three main sources: Practical autonomy on the job, especially relative to prior work in the service sector; skills building; and doing dirty work. I interpret these rewards as key mechanisms through which aides import dignity into a stigmatized and relatively invisible occupation.

Dignity has intrinsic value for the worker, but it also serves to mediate the obvious constraints of poor pay, job insecurity and emotional/physical strain that often accompany paid carework. Although in the long run, the sense of dignity may not prevent worker turnover or burnout, in the short term dignity keeps workers on the job. These findings support recent evidence within the sociology of work and occupations suggesting that workers find ways to maneuver and manage risk within the constraints of the new economy (Smith 2001). Given that the healthcare industry generally, and home care services specifically, comprise a significant portion of the growing service sector in the U.S. and elsewhere, we must understand how workers manage the constraints of their employment and to what extent they craft a sense of ownership, satisfaction and dignity on the job.

## Labouring in Home Care

Home health is a growth industry, especially in the areas of personal care and homemaker services (Bureau of Labor Statistics 2004, Stone and Weiner 2001). Unlike institutional care (i.e. nursing home or convalescent care), home care in the U.S. is an amorphous industry composed of a complex array of publicly funded, not-for profit social services and for-profit agencies (Benjamin 1993, Stone and Weiner 2001). In California and in most of the U.S., both skilled and unskilled providers work in home care. Public health nurses, home health nurses, and registered nurses work as skilled providers, usually tending to patients for a limited period of time after a stay in the hospital. These workers tend to work for a hospital, Health Maintenance Organization (HMO) or agency, providing hands on medical care to clients, such as post-operative care, changing catheters or administering IV drugs. Pay and benefits are relatively high for this professional group. Home health nurses, for example, receive a median annual income of \$45,890 (Bureau of Labor Statistics 2004).

Unskilled providers working in home care include personal home care aides and home health aides. Home *care* aides—the subject of this study—generally work on their own, with only periodic supervision from a nurse or social worker. As a result, aides are strictly limited to non-medical care of clients. Generally, they provide housekeeping and personal care services, such as bathing, dressing, meal preparation and companionship. Home *health* aides, in contrast, tend to work directly with a registered nurse as she visits clients in their homes. Neither position—home care aide or home health aide—requires formal general education or medical training, although some agencies require CPR certification, evidence of basic first aid skills, or other minimum qualifications. Aides

may also opt (and are sometimes required) to train as a Certified Nursing Assistant (CNA), which amounts to about 150 hours of training and competency evaluation (Ong et al. 2002).

The pay of home care workers varies based on region, the employer and whether the employees are unionized. The median hourly wage of a home care aide in the U.S. is \$7.81/hr, with the lowest 10 percent earning less than \$5.90 an hour and the highest 10 percent earning more than \$10.67 an hour (Bureau of Labor Statistics 2004). Recent labour victories in California, New York and Illinois represent an important shift in bargaining power of home care workers in the U.S. For example, in California, wages for state home care workers rose to an average of \$9.00 per hour in 2002 after unionization, from a wage that hovered around \$7.00 an hour only two years earlier. While these changes reflect a significant increase in pay, entry-level earnings still fall below the federal poverty level and in many places, like California, the pay fails to constitute a living wage (Howes 2002; Ong et al. 2002). Benefits such as health insurance or retirement pay are rare, especially for part-time workers (Ong et al. 2002).

The lack of standardized pay, health benefits and overtime compensation for home care workers in the U.S. stems from confusion and ambivalence—on the part of the state, workers and employers alike—about whether the act of caring for someone in their home qualifies as waged labour. For example, the Fair Labor Standards Act (FLSA), initially passed by Congress in 1938 and amended in 1974 to include domestic workers, continues to exempt certain types of domestic caregivers from the protections of the Act, namely minimum wage and overtime pay. Although nurses and even housekeepers are protected by the Act, most home care aides are exempt because they are seen as

“companions” to their elderly or disabled clients (Biklen 2003). Although workers have begun to challenge this narrow interpretation of the FLSA, they nonetheless continue to provide care under highly variable conditions, depending on where they live, how they are employed and whether unions have succeeded in organizing workers in the area.

### **Method and Description of Sample**

This research is based on a grounded theory approach (Glaser and Strauss 1967, Strauss and Corbin 1990) to qualitative data collection and analysis. Data are drawn from a yearlong qualitative study of home care services in Central City, California, a medium sized city with approximately half a million residents. In-depth interviews were conducted with 33 home care workers: 23 work for a state funded social services agency, California Home Services (CHS) and 10 are employed by a private agency, It’s For You! home care. Particular emphasis is placed on CHS workers because the program is the country’s largest state funded home care employer, with just over 200, 000 workers (Schneider 2003). Central City, California Home Services (CHS), and It’s For You! are pseudonyms used to protect the confidentiality of study participants. Written and oral consent were obtained from all respondents.

In order to ensure validity of results, the interview data were triangulated with on-site observations of home care (approximately 30 observations), union meetings (2), worker trainings (20), new employee orientations (2) and worker appreciation ceremonies (2). In addition to interviews with 33 home care workers, I interviewed nine public health nurses, three county social workers and five agency administrators/proprietors, all of whom work in home care in Central City. Permission was granted by both the state agency and the private home care company to do the research, although I was restricted

from formally recruiting and interviewing elderly or disabled clients (informal questioning was permitted).

Observations of home care “on-site” took place in two ways: During site visits with public health nurses and in conjunction with interviews of home care aides. For six months, I shadowed public health nurses as they visited elderly or disabled CHS clients with escalating health problems. During each site visit, I introduced myself to clients and home care workers as a sociologist learning about home care. Nurses generally conducted two or three home visits a day, each one lasting between one and two hours. “Jotted notes” (Lofland and Lofland 1995) were taken on site and then expanded into full fieldnotes at the end of each day of observation. On a few occasions, on-site observations with the nurses led to a follow-up interview with a home care aide.

More often than not interviews with home care aides were secured at caregiver trainings, orientations or union meetings. After gaining permission from the event organizer, I announced my research to the room and asked for study participants, sending around a sign-up sheet for those interested. These events yielded the 23 interviews conducted with CHS (state employed) workers. Although as many as twenty-five caregivers would sign-up for interviews during a given meeting, most declined to be interviewed on follow-up, even though I offered a \$20 stipend to each study participant. It’s For You! (private agency) workers were recruited over the phone from a complete list of home care workers obtained from the agency and from flyers posted in the agency office. Of the approximately thirty active aides on payroll, ten agreed to an interview.

Home care workers were interviewed in client homes, their own home or a public place. When I interviewed home care workers in client homes, an elderly or disabled

client was usually present, although in most cases the client was asleep in another room or did not appear sufficiently mentally competent (or interested enough) to follow the conversation. Written and oral consent were obtained from workers prior to the interview. More often than not, caregivers generously opened up their homes (or places of work) to me; many spent time giving me a tour of their home or “workplace.” Interviews with home care aides lasted anywhere from one and a half hours to three hours, depending on the location. Interviews with caregivers “on the job” lasted anywhere from 3-5 hours, as part of the time was spent observing caregivers as they tended to clients or as they completed household tasks.

After transcribing all interviews verbatim, data were analyzed using EthnoNote, a Qualitative Data Analysis (QDA) software tool that helps to organize, search and sort data by code. Although the interview sample yielded a wide variety of caregivers, with a range of motivations and levels of commitment, the fact that I sampled caregivers from voluntary trainings and orientation meetings means that workers who take seriously their care responsibilities are over-represented. That said, workshops attract caregivers through incentives of free dinner, gifts, or money, which suggests the pool of caregivers might represent a somewhat broader range of caring commitments and motivations among this population of workers.

Home health aides discussed in the paper vary in the number of hours they work, their work experience and training; and the extent to which they are the primary (as opposed to secondary or tertiary) caregiver for a client. The hourly wages of workers interviewed ranged between \$7.25 per hour and \$9.25 per hour. The participants all live and work in Central City, California and range in age from 21 to 70 years. The median

age of the home care worker is 52 years. The racial composition of the sample of home care workers is as follows: 36% (12) White, 27% (9) Black, 18% (6) Latino, 12% (4) Asian and 6% (2) Other. Of home care aides interviewed, 82% (27) are female and 18% (6) are male. The sample roughly mirrors the general population of home care workers in California and the U.S., with a high percentage of women and an overrepresentation of racial and ethnic minorities (U.S. Bureau of Labor Statistics 2003). The breakdown of clients by race/ethnicity matches the breakdown of home care aides: Of the 33 aides interviewed, only four were caring at the time for a person of a race or ethnicity different from their own.

### **Literature Review: Dignity at Work**

Recent scholarship in the sociology of work and occupations focuses on the innumerable constraints facing low-wage workers in the new capitalist economy (Ehrenreich 2001; Hodson 2001; Munger 2002; Sennett 1998; Smith 2001). Comprised largely of poorly compensated service sector jobs, the current work environment demands increased flexibility on the part of workers who must contend with decentralized workplaces, part-time or contingent work arrangements, and worker participation programs promoting “team building” and increased worker initiative. While the demands for employee flexibility have increased, the traditional material rewards of work—a living wage, benefits, and the right to union representation—continue to erode.

Critics of the new capitalist economy argue that lack of financial security is not the only constraint facing workers today. Richard Sennett (1998) makes the case in *Corrosion of Character: The Personal Consequences of Work in the New Capitalism* that it is nearly impossible for workers to form a coherent identity on the job, due to the

impermanent, insecure nature of contemporary work arrangements. Sennett conveys the important point that the trend toward so-called flexible employment compromises not only the financial well being of workers, but also affects their selfhood. In essence, the worker pays the price in character, while the employer benefits in profit.

While Sennett provides a timely and critical portrait of the changing nature of work, recent scholarship in sociology extends his account to consider how workers themselves experience and understand new employment arrangements. Sociologists Randy Hodson (1991, 2001) and Vicki Smith (2001) emphasize the importance of empirically grounded accounts when assessing the implications of constraining work environments. Greater attention is given to worker agency in a grounded approach, so as to assess—rather than assume—the deleterious effects of the new economy on workers. Hodson (1991) in particular takes issue with the “theoretical straightjackets” that tend to limit critical studies of work. In his estimation, radical perspectives tend to explain worker behavior either in terms of “acquiescence (false consciousness) or resistance to capitalist control of the workplace” (Hodson 1991: 48). Unsatisfied with either view, Hodson proposes a study of work that pays close attention to the social contexts and social interactions that inform the work experience. Recalling the classic work of Everett Hughes (1958,1971), Hodson seeks to understand how workers—through interactions on the job with co-workers as well as clients or customers— attach meaning to their labour, often finding autonomy and dignity in a job that outsiders perceive to be thankless dirty work (Hodson 1991).

Recent ethnographies of work in the service sector take up Hodson’s call for grounded accounts of worker experience. Katherine Newman (1999) argues that low-

waged workers in the inner-city derive a sense of dignity from their work as fast food employees, primarily because they take pride in making a conscious choice to avoid unemployment, street crime or dependence on welfare. Although the jobs are poorly compensated and demanding, Newman suggests that workers borrow from middle class sensibilities of responsibility to import meaning into the work and to extract as much as they can from the job, whether in terms of job skills or a sense of fulfillment. Smith (2001) looks at a broader class of service workers in the U.S. and finds that workers in the three companies she studied were willing to accept economic uncertainty because “they felt they were gaining skills and insights that would allow them to maintain a solid footing in the new economy” (2001: 9). In other words, Smith finds that even though the contemporary workplace is indeed uncertain, workers find ways to maneuver within these constraints.

### *Low-waged Healthcare Work*

Low-level healthcare jobs comprise a significant portion of the growing service sector and yet relatively little research in sociology considers the organization of these jobs and their impact on workers. Existing health service research on low-skill health workers is generally quantitative and emphasizes the macro-structural conditions that cause provider turnover and burnout (Crown 1994, Hollander Feldman 1994, Stone 2001, Yamada 2002).

The few ethnographic studies of unskilled health providers tend to focus on workers in institutional settings such as hospitals or nursing homes. Tim Diamond (1992) and Nancy Foner (1994) both examine how nursing home aides manage a job that takes place in an increasingly bureaucratic and profit driven environment. Of particular

interest to the authors are the ways that aides struggle to maintain a sense of ownership and autonomy in a context where corporate and middle management restrict the amount and quality of care given to elderly clients. Diamond (1992) finds that while nursing home aides become distressed and jaded by the work conditions, they collaborate with clients to find ways to subvert management control, thereby maintaining a sense of autonomy and dignity over their work. Foner (1994) finds workers respond similarly to the “speed-up” of care but suggests that while autonomy may give aides a sense of ownership and dignity on the job, it is possible that such autonomy may be misapplied to the detriment of client well being. Both Diamond and Foner provide rich ethnographic examples of how low-skilled health workers manage to create dignity and autonomy on the job, in spite of bureaucratic controls on their labour.

It is curious, given this increased interest in the questions of bureaucratic constraint and worker autonomy among nursing home aides that the analysis has not been extended to home care workers. Deborah Stone (2000), in one of the few qualitative studies on unskilled home care workers, concludes that caregivers have a great deal of freedom to direct care, but rarely misapply this autonomy to the detriment of client well-being, as Nancy Foner portends. Stone finds that home health workers go out of their way to spend extra time with clients and pay out of pocket for client expenses, thereby preserving their own ethic of care. Aronson and Neysmith (1996) take a more critical view, suggesting that the interpersonal bonds that develop between caregivers and their clients obscure the fundamentally exploitive nature of the arrangement.

While each of these authors makes an important contribution to the nascent literature on home care work, the tendency is to either romanticize the importance of

affective ties between worker and client, or overstate the exploitive nature of the relationship. I argue that the reality of the work experience of the home care provider lies somewhere between the two positions. On the one hand, workers recognize and lament the constraints of their low-wage labour; on the other, they find reward in a job that allows them to experience some autonomy and creativity through their carework. I suggest the rewards that come from caregiving allow workers to import dignity into a highly stigmatized (“dirty”) occupation. Dignity is most salient for those workers who discover home care after fleeing a particularly alienating service job, either within or outside of the healthcare industry. For these workers especially, home care becomes an important point of connection to their labour, rather than a source of alienation.

## **Findings**

Grounded accounts from home care workers in Central City tell a complex and contradictory story about the labour of caregiving. Aides are quick to identify the constraints that make their work difficult, including overwork and added responsibilities; increased risk on the job; and the physical and emotional strain of providing care. At the same time, workers talk at length about the dignity they derive from working with clients. Based on the interviews and observations, I identify three sources of dignity in home care: Practical autonomy on the job, especially relative to prior work in the service sector; skills building; and pride and honor in dirty work.

### *“We’re Maids Plus”: Overwork and Added Responsibility*

Like many service jobs in the U.S., the work of the home health aide requires a great deal of emotional commitment and flexibility, at the same time that it offers very little in the way of job security or wages. In my sample, 23 of 33 aides discussed the

stress that comes from working multiple jobs for multiple clients to ensure enough weekly income to simply pay their own bills and rent. All caregivers agreed that they should be paid more for what they do. In general, when I asked aides why they thought they were underpaid, most cited the undervalued nature of the work. In general, caregivers minimize the low-pay and insecurity of the work as “part of the job.”

Katy, a mixed-race white and Filipina woman who has worked in home care for over thirty years, now accepts that “outsiders,” including doctors, nurses and family members, fail to recognize the contribution of home care aides. Over lunch at a coffee shop, we discussed the lack of respect she’s faced over the years:

Nobody’ll listen to you...you’re just the aides. I get so tired of being thought of as incompetent and stupid and don’t know anything. But I think it’s always been that way. And I think it will continue to be that way. We’re the ones that know the patients, and everything. But it’s the power trip, the control trip...I could care less. I do what I do, you know?

Aside from the obvious drawbacks of working in a low-paid, undervalued job, home care aides identify overwork and added responsibilities as significant constraints of the job. Aides who care for a client and feel a sense of loyalty to him or her, often find themselves in a situation where they are being asked to stay a little longer, lend a little money or take on a little more cooking and cleaning. Rosa, a recent immigrant to the U.S. from Mexico, supports two sons on her income as a home care aide, and while she loves the work of caring for people, she often contemplates leaving home care to work as a house cleaner because the pay is better and the hours more finite. As Rosa put it when I asked her to describe the drawbacks of her carework: “We’re Maids Plus, you know? Maids plus companion, maids plus nurse, maids plus family.”

Sophie, a Hungarian woman in her fifties who recently immigrated to the U.S., spoke of the expectations that were placed on her in a recent home care job where she effectively became “one of the family.” She explains how the blurring between work and family can create a situation where overwork simply becomes part of playing the role of fictive family member:

Now in this family, they made me kind of part of the family, and the lady was very nice, but with being part of the family they expected me to be with her when the daughter was out of town on Thanksgiving. I said, "well I would like to visit my husband's family in Southern California." The lady said, "well I will need you because my daughter's out of town and I need you."

As is the case for the domestics discussed in Hondagneu-Sotelo’s (2001) *Domestica*, the rhetoric of the ‘family bond’ in home care often masks the inequality and exploitation of the carework arrangement. Certainly, the overwork demanded of aides stems, in part, from the fact that carework generally blurs the line between informal and formal labour (Folbre 2001, Glazer 1993, Harrington Meyer 2000). Kelly, a white sixty-year-old aide, often lets her client sleep at her home, even though the terms of their contract forbid this. Kelly is paid for three hours of care a day, but often spends a week of uninterrupted time with her elderly client. She is aware of breaking the rules, but says that both she and the client like the companionship and that the client is afraid to stay alone at night in her home. Kelly explains that “It’s not an issue, we’re friends. We enjoy each other’s company and we go out to eat together...I don’t need a whole lot of money.”

Kelly’s willingness to take on extra, uncompensated work to help her elderly client makes sense when considering her recent history as an unpaid caregiver of a son who died of AIDS and a husband who two-years later died after battling cancer.

Although Kelly acknowledges that she struggles to make ends meet and that she should be paid more for the work, she also seems to accept the situation, as it closely resembles her prior work as an informal, unpaid caregiver.

For other home care aides, caring for someone means taking on the added responsibility of paying for living or medical expenses. Given that many clients, especially in the CHS program, are often as poor as the caregivers, it is not surprising that workers become involved in helping to support a client who, in many instances, becomes a friend. Martina, a sixty-year-old African-American aide caring for a disabled African-American man in his fifties, recounts a story about paying for her client's medication because it was no longer covered by insurance:

We went to the neurologist [who said], "well, I'm going to give you some lidocaine pads." I went to the pharmacist and the pharmacist said, "they're not going to pay for this." They were \$175 dollars, so what are you going to do? Then after I bought them and we put them on his foot...he said it froze it and he didn't like it. So now I'm stuck with \$175 dollars worth of lidocaine pads. And the Vicodin he takes, Medi-Cal doesn't pay for them cause they're too strong... those I paid \$78 dollars for.

Andrew, a fifty-five year-old African-American caregiver, also absorbs some of the costs associated with his client's care. The client is a young, schizophrenic African-American man "living-in" with Andrew and his wife because he requires full supervision. Andrew's contract specifies that the client must pay him over \$500 for rent, although when I interviewed Andrew, he had recently reduced the rent commenting, "I was seeing that he was struggling with that, he was having real problems." Although Andrew's generosity is to be commended, the larger question is why someone like Andrew, as a low-income caregiver, absorbs financial responsibility for a client whose federal disability allowance fails to even cover his rent. Once Andrew's client had settled

into his home, it became difficult for Andrew to remain rigid about the terms of the work contract, an example of how blurred boundary between formal and informal labour helps to sustain overwork and added responsibilities among caregivers.

### *Risks of Providing Care*

While agencies are careful to remind aides during trainings that they are forbidden from providing medical services like changing catheters, dressing bandages or injecting insulin, in practice agencies seem to take a “don’t ask, don’t tell” approach to monitoring aides. The aides I spoke with and observed on the job are aware that the inattentiveness of agencies shifts responsibility—and risk—into their untrained hands. In response to this risk, some aides maintain rigid boundaries and refuse to take on medical tasks, while other aides accept—even welcome—the risk as part of the job.

Jennifer, a white caregiver who works for an elderly woman on the outskirts of Central City, was given a great deal of latitude to monitor and treat her client’s diabetes, even though she wasn’t completely comfortable doing so. She recounted a story of the time her client’s nurse “ordered” her to “use her discretion” when supplying the client with insulin, even though Jennifer expressed concern to the nurse that such decisions were beyond her expertise. Eventually, Jennifer realized no one else was going to provide the care, so she cautiously accepted the responsibility, learning over time to manage her client’s disease.

Jennifer displays some hesitation to take on work she is not trained to do, and her caution is not unwarranted: If something were to happen to her client, Jennifer could be held liable. CHS, the state agency that pays Jennifer’s wage, does not assume responsibility for caregiver behavior, arguing that the contractual relationship is between

the client and the caregiver, not the caregiver and the agency. Private agencies like It's For You! do contract directly with the client (and then "assign" a caregiver to the client) and, as a result, appear more diligent about reminding aides that they should not provide medical care for clients. Nevertheless, home care aides from both agencies in the study report having to occasionally provide care outside of their skill set.

Andrew explains that helping clients with their medical needs comes naturally to him, after years of watching and learning on the job. He suggests the agencies are fully aware of the fact that aides often do work they are not formally trained to do:

It's not in agreement with the agency but they know we do a lot of things personally for our clients, cause once you're with a client for four or five years, you establish a kind of rapport with them, a friendship and trust. I had one [client], BD, he's a very wealthy man, and I did just about everything for him.

Mark, an Asian-American caregiver in his forties, claims that in the CHS program, aides often provide more hands on care than public health nurses, even though PHNs are some of the most highly trained professionals in the field:

Aides can get away with more things because they do not have the censorship or the people that they have to report to all the time. Literally and legally, if you had four and five different medications that you had to take, I could literally lay 'em out and have you take 'em. And maybe even illegally but legally place them in your mouth because you needed help. Whereas an RN is not qualified to do it. Even though I'm not [an RN], I could get away with it and I'd have more range and variance, whereas an RN, they have to be put under constant microscope, having to report to everything and everybody. And so basically we can do almost the same things they can to a certain degree, we just can get away with it without the training.

Although Mark seems confused about the work responsibilities of nurses in home care—they can in fact administer medication orally—he nonetheless touches on the strict guidelines limiting nurses in the field. During my observations, CHS public health

nurses expressed frustration at being unable to provide direct medical care to patients. Shadowing one nurse, I watched as she instructed an elderly, nervous diabetic client how to take an insulin reading. Unable to touch the client—CHS nurses cannot touch patients in situations where there is blood or an open wound—the nurse could only stand and watch as the client fumbled the task. Limited in practice because they are not directly under a doctor’s order, CHS public health nurses acknowledge that aides often absorb responsibility for minor medical care of clients, simply because there is no one else to do it. Although nurses resent their shrinking jurisdictional boundaries in home care, it is the clients and home care workers who truly absorb the risk of this arrangement. Aides run the risk of losing their jobs if they “get caught” or if they harm a client; and clients are often forced to choose between substandard care from an aide or none at all.

Given the risk to both aide and client, it is not surprising that some home care workers I interviewed refused to take on medical care of clients. Fahima, a Belizian born caregiver who has lived in the U.S. for ten years refuses to jeopardize her job by performing tasks outside her expertise. She explains:

If they have a wound that has a band-aid or something like that, I’m going to take that off and clean it with peroxide and put it back on. But if they have a big open wound, I’m not going to do that. And I let them know, I’m not going to do that, I’m not going to change no IV for you. I’m going to stick to what I’m supposed to do. And that’s it. If you don’t want it, that’s just too bad. But I’m not going to cross the line. I’m not going to jeopardize my job to please nobody.

While Fahima’s clear boundaries protect her (and arguably the client) in the long run, many aides describe feeling “torn” because if they don’t provide the medical care, the client often goes without. Given that many aides feel “like family” to their clients, it makes sense that some are willing to absorb risk associated with this type of care.

### *Physical and Emotional Strain*

The risks of working in home care go beyond the fear of harming another or of losing one's job. Far more common are the risks associated with the physical and emotional strain of providing direct care to another person. Home care and nursing home aides, for example, suffer from the highest number of musculoskeletal disorders of any occupational group in the U.S. (Bureau of Labor Statistics 2004). Given that many clients are unable to move without the help of an aide, transferring a patient from one place to another becomes an important—and dangerous—requirement of the job. After I attended a “transfer” course with a group of caregivers, it became clear that even the smallest aide can safely lift the largest client if properly trained. However, the training courses are optional and many aides cite lack of time as reasons why they do not learn the proper technique for transfers. As a result, approximately one third of the sample (10 aides) report some kind of job related injury, although only one notified her employer.

Joyce, an African-American caregiver in her sixties, went into home care after losing her life-long job delivering phone books for a local telephone company. Joyce currently cares for her brother with cancer, but explains how she obtained a back injury while caring for an elderly woman over two years ago:

This particular morning I'd sat her on the potty chair, but then instead of her going to the potty chair she went the other way, which means that I had to go the other way and pull some muscles in my body. As an end result of that I didn't work anymore. I went to a doctor and of course the insurance bucked, I mean really bucked. The doctors did not act in my behalf because they wrote a note saying that I could go back to work. I could not go back to work, and I did not. It cost some 300 dollars for me to go there [chiropractor] for an hour, and I'm saying, wait a minute, he's not doing that good. So I stopped going to physical therapy and I still have problems with my back.

Sophie, a Hungarian caregiver, reports similar troubles transferring a large, young man, disabled after a car accident. For her, the problem of moving a client was not insignificant; she left the job after realizing she didn't have the skills to do the work safely. She describes how her client leaned "like a tree" and that she would always fall in the direction that he did. Eventually, Sophie quit because she realized that transferring her client was dangerous. Considering the severity of the client's disability and Sophie's reluctance to learn the proper transfer techniques, it is probably best for all involved that she did not continue to work with this particular family. However, it is not difficult to imagine a scenario where a caregiver might persevere through such physical difficulties because of the need for work, even though she might potentially harm herself or the client.

In addition to physical strain, home care aides also identify the emotional toll produced by this type of carework. Emotional strain comes from failing to connect with a client, as well as from emotionally over-investing in a client's well being. Andrew speaks about the way his work sometimes makes him feel disconnected, or "robotic":

Sometimes he [the client] comes in with a big demand, you know, and he forgets that I'm human, he thinks I'm a robot. Like I say, it has to take a special type of person to do this kind of work because sometimes people, clients, they forget that you're human. They don't care. You have to remind them, "hey look, I'm a human being."

Andrew's complaint that his client fails to recognize him as human reflects an alienation of self most commonly associated with emotion work. As Hochschild (1983) reminds us, however, emotional labour can also be a problem when a worker over-invests too much of the self into work, such that burnout from emotional involvement becomes likely (Hochschild 1983, Wharton 1999). While the cost to workers in this scenario is

not as high as compared to situations that produce an alienation of the self, the emotional toll of over-involvement is still significant (Hochschild 1983). Confirming Hochschild's assertions, home health workers in this study spoke of the emotional costs associated with investing so much into the care and well being of another person. Luis, a Puerto Rican caregiver explained how he feels when a client passes away:

You get close to people. First thing they taught me when I was in school was, don't get attached. But, it's a lot of malarkey; it doesn't work that way, not in real life. You could tell somebody that but when you're working, you get close to somebody, and when that person passes on you feel it. They say that it gets easier to accept, but every once in awhile you're going to have someone who's special to you and it's going to hurt.

Lupe, a Mexican American home health aide, has a very conflicted emotional relationship with her client. The woman for whom she cares, a white woman in her nineties, is very demanding, deriding Lupe for "eating too much junk food" or for "being fat" at the same time that she begs Lupe to stay with her. Lupe seems torn between feeling a strong connection with her client and fearing her rejection. In many ways, the dynamics that emerge are reminiscent of those between unpaid family caregivers and their kin (Karner 1998), producing many of the same effects of burnout and emotional over-involvement.

Andrew also talks about the tumultuous caregiving relationship, describing how he would "clash and argue" with clients but ultimately reconcile. In one case, Andrew did leave his client, saying that it was "like breaking up from your wife or something." Andrew admits to feeling over-involved with other clients, likening the bond to "being married...not like being gay, but it's like your family." It was not uncommon for caregivers, like Andrew, to emphasize both the benefits and drawbacks of the over-involvement that comes from close ties to another person. In some cases, the emotional

toll is so great that caregivers ask the agency to place them with a different client. One can also imagine how such emotional over-involvement might result in burnout and an inclination to leave the occupation altogether, a supposition supported by recent evidence suggesting significant turnover in the home care workforce (Ong et. al 2002).

### **Finding Dignity in Dirty Work**

Although home care workers identify several ways that their work is constraining, they also talk about the rewards of caregiving. I identify three sources of reward for aides: Practical autonomy on the job, especially relative to prior work in the service sector; skills building; and doing dirty work. The first two rewards—practical autonomy and skills building—can be interpreted as individual rewards, or rewards that allow workers to achieve a sense of ownership and control over their labor, two factors central to maintaining dignity on the job (Hodson 2001, Wardell 1992). For home care aides, however, there is also a third reward—doing dirty work—that is unique to the caregiving relationship and relational (rather than individual) in nature. Workers draw meaning from their willingness and ability to perform dirty and mundane tasks that others avoid, knowing that their efforts improve the lives of clients. Taking on dirty work, therefore, is an important source of dignity for workers whose labour is invisible and undervalued by the general public.

#### *Practical Autonomy*

Agencies generally dictate—at least on paper—how many hours home care aides may cook and clean, and how much time should be spent on bathing, dressing and running errands. However, because workers are generally not supervised on a day-to-day basis, they report taking as much or as little time as needed for a task without much

regard for the bureaucratic dictates of the job. The fact that caregivers are free, relative to their colleagues in nursing home care, to use their own discretion when assigning time to tasks, translates to a form of “practical autonomy” on the job (Wardell 1992). Distinct from professional or absolute autonomy, practical autonomy is a way that workers create and manage their own environments within certain constraints. Wardell (1992) argues that most employers overlook, or even encourage such autonomy, precisely because it allows the business enterprise to proceed smoothly. Home care workers welcome practical autonomy because it gives them greater control over their labor, a significant factor in attaining dignity in the workplace (Hodson 2001).

Home care workers interviewed describe a sense of practical autonomy that comes from having the freedom to informally negotiate certain terms of employment with clients, depending on client needs and level of functioning (i.e. what time to arrive and depart; when to perform certain caregiving tasks). In both the context of CHS and for-profit home care, all aides—in some way or another—seek out and hold on to jobs where they have some flexibility to determine hours worked and control over care. Some workers describe this as a sense of “being your own boss,” while others simply like that they can work with the client to determine when and how to provide care. Of course, practical autonomy is also linked to the earlier discussion of risk. While workers can exercise some creativity on the job, this “freedom” often means they must assume the risk of taking charge of medical care outside their formal training. Aides seem conflicted about this tension: Like most of us, they seek jobs that allow for creativity and autonomy because of the sense of dignity they provide; but with this creativity and autonomy often come unwanted—and risky—responsibilities.

The most common way home care aides describe the value of practical autonomy is to compare their home care work with prior experiences in the service sector. Of 33 aides, 32 have worked in other kinds of service jobs, including flipping hamburgers at McDonalds, working as janitors or domestics, or providing care in institutional settings. Several workers sought out home care as a way to flee unsatisfying or inflexible work environments, while others “fell into” carework more informally (caring for a relative or friend) and then realized that they could get paid for this type of work. One constant among respondents who left other service jobs and moved into home care is the report of increased autonomy and decreased stress. Although respondents admit carework is very stressful at times, most make clear that other service work is even more so.

The rewards of autonomy are most salient for those aides with prior experience working in an institutional care setting. Without exception, the 19 (57%) aides in the sample who have prior experience in nursing homes or mental health facilities speak about the poor working conditions and the depressing nature of the work, likening facilities to “factory assembly lines.” Most recount emotional stories of working eight or ten hour shifts without a break and feeling as though no matter how hard they tried, clients did not receive the proper care. Much of what the workers lament is the lack of autonomy to provide the kind of care nursing home clients need, a sentiment found in Diamond (1992) and Foner’s (1994) ethnographic accounts of working conditions in nursing facilities.

Luis, a Puerto Rican man working in home care, claims he would never go back to institutional care, where he worked for twenty-years, because of the poor working conditions and low-standards of care:

A lot of places, the workers don't have the time, there's not enough time in the day to do it. Me, I didn't have much time either because I hardly got to lunch. I had maybe a 15-minute break in my whole shift because I had to make sure these people were right. Taking into account that they are going to give low man on the totem pole all the patients that no one else wants. It's hard for you to dedicate enough time for each one of the residents.

Camilla, a forty-two year old African American aide expresses a similar sentiment about her experience working in a nursing home, emphasizing that the client also suffers when care is “sped up”:

To me it's too busy. It's not enough time for the client. You know what I mean? You have no personal time with them. You are going to give them a bath real quick, check their temperature, blood pressure, and you're out of there. What about “how do you feel today?” or “Did you sleep well?” “Did you have any dreams?” “Is there anything bothering you?” You know, rub their head and take time to do all that. The important stuff, that's what I do.”

Caregivers like Camilla and Luis welcome the practical autonomy of home care precisely because they are relatively free to care according to their own standards, without working under bureaucratic management that encourages “speed up” of services (Diamond 1992). Considering their prior experiences in the service sector, especially the nursing home industry, practical autonomy becomes a key mechanism through which home care workers maintain greater control over their labor (and therefore the care of the patient). Although there are potential drawbacks to increased worker autonomy for both caregiver and patient (Foner 1994), autonomy also promotes a sense of ownership over the standard of care and, by extension, a sense of dignity for the worker.

### *Building Skills in Home Care*

A common view of home care—among doctors, nurses, family members and the general population—is that it constitutes a “dead-end” job that anyone can do. Indeed, a

public health nurse commented that agencies accept “anyone off the street,” which leads in her estimation to a workforce that cares little about the skill or craft of caregiving. While there is no doubt that a certain percentage of home care aides simply log their hours and go home, aides I interviewed view home care as an occupation that provides them with a unique caregiving skill set. A subset of these workers also emphasize that they intend to put these skills to use in other careers, in and outside of the healthcare field. Irrespective of whether skills building provides home care aides with horizontal or vertical mobility within the job market, the perception of skill is central to the way that aides craft dignity on the job, countering misperceptions that caregiving is work “anyone can do.”

Jackie, an African-American caregiver believes she has perfected the skill of bathing clients, something she now “specializes” in. When I ask her to elaborate, she responds:

Let me make this note. I’m going to tell you, if you ever meet one of my clients, they would tell you, I give them the best bath, shower, even the men. Everybody does not know how to give a bath. I wish I could teach ‘em how. I don’t want to sound racist or nothing. The white women that I that I’ve worked with and I’ve seen give a shower, they don’t know how to do it. They do not know how to give a shower.

Jackie considers herself something of an expert when it comes to bathing and showering, a skill she indirectly attributes to her racial and cultural background. Jackie is not alone in her assertion of a “cultural skill” or predisposition to care. George and Hannah, a married Filipino couple that immigrated to the U.S. on a work visa sponsored by the agency, feel that Filipino workers are more “industrious” than American workers and that they have “that thing” that makes them attractive caregivers. The couple also

feels they have skills as caregivers that doctors and nurses do not have, claiming that “nurses only give medications and do none of this intimate or personal thing with the patient.” Such “boundary work” (Lamont 1992) is not uncommon among caregivers, who draw a sense of dignity from the belief that they possess skills that more credentialed providers do not possess.

Jennifer, a white aide caring for a frail elderly woman, views caregiving skills as part of her “nature,” but she also sees her work in more pragmatic terms. She describes her job as a “stepping stone” that will lead to other opportunities in home care, such as owning her own small residential home for the elderly. Jennifer attends training workshops regularly, actively building her skill set in the hopes of creating opportunities for herself down the road. Other caregivers see their “soft” skills, such as inter-personal communication, as key ingredients to future success on the job market. Andrew discusses the importance of his ability to “get along with people,” something he learned from caring for clients of different races and backgrounds:

I learned a lot from dealing with other cultures and different backgrounds as well. I learned a tremendous amount about what people think about other people, and their background and race. You learn so much. Very educational. It's been quite an experience for me and it's opened up other avenues for me. I probably wouldn't even want to go into real estate now if I hadn't had this experience. I mean, I'm venturing out and communicating with people from all different races and walks of life.

Andrew describes a new set of interpersonal skills that have come from his work in home care. In a sense, the interactive work of caring for people from different backgrounds helps build Andrew's human and cultural capital, skills that he hopes will translate into future job prospects. The perception on the part of workers that they are picking up important skills while caregiving helps in part explain why aides accommodate work

conditions that, on the surface, appear constraining and against their best interest (Smith 1996). Whether these workers go on to achieve long-term job mobility is an unanswered empirical question and beyond the scope of this paper. However, it is clear that in the short-term, aides view caregiving as a way to build job skills, thereby crafting a sense of dignity within the confines of a job often seen by outsiders as unskilled and menial.

### *Doing Dirty Work*

Perhaps the most compelling—and counterintuitive—way that aides derive dignity on the job is through a sense of pride that comes from doing “dirty work” (Hughes 1971). Home care is both dirty in the literal sense (taking charge of someone’s personal hygiene) as well as in a broader Hughesian sense, referring to the mundane and repetitive nature of the work (Hughes 1971). As mentioned earlier in the paper, aides recognize their work as dirty, but don’t necessarily internalize this stigma in obvious or predictable ways. As Everett Hughes (1971) reminds us, “people do develop collective pretensions—to give their work, and consequently themselves, value in the eyes of each other and of outsiders” (1971: 340).

One way that aides import value and dignity into home care is to emphasize how well they have mastered the dirtiest aspects of the job. Katy, a caregiver nearing retirement, describes herself as highly capable when it comes to personal care (bowel and bladder care). Over lunch, she explains to me that she is very comfortable with such tasks, something that distinguishes her from informal family caregivers:

You know, families don’t cope well with it [personal care]. It gets into the couch and those kinds of things. Then I come over and clean it up...it doesn’t seem odd to me. That’s what older people do. It’s about knowing that, for an old person, when you cough, you wet your pants. Wonderful. It’s wonderful.

Few caregivers express as much enthusiasm about bowel and bladder care as Katy. However, nearly all take pride in the fact that they provide a valuable service that most people won't even talk about, let alone perform. Luis, for example, has worked as both a home care aide and nursing home aide. He takes great pride in the cleanliness and appearance of his clients. It is clear that he views the hygiene to be of utmost importance, because good hygiene humanizes his clients while also marking him as an exemplary care provider:

My men, I don't like to see my men with any kind of, you know, shabby looking beards. Sometimes I had a gentleman that might want to grow a beard—that's okay—you can grow it, but we're going to keep it trimmed. The minute I see that it ain't working, it's coming off. We don't want you looking shabby. It just made a difference to all of them, you know, I mean their personal care. It's just hygiene, getting them dressed every day in something different. It could still be clean and I would say, "no, I want to put something different on you today." That's what they need because it's something that they used to be able to do but they can no longer do it. A lot of places, the workers don't have the time.

Providing daily care to clients—however dirty the work—translates into a sense of pride and even moral authority vis-à-vis other providers in the medical community. Home care workers are clearly at the bottom of the medical hierarchy and, not surprisingly, they report being disrespected or ignored by busy doctors or nurses. Even so, aides maintain a sense of dignity by distinguishing themselves from hurried, out of touch medical professionals. Camilla, an African-American caregiver, expressed her feelings in this way:

When you're a CNA [aide], that's the bottom they say. But you spend more time with the clients. And that's why I'll stay a CNA for a little while, because with the other ones—LVN and RNs—they do a lot of paperwork. They don't spend their life with people. They don't know. They come to the CNAs to ask about the patient, because they don't know. I'm like the number one person. I spend a majority of the time with them.

Camilla emphasizes the unique bond that is formed between aides and clients, highlighting the relational nature of the work. As scholars of carework note, this “relationality” is not a one directional relationship of dependency. Rather, both caregiver and care recipient draw value—and I would argue a sense of dignity— from constant, and often very intimate, social interaction (Kittay 1999, Parks 2003, Tronto 1993). Lupe, for example, works nights as a packer for Target, in addition to her work as a caregiver. Lupe is always tired from working two jobs and I ask her why she keeps the caregiving job, given that it has no benefits, pays a lot less than her packing job at Target, and causes her so much emotional distress. She acknowledges that the stress of it all takes a toll but that she keeps with it because, “it (caregiving) makes you feel good, like nothing else.”

Similarly, Luis has worked in home and residential care for nearly twenty years, earning as little as \$2.50 an hour early in his career. He explains why he stays in home care even though the work can be repetitive and thankless:

Yeah, I mean, it just keeps you going. It gives you more to keep doing more...it just makes you feel like, oh, I'm doing something good. I'm doing something I want to keep doing.

For Luis, and other aides like him, pride and honor come from being able to positively affect the emotional state of clients, simply by providing for their daily needs. Luis’ assertion that “it gives you more to keep doing more” also suggests that he finds home care a place where he can invest as much emotional energy as he deems necessary and that this, in turn, provides him with a sense of dignity on the job. These findings support the recent work by Teresa Scheid (2004), who suggests careworkers would benefit from greater *support* for their emotional labor, rather than policies that regulate or restrict it.

Without sufficient outlets for emotional labour, Scheid argues, the worker is prevented from making a meaningful investment of self in their work (Scheid 2004).

Home care providers appear to draw significant reward from doing emotionally intense carework, even though the work is dirty and mundane at times. Fueling the dignity of dirty work is the sense, among aides, that they alone take responsibility for tasks that few others will do; work that directly impacts the well being of their clients. Combined with a new sense of autonomy—relative to prior work in the service sector—and the belief that they are building skills on the job, it becomes clear why some home care aides find dignity in the work of caring for an elderly or disabled adult.

### **Conclusion**

As the population ages, in the U.S. and elsewhere, the demand for home care services is expected to increase significantly (Bureau of Labor Statistics 2004). Unskilled home care aides will be on the front lines of this burgeoning industry, confronted with the realities of poor pay, job insecurity and the low-status of the work. While health services research makes clear that the conditions of labour must change to prevent burnout and turnover, little is known about how home care aides themselves perceive the constraints of their “dirty work.”

I suggest here that workers have complex and sometimes contradictory relationships to their labour. Aides identify three broad work constraints that compromise their ability to do a good job or to experience their work as meaningful: Overwork and added responsibilities; increased risk; and the physical and emotional strain of the job. While these represent significant constraints, workers interviewed also highlight the rewards that come from experiencing practical autonomy on the job, building skills and

doing dirty work. The dignity that workers draw from these rewards helps mediate the obvious constraints of a low-paying and demanding service sector job. In short, although many outsiders view the work as without skill or “dead-end,” workers interpret their responsibilities and contributions in a very different light.

Findings support recent claims within the sociology of work and occupations that workers create opportunity and satisfaction, even in jobs characterized by low pay and insecurity (Smith 2001, Hodson 2001). Dignity is central to the job satisfaction for the home care aide, a factor that is generally downplayed (or ignored) in overly deterministic accounts of work in the new economy. Of course, the implication of worker dignity is not entirely rosy, at least in the case of home caregivers. As I argue elsewhere (Stacey 2004) the dignity workers draw from caring labour obscures the structural inequalities faced by aides, making the task of unionizing home care workers very difficult. Precisely because aides derive meaning from the bonds formed with clients, conventional approaches to organizing workers—i.e. in relation to their material interests—is inadequate for a labour force that finds intense meaning in the non-material aspects of the work. In a country generally hostile to unionization, it is imperative that future organizing campaigns address the material needs of workers while also validating the caregiving relationship that serves as foundation for their sense of dignity.

This research also raises questions about the meaning of emotional labour for healthcare workers. Conventional reasoning tells us that burnout among direct care workers is a result of the burdens of emotional labour. The home care workers in the sample, however, tell us they find relief in work that promotes, even fosters, deep emotional connections with clients. The finding is especially true for those workers who

discover home care after fleeing employment in a nursing home. Data further confirm Teresa Scheid's (2004) assertion that burnout in healthcare organizations is a result of the suppression of a worker's emotional labour, rather than a product of intense emotional over-involvement.

Given these findings, one important empirical question remains unanswered: Does the dignity of the worker correlate with improved quality of care for the client? Future research must consider this relationship carefully, with attention to the ways that autonomy and dignity serve as important foundations for the caregiving bond.

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