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"Careworkers don't have a voice:" Epistemological violence in residential care for older people

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ABSTRACT

Drawing on feminist epistemologies, this paper attends to the way the reductionist assumptions have shaped the organization of nursing home carework in manners that are insufficient to the needs of relational care. This paper is informed by a study involving nine focus groups and a survey of Canadian residential care workers (141 RNs, 139 LPNs and 415 frontline careworkers). Four major themes were identified. Reductionist assumptions contributed to routinized, task-based approaches to care, resulting in what careworkers termed "*assembly line care*." Insufficient time and emphasis on the relational dimensions of care made it difficult to "*treat residents as human beings*." Accountability, enacted as counting and documenting, led to an "*avalanche of paperwork*" that took time away from care. Finally, hierarchies of knowledge contributed to systemic exclusions and the perception that "careworkers' don't have a voice." Careworkers reported distress as a result of the tensions between the organization of work and the needs of relational care. We theorize these findings as examples of "epistemological violence," a concept coined by Vandana Shiva (1988) to name the harm that results from the hegemony of reductionist assumptions. While not acting alone, we argue that reductionism has played an important role in shaping the context of care both at a policy and organizational level, and it continues to shape the solutions to problems in nursing home care in ways that pose challenges for careworkers. We conclude by suggesting that improving the quality of both work and care will require respecting the specificities of care and its unique epistemological and ontological nature.

Introduction

> "I don't know how to fix it all. But treating people as human beings, be them coworkers, patients, or residents would be a good start."—Frontline careworker

A cup of coffee is misleadingly mundane. Compared to the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) – an instrument that is rapidly being institutionalized in residential care facilities as the next generation of information gathering and care planning technology – a cup of coffee is surely unimpressive. However, the careworkers we surveyed went to great lengths to emphasize the importance of a cup of coffee in creating a space where relations were forged, knowledge gained and care provided. Careworkers told us that it was often over coffee that they learned important details about residents that proved essential to personalizing their care, balancing tensions and mitigating aggression.

The familiarity gained by sharing coffee with residents is exemplary of a "rationality of caring" (Waerness, 1984) that

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differs markedly from the reductionist rationality that makes the RAI-MDS possible. Rationalities of care combine emotional, cognitive and contextual dimensions – such as affective proximity, the intimate knowledge of personal details, and the needs of other residents – to enable a situated understanding (Haraway, 1991; Ruddick, 1995). Furthermore, the development of familiarity requires policy commitments, organizational processes and labor practices that differ considerably from those required to institutionalize the RAI-MDS. While these "relational practices" (Fletcher, 1999) are not incompatible with the RAI-MDS, unlike informatics and auditing they have a hard time surviving in an environment where reductionist assumptions shape how care is known, funded, organized and assessed.

This paper contributes to a line of inquiry seeking to address the marginalization of careworkers and the conditions of work within nursing homes: factors that are intimately tied to the quality of care residents receive (Eaton, 2000). Research on the conditions of work within North American nursing homes has traditionally painted a bleak portrait. It has revealed highly regimented work environments, with careworkers following strict routines and often struggling to balance the tension between bureaucratic requirements and the immediate, individual needs of elderly residents (Foner, 1994; Gass, 2004). Research has also found nursing homes to be understaffed and under-resourced (Harrington et al., 2012), with aides struggling to provide adequate bodily care and unlikely to find time to offer social, emotional and spiritual care (Gubrium, 1997; Hung & Chaudhury, 2011). Under such conditions, intimate care is frequently rushed and can provoke violent retaliation from residents (Shaw, 2004). Inequity is also a concern, with those workers providing the bulk of hands-on care sitting at the bottom of an occupational hierarchy and increasingly drawn from marginalized sectors of society (Diamond, 1992; Potter, Churilla, & Smith, 2006).

There are multiple factors that have contributed to the challenging conditions experienced by workers within North American nursing homes (Armstrong & Banerjee, 2009), and likewise there are also promising attempts to improve the care residents receive (cf. Baur & Abama, 2011). In this paper we aim to draw attention to one persistent barrier to quality, specifically the dominance of the reductionist worldview. We argue that reductionist assumptions have shaped the funding, development and organization of nursing home work in ways that impede relational care. And it continues to inform solutions to quality concerns through, for instance, the institutionalization of the RAI-MDS or the increasing regulation and auditing of care tasks. Thus while we agree with Kontos, Miller, and Mitchell's (2010) assessment that the increasing standardization of care planning through the RAI-MDS privileges clinical factors and excludes input from frontline careworkers, in this paper we wish to take a step back and raise questions about the epistemic assumptions that shape these inclusions and exclusions in the first place. We believe that attending to these epistemic assumptions may help us understand why policy changes aimed at improving care can sometimes make carework more difficult (DeForge, van Wyk, Hall, & Salmoni, 2011).

To name the harms posed by the dominance of reductionist knowing we employ the concept of "epistemological violence," and use it to theorize the challenges reported by careworkers in this study. The concept was developed by Shiva (1988) to denote the violence that stems from reductionism's monopoly of knowledge. "This monopoly," Shiva observes, "results in fourfold violence — violence against the subject of knowledge, the object of knowledge, the beneficiary of knowledge, and against knowledge itself" (233). The consequences of epistemological violence are serious and, as the careworker quoted above cautions, the humanity of both workers and residents is at stake. One of the aims of this paper is to follow this careworker's advice, by raising questions around the styles of knowing that are required to treat workers and residents as human beings as well as attending to the organizational and policy processes that support or thwart this. We begin with a discussion of reductionism and its role in shaping the long-term residential care environment, before turning to a presentation and discussion of our findings.

Reductionism and residential care restructuring

Reductionism is more than a way of knowing or a collection of facts (Haraway, 1991; Harding, 1991; Keller, 1992; Shiva, 1989). Reductionism involves assumptions about the nature of reality and the best way to know it. It orients to the world as mechanical, composed of discrete components that can be taken apart and understood in isolation, independent of the whole. Reductionism makes important assumptions about human beings as knowers and the goals of knowledge. It assumes that valid knowledge is a direct reflection of external reality, one that is unbiased by the subjectivity of the knower and unaffected by the cultural, political and economic contexts of its production. Hence "objectivity" – understood as value neutrality, context independence and affective detachment – is a key marker of reductionist knowledge.

Despite claims to value neutrality, reductionism is governed by an ethos of mastery (Daston & Galison, 2007). As originally imagined by Bacon (1620) reductionist science was meant to grant power over nature; it was never intended to foster compassion. The misogyny of a masculine knower taming a feminine – "mother" – nature in Bacon's writings has not escaped feminist scholars (Merchant, 1988). Similarly, from a postcolonial perspective, the violence associated with reductionism has long been apparent, with Nandy (1988) observing that Bacon's vision of progress was inspired by developments in weapon technology. Indeed, Shiva (1988) observes that reductionism emerged and developed in tandem with other projects of Western domination. "The reductionist worldview, the industrial revolution and the capitalist economy," she writes, "were the philosophical, technological, and economic components of the same process" (238). The reductionist worldview thus evokes dreams of mastery, expansion and conquest, which shape not only our thinking but our aspirations and visions of hope (Code, 2006).

Not least, reductionist dreams of mastery have funneled social and economic resources towards curative endeavors and heroic medicine, promising to solve the problem of death one disease at a time (Bauman, 1993). In the context of modern ambitions, nursing homes are scandalous reminders of our inherent vulnerability and our inevitable dependency. Their funding and the status of those who opt for aging care work compared to other health professions reflect this. And hence much of what is possible to do within nursing homes is already shaped, before one even enters the home, by cultural priorities