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Enacting efficient care within a context of rationalisation

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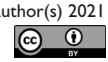

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Abstract

Scholars have described how care cannot be completely commodified or withdrawn because it is a disposition anchored in the commitment to the needs of others. This article advances the literature on care ethics and inequality by examining how care workers resist and negotiate the rationalisation of care work. Building on ethnographic fieldwork on auxiliary nurses in Norwegian nursing homes, the study shows that despite care workers facing increasingly rationalised forms of control, they continue to act out of the caring self, which centres on the desire to give meaningful care. However, by addressing how power differences and ethnic stratification between workers influence their strategies of coping and resistance, the findings also illustrate how the most vulnerable care workers respond to rationalisation by providing efficient care – that is, careless care – to their patients. Drawing from alternative perspectives on care work as ambivalent work, the study's main theoretical contribution is to offer insight into how precarious work contexts may pose a threat to the caring self, especially when inequalities exist between care workers.

Keywords

care, immigrants, rationalisation, resistance

Introduction

Care is central to the global economy, its inequalities and its crises. Across the world, care work carries all the hallmarks of non-standard employment, being low waged, temporary, part-time, precarious and insecure (Williams, 2018). Scholars have raised concern over heightened rationalisation (Brown & Korczynski, 2017) and the social misrecognition and devaluation of care work (Budig et al., 2019; Elstad & Vabø, 2021). While feminist scholars have documented the vulnerability and interdependency in care practices, recent contributions have argued that the importance of care in creating social injustice in contemporary societies is underestimated in mainstream sociology (Lynch

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et al., 2021). Taking a care-ethical approach, these scholars argue that care relations are different from other systems of social relations, because they operate under an ethic of other-centeredness (Lynch et al., 2021; Williams, 2018). Care involves a distinct set of social relations with its own logic: it cannot be completely marketised and commodified or withdrawn (Lynch et al., 2021). Thus, a key question is how the 'caring self' is produced and constrained in a context of devaluation and heightened rationalisation (Brown & Korczynski, 2017).

The caring self rests on the desire to give meaningful care and to be centred on caring for others' needs (Brown & Korczynski, 2017). Yet, as Tronto (2018) argues, care is about both actual work and how that work is done, and the resources distributed to do such work. Previous research on care work has demonstrated how rationalisation, relating to cost-cutting pressure and standardisation in New Public Management (NPM), not only affects the workers' roles and tasks but also results in fragmented and commodified professional selves, as well as diminished control and autonomy (Dahl, 2009; Rasmussen, 2004). While some studies illustrate how care workers respond to structures of power by engaging in collective resistance, such as protests and strikes (Mulinari, 2018; Rogalewski, 2018), others have described how care workers act as invisible buffers that enable the smooth functioning of NPM (Vabø, 2006); the care workers on the ground carry the burden of budget cuts and solve dilemmas because they are the ones who meet the affected patients (Rasmussen & Kjevik-Wycherley, 2019). Thus, in acting out of the ethic of care, care workers cover up the cracks of the crisis of care (Brown & Korczynski, 2017).

This article contributes to existing literature on care ethics and inequality by exploring how care workers negotiate and resist the rationalisation and devaluation of care work. Building on ethnographic fieldwork on auxiliary nurses in Norwegian nursing homes, the study shows that despite care workers facing increasingly rationalised forms of control, they continue to provide care for their patients through the ethic of the caring self. They enact a client-oriented defence of autonomy (Brown & Korczynski, 2017, p. 836). However, by addressing how power differences between workers influence their coping and resistance strategies, the findings in this study also illustrate how the most disadvantaged care workers become cynical and efficient workers. Drawing from alternative perspectives on care work, such as manual labour and bodywork, the study's main theoretical contribution is to offer insight into how precarious work contexts may pose a threat to the caring self, especially when inequalities exist between care workers. The study identifies various types of resistance that auxiliary nurses deploy to mitigate control in the workplace and shows how these responses are not only distinct in their character but also not equally available to natives and immigrants.

The caring self and resistance

The caring self or a care consciousness, an idea central to the literature on care ethics, points to a commitment to the needs of others (Brown & Korczynski, 2017; Williams, 2018). As Tronto (2018) notes, 'care is not only work or labour; it is also a disposition and an attitude taken that requires one to focus on the needs of the cared-for object or person or group' (p. 22). Thus, in contrast to other systems of social relations, care

relations operate under an ethic of other-centredness – being centred on the development and well-being of another (Lynch et al., 2021). One main argument underpinning this branch of scholarship is that care cannot be completely marketised and commodified or withdrawn (Lynch et al., 2021; Williams, 2018). However, due to the distinct ethically informed character of care relations, care is especially vulnerable to exploitation and social injustice. Scholars have, therefore, examined who benefits from and is disadvantaged by current care policies. Existing research has described how care is central in the reproduction of existing power relations: the least well-off in society, such as women, immigrants and racial minorities, disproportionately perform the work of caring (Duffy, 2007; Williams, 2018). Care work jobs are even more likely to be devalued than other female-dominated jobs because of their association with motherhood and women's traditional unpaid work (England et al., 2002). Despite the professionalisation and institutionalisation of care, much labour market care work continues to be regarded as low status; it is relatively low paid and labelled as women's work (Budig et al., 2019). Previous research further illustrates how care often involves complex power relations between those who provide care and those who are vulnerable and highly dependent on receiving care due to illness, disability or age (Sahraoui, 2020).

In addition to viewing care as a practice and a disposition, scholars stress the need to focus on care as discursive (Tronto, 2018). Care is about not only actual work but also the distribution of resources to perform the work and the justifications for the distributions. A key concern within the literature on care ethics is that contemporary policies of care and the distribution of care-work resources are not built on the relational and other-centred logic of care. The ethic of care is replaced by the ethic of neoliberal capitalism – of carelessness and indifference (Lynch et al., 2021). Cost-cutting pressure followed by the aim to deliver equivalent care with fewer resources, as well as the standardisation of care and introduction of systems of accountability to control expenditure and increase efficiency, are two major sources of rationalisation in current political economy (Brown & Korczynski, 2017).

A key question in the context of rationalisation and commodification of care is how care workers respond to and negotiate this reality. A recent study from the United Kingdom describes how home-care aides continue to care for their clients' needs, despite the diminishing of resources and standardisation of their work (Brown & Korczynski, 2017). This finding aligns with similar studies in the Norwegian context. Despite strong rationalisation forces in care work, care workers respond to rationalisation and NPM by working harder and suppressing their own needs to care for their patients and clients (Rasmussen & Kjevik-Wycherley, 2019). Some scholars identify such responses as resistance because the care workers enact the ethics of care by defending their and their patients' autonomy (Brown & Korczynski, 2017). Others, however, see them as compliance (Vabø, 2006), with care workers acting as invisible buffers that enable the smooth functioning of NPM. Regardless of how they identify and define the carers' responses, these studies all offer support for the thesis of the caring self and prevalence of a care consciousness within contexts of rationalisation. In response to the logic and ethics of neoliberal capitalism, care workers do not withdraw their care and act with indifference to others' needs.

Care work as ambivalent work

This study builds on existing research on care ethics and examines how care workers manage and resist the rationalisation and devaluation of care work. However, to examine agency and how workers respond to precarious work contexts, it is important to acknowledge the coexistence of positive and negative experiences and multiple projects of the self (Manolchev, 2020). That is, although the caring self is found to be centred on altruism and otherness, care work can also be chosen and performed to suit instrumental needs. Several scholars have questioned the thesis of the caring self, arguing that the concept of care derives from the scholarly work on unpaid care and caring for family members in private homes, and embeds care in the feelings and emotions that make up family life (Lee-Treweek, 1997; Twigg, 2000). As Twigg (2000) observes, a problem with viewing care work as requiring a specific disposition and being inherently different from other systems of social relations is that it detaches care work from its physical aspects and being recognised as manual labour and bodywork similar to many male working-class jobs. The work is heavy, dirty, repetitive, low paid and framed by difficult conditions created by others in the occupational hierarchy (Lee-Treweek, 1997). By drawing the sociological attention to the less attractive aspects of care work, these studies point to how the status of a professional group often is marked by its distance from the bodily. When an individual or occupation rises in status, it retreats from direct body contact, thus revoking the broader cultural distinction between the relative status of the body and the mind (Twigg, 2000). In nursing, the direct bodywork is delegated to the junior staff, like trainee nurses or auxiliaries (Lee-Treweek, 1997), whilst the social construction of medicine as a technical scientific occupation disassociates it from direct work on the bodies of others, with its link to male workers in a high status well paid occupation (McDowell, 2009). Building on this 'worker' perspective on care work, research has illustrated how workers anchor their work identities in instrumental motives – care work is chosen to pay the bills (Lee-Treweek, 1997) – and withdraw their emotional labour by refusing to do anything extra for patients (Dahl, 2009) in response to poor working conditions. Therefore, further investigation is needed into how care workers respond to increased rationalisation and the space of resistance in such a context rather than assuming that the caring self will not be colonised by the competing ethics of carelessness and indifference. To do so, this study adopts a theoretical lens, which treats care work as *ambivalent* work: it both involves emotional pleasure and other-centredness, but it also evokes the necessity to dealing with 'dirty work' and hard manual labour (Twigg, 2000).

Positional power and different repertoires of resistance

A growing literature on women in the labour movement describes how care workers resist work-related problems through collective mobilisation, including strikes and public protests (Mulinari, 2018; Rogalewski, 2018). Through verbal and physical protest, workers engage in overt resistance (Hollander & Einwohner, 2004). Overt resistance, such as speaking up and engaging in 'fight' responses, is important in workers' efforts to change their working conditions (Hirschman, 1970). However, previous research has

illustrated that non-dominant groups, including immigrants and racial minorities, are less likely to engage in overt forms of resistance than dominant groups, such as white employees (Behtoui et al., 2017; Travis & Mor Barak, 2010). Rather than treating the lack of (overt) resistance among ethnic minorities as an expression of different cultural values, scholars have emphasised the differences in *positional power* in the workplace (Behtoui et al., 2017). Compared to the ethnic and racial majority, immigrants and racial minorities occupy a more precarious situation in the labour market and are concentrated in the worst care work jobs (Behtoui et al., 2017; Duffy, 2007). Thus, to examine agency and how ethnic differentiation within the care workforce influences the workers' resistance repertoires, I view resistance through a broad theoretical lens. In his seminal work on routine resistance among peasants, Scott (1985) points out that the powerless do not have the opportunity to resist openly and that by focusing on overt, visible resistance, subtle but powerful *everyday forms of resistance* are neglected. By distinguishing between acts that are overt and visible to the other party in the power relation – the 'public transcript' – and acts that take place offstage where those in power cannot see or punish them – the 'hidden transcript' – Scott (1985, p. 2) expands the definition of what constitutes resistance. Workers resist or mitigate demands by the management through their everyday acts. This form of resistance occurs under the managements' radar and is often characterised by practices of 'disengagement' whereby the worker detaches him- or herself from the work task or management's expectations by, for example, working slowly, cheating or expressing irony or cynicism (Fleming & Sewell, 2002).

In this study, I am interested in how care workers respond to rationalisation and create spaces of both overt and covert resistance in the process. This implies that I am also interested in resistance that fails to achieve structural change in the organisation but temporarily grants workers spaces that shield them from pain and stress (Korczynski, 2003). A key argument in the literature on everyday resistance is that despite its individualised and unorganised character, such practices enable employees to voice their dissatisfaction, survive regimes of control and create a sense of self-value (Fleming & Spicer, 2003). However, it remains challenging to distinguish resistant actions from the numerous other (possibly non-resistant) ones (Prasad & Prasad, 2000). In precarious contexts in which employment relations become more contingent, workers complement resistance with other types of oppositional practices, such as resilience or coping, to maximise their chances of survival (Anwar & Graham, 2020). To grasp the complex ways workers negotiate their work-related challenges, I also use the term *coping* to analyse and interpret behaviours through which actors are 'only' attempting to manage feelings of distress. I understand coping as a way to protect the self against work-related challenges by creating emotional distance or escaping confrontation. In contrast to overt and covert resistance, such behaviour is not intended to mitigate demands from the management or to achieve a change in the organisation.

Study setting

This article discusses findings from an ethnographic study of auxiliary nurses in Norwegian nursing homes. Initially, the study's primary focus was to explore the competence and feelings of worth and recognition among auxiliaries. However, during the

fieldwork, how the auxiliaries negotiated and resisted the challenges of their job grabbed my analytical attention. Thus, the topic of this article – resistance – is empirically driven.

The study was conducted in two large nursing homes located in two of Norway's largest cities. The nursing homes were selected because they had a high proportion of employees with immigrant backgrounds and shared several organisational similarities. Both were owned by municipalities but managed by private, for-profit companies. In recent years, Norway has undergone changes influenced by the global wave of NPM and the marketisation of care, such as competitive tendering and user-choice models, and an increase in the private, for-profit provision of care services (Vabø et al., 2013). The working conditions in the elderly sector are characterised by diminishing resources, extensive use of part-time employees and low pay.

The two nursing homes were staffed by different occupational groups, of which auxiliary nurses were the largest group (between 30 and 50 part- and full-time employed auxiliaries), followed by nurses (between 15 and 25 part- and full-time employed nurses). The two institutions were divided into six and four smaller departments, respectively, each accommodating approximately 30 patients. In both nursing homes, I conducted research in one of these departments to become acquainted with the patients and workers. During one working day (both the day and evening shifts) between nine and 12 auxiliaries worked in one department. Both nursing homes also had a medical doctor who visited regularly. Except for the doctors and managers, who were older, the majority of the auxiliaries and nurses were between 23 and 38 years old. The care industry is the single largest employer in the Norwegian labour market, and care work is heavily female-dominated and employs many workers from immigrant backgrounds (Reisel & Teigen, 2014). The staff in the nursing homes was female-dominated, yet several male auxiliaries with immigrant backgrounds and sometimes one or two male assistants of ethnic and racial majority backgrounds (a student with a part-time job) were also employed in the departments in which I worked, occasionally providing a near gender balance.

Compared to the ethnic and racial majority, immigrants occupied a more precarious situation in the nursing homes. First-generation immigrants from Central and Eastern Europe, Southeast Asia and North and East Africa, in particular, were constrained by the working conditions. They often held several jobs and worked in the shortest part-time positions, with some holding two or three jobs in different nursing homes. Others had an employment contract linked to their residence permit from the Norwegian Directorate of Immigration, requiring them to remain employed as an auxiliary nurse to retain the permit. Thus, the way ethnic and racial backgrounds intersect with workplace vulnerabilities is highly connected to immigrant status.

Research methods and data analysis

Studying complex processes, such as employee resistance, requires engagement in the everyday world of the organisation being examined (Prasad & Prasad, 2000). During the spring and summer of 2018, I worked regular shifts as an unskilled assistant while conducting research on auxiliaries in nursing homes. The study involved intense researcher involvement in the field, and I tried to enter the daily lives of the auxiliaries by gathering local interpretations and accounts. Thus, the study can best

be characterised as ethnography. Working voluntarily as an assistant while carrying out research provided a unique opportunity to study the everyday activities and relationships between the workers and different professional groups, as well as the auxiliaries' involvement with patients. Engaging in the nursing homes' activities also provided insight into the auxiliaries' tacit competence. Working alongside and observing the auxiliaries, I received access to their 'taken-for-granted' knowledge, which I may have not gained from interviews alone. Moreover, by working with various auxiliaries, I learned how different workers manage and respond to stress and problems. Ethnography also enabled me to observe the 'hidden transcripts' of resistance happening in the nursing homes' backstage contexts, such as the patient rooms.

The ethnographic fieldwork was short but intense. I worked regular shifts for two weeks in each nursing home and took field notes every day, both after the workday and during the shifts. I distinguished between different sorts of notes, such as descriptive notes about the situation, place and interactions (observational notes), and more theoretical, methodological and emotional notes (Gobo & Molle, 2017). The field notes were coded in HyperResearch. In addition to being informed by the literature on resistance, the coding process was empirically driven. The initial thematic codes, such as 'working conditions', 'devaluation' and 'resistance', were expanded with more descriptive subcodes, including 'autonomy', 'complaints' and 'work performance'.

The study obtained all necessary authorisation from the Norwegian Centre for Research Data. However, although I emphasised the informants' rights, such as informed consent, I am unsure if the workers understood my role and purpose as a researcher; I continually told my co-workers that I was pursuing a research project as a sociologist, but they repeatedly asked if I had managed to secure a permanent contract as an assistant and when I would finish my auxiliary nurse certificate. When I replied that I already had a job as sociologist, a common response was 'So what?', implying that most of them also had several jobs. Some informants who understood my role as a researcher continually raised questions such as, 'What is there to study here?' or 'Are you still taking notes?!' In a very different context, Wacquant (2005) points to similar experiences in his fieldwork in a boxing gym in the United States. He argues that the difficulty he faced in explaining to the boxers what a sociologist is and does may reflect the social distance between the researcher and informants, to whom academic culture may seem alien. The position the researcher is granted in the field depends on the kinds of roles available in the setting (Wind, 2008). On the one hand, my difficulties in explaining my mission may reflect a social *distance.* On the other hand, the workers' inclusion of me may also reflect a *familiarity* due to the specific gendered and racial characteristics of the work context. Being a brown-skinned woman born and raised in Norway may have allowed me a 'middle position' among a female-dominated and ethnically diverse staff; I was treated as one of the staff by the auxiliaries from both racial minority and majority backgrounds.

As this article concerns resistance that occurs under the management's radar, to protect the workers' anonymity and prevent them from being negatively affected by my analysis, I do not detail the context nor differentiate between the two nursing homes in the analysis. Although some differences exist, the contextual differences were far less striking than the similarities.

Resisting rationalisation and devaluation

As this article focuses on how auxiliary nurses negotiate the challenges of their jobs and resist and cope with the demands of authorities above them in the occupational hierarchy, it is necessary to briefly describe the challenges and problems they face. The auxiliary nurses encounter two distinct systems of control that contribute to undermining their status, worth and professionalism. First, they are constrained by the implementation of NPM in the care sector, and, second, they suffer from being misrecognised by professional groups positioned above them in the occupational hierarchy.

Although Norway has implemented soft versions of NPM compared to other countries, the elderly sector is characterised by poor working conditions (Rasmussen & Kjevik-Wycherley, 2019). Norwegian auxiliary nurses not only comprise the highest proportion of part-time employees in the Nordic countries (two-thirds of jobs are part-time) but also the highest proportion who work short, part-time shifts (Vabø et al., 2019). In both the nursing homes, some auxiliaries experienced stress and uncertainty concerning their work contract and shifts, such as whether they would accumulate sufficient working time during the month, how they would combine shifts and balance timetables from different work organisations and whether their temporary working contracts would be extended.

However, although the type of contract certainly influenced the auxiliaries' working lives, their daily work was primarily constrained by how the management controlled and surveyed their care work. The care workers often faced a discrepancy between the time required to meet the patients' individual needs and the actual time available for each patient. Budget cuts and new management instruments resulted in three interrelated changes in the organisations that constrained the workers' time and autonomy. First, institutional changes, such as removing the kitchen service, resulted in a greater workload; care staff now performed tasks previously performed by a kitchen chef, including picking up the patients' food from the stock daily, preparing every meal and washing the dishes. Second, the management used technology to measure and count care tasks, thereby standardising and governing the details of the auxiliaries' workdays. Third, the management expected the care staff to perform extra and often unforeseen tasks during the day without providing extra staff or economic compensation. These three changes can be seen as conforming to NPM's aim of 'getting more for less' by introducing 'professional' management and systems of accountability to control expenditure and increase efficiency (Rasmussen, 2004).

In addition to poor working conditions and new management instruments, the auxiliaries also dealt with professional groups positioned above them in the occupational hierarchy. During the fieldwork, it became clear that both homes were organised hierarchically; although the auxiliaries were the numerical majority, the nurses' and doctors' jurisdiction defined organisational knowledge. The nurses, doctor and managers devalued the auxiliary nurses' competence and often described it as 'detail knowledge'. Several auxiliary nurses, however, perceived this so-called 'detail knowledge' as crucial to providing good care and medical help and as a central part of their ethics of care and 'caring self' (Brown & Korczynski, 2017; Lynch et al., 2021). Such 'detailed knowledge' involves taking time for small talk, touching or telling the patient what is going to happen

before performing the task; it is about taking care of the small details, such as closing the curtains before undressing the patient or removing the plastic gloves when cleaning the patient's face, to give meaningful care. In addition to the formal division of work tasks due to differences in formal competence (the nurses were responsible for distributing medicine), the nurses cared for patients who did not require excessive 'hands-on' care while the auxiliaries worked with the patients who required intense physical labour. Thus, despite being the numeric majority, the auxiliaries were at the bottom of the organisations' 'professional hierarchies'.

Speaking up to provide decent care

Opposition by which workers openly resisted the problems in their jobs was relatively rare in the nursing homes. When the auxiliaries identified and described their own actions as confrontational or oppositional, the examples were usually of verbal, face-to-face confrontations with the management, nurses and doctors. They resisted by 'speaking up' in attempts to mitigate their problems (Hirschman, 1970). During my fieldwork, I observed most examples of overt resistance during the staff meetings, situations in which the auxiliaries interacted with the management and other professional groups, such as the nurses and doctor.

The auxiliaries engaged in overt resistance when their knowledge and perspectives on care were ignored by the nurses, doctor or management. Despite numerous attempts to highlight the important, and sometimes urgent, needs of the patients, most auxiliary nurses felt that they were not being heard. When their confrontation with the nurses did not produce any results, some auxiliaries tried to seek alliances with the doctor or management. In the weekly staff meeting attended by the doctor, usually only the manager, head nurse and doctor speak. However, during my stay, Helen, an auxiliary of an ethnic and racial majority background, spoke up at this weekly meeting about what she felt was a critical issue with one of the patients, a urinary tract infection, and presented it as an issue ignored by the nurses. By interrupting the conversation between the 'higher status' professions and framing the situation as an example of her not being heard by the nurses, Helen tried to protest against the nurses by seeking an alliance with the doctor. Her attempt to resist failed. Even before she had finished her description and critique of the nurses, the doctor interrupted her by physically turning back to the head nurse and stating 'I cannot deal with these details.'

The auxiliary nurses' attempts to influence the professional knowledge that organises their day and defines what type of care the patient receives were either ignored or sanctioned by their superiors. The management, doctor and nurses often had a different view of the situation and understanding of the problem than the auxiliary nurses, yet the auxiliaries lacked the symbolic power to impose their views. However, despite their powerlessness, several auxiliaries kept raising their voices and concerns. In one of the nursing homes, after losing countless battles over a new toilet chair for her patient, an auxiliary succeeded in being heard by the management and nurses by contacting the patients' family. The protest and resistance led to change only after the auxiliary involved the patient's family members.

By protesting what they see as neglect and practices that harm the patients, the auxiliaries enact a 'client-oriented defence of autonomy' (Brown & Korczynski, 2017). By

arguing against or defying the management and nurses, they attempt to disregard the formal professional hierarchy to provide what they see as decent and vital care for their patients. Although there were few examples of overt resistance in the nursing homes, the examples above illustrate how some auxiliaries used their voices in an attempt to influence the organisational knowledge of patients' health and wellbeing. In my observations, only auxiliaries from ethnic and racial majority backgrounds engaged in overt resistance. As previous research has also illustrated, non-dominant groups, such as immigrants and racial minorities, seldom engaged in overt resistance (Behtoui et al., 2017; Travis & Mor Barak, 2010).

Bending the rules to make time for the patients

Most workers' efforts to change work-related problems occurred under the managers' radar. To gain some control over their workday, the auxiliaries refused or mitigated the management's demands through their everyday acts, skirting and bending the rules.

One example of covert resistance was to ignore extra work tasks to ease the workload. After budget cuts, the laundry service, which had previously washed everything, cleaned only bed linen and towels. The auxiliary nurses were expected to wash the patients' clothes, as well as towels and linen with body waste, such as excrement. In a busy workday, the auxiliary nurses experienced this requirement as problematic: linen, sheets and towels were often covered in body waste, and time was already scarce. Instead of verbally protesting to change the management's demands, the workers threw everything with excrement into the rubbish, as I soon learned as an assistant at one of the nursing homes. There was a silent consensus about this practice, which was evident in the training and integration of new care workers. The passage below is drawn from my field notes taken while observing an experienced auxiliary nurse from Central and Eastern Europe train a new assistant on the assistant's first working day:

> The patient is too ill to leave the bed, so the auxiliary nurse washes her body while she is lying down. The auxiliary nurse explains in detail to the assistant what he is doing and why while performing his tasks. That you must fold the cloth around your hand in a certain way, that you should touch the patient gently on the arm and tell her what is about to happen before lifting the arm to wash it, that you use the sheets to turn the patient's body and how to manoeuvre the electronic lift. After finishing washing the patient, we bring the dirty sheets and linen out into the corridor. The auxiliary nurse shows the assistant the laundry's wall shaft for dirty linen and towels. However, there is one exception. Auxiliary nurse: 'If there is shit on the linen and towels, you don't send it to the laundry. You just take it in a waste bag and throw it in the rubbish container. There is a person working down there at the laundry who sorts all the cloth. And it's not cool for them to be covered in shit, you know. So, you don't send linen with shit down to them. You throw it away.'

The auxiliary nurse did not tell the new assistant that the management expected the care workers to wash the linen and sheets themselves or that the main reason for throwing them away was time constraints. He presented it as a matter of protecting the laundry workers. Despite the multiple meanings of this practice, it is an example of how apparently individual actions performed below the management's radar transform into

collective actions of resistance. A silent consensus existed among the workers that 'this is how we do it here'. Moreover, the example above also illustrates how the auxiliaries do not work harder when the management assigns them additional work, but downgrade the extra tasks so that the patients receive meaningful care. Thus, through their engagement in covert resistance, they enact the caring self in response to rationalisation (Brown & Korczynski, 2017). In the cleaning situation, instead of rushing to fulfil all management's demands, they take control of the situation and reclaim the time to attend to the small, yet important details of caring during the cleaning of the patient.

A similar consensus occurred around the auxiliaries' refusal to report care as 'quality time' in the reports. In addition to registering the cleaning and feeding of patients in a computer program, the staff must document other activities, such as 60 minutes of individual quality time and three outdoor trips with patients each week. The auxiliary nurses resisted reporting care as 'quality time' not so much because of conflicting views about what constitutes the standards of good care but out of opposition to the detailed management of their workday and the measurement and quantification of their tasks. In one of the nursing homes, the management was continually dissatisfied with the workers' efforts to register and quantify their care tasks in the computer system. However, even when the manager explicitly raised her concerns about the missing reports of this task, the workers did not verbally protest. Rather, their resistance took place subtly, such as by continuing to not register quality time or by redefining this task and registering what they were already doing, such as cleaning and feeding, as quality time.

The workers engaged in covert resistance by bending and stretching the management's rules. Regardless of their racial and ethnic backgrounds, the workers resisted the management by throwing away dirty cloth and redefining/not registering quality time. As previous research has also found, ethnic difference did not affect workers' engagement in covert resistance (Travis & Mor Barak, 2010). Although these responses to rationalisation did not change the structures in their organisations, they enabled the workers to gain autonomy during a highly regulated work day and to carve out some extra time to care for their patients.

Coping through efficient care

In addition to overt and covert forms of resistance, the auxiliary nurses had a third way of handling the time constraints and demands from superiors. During my fieldwork, it became evident that some workers neglected the care of their patients. To deal with distress and problems, they escaped through *disengagement.* One way the auxiliary nurses disengaged was by redefining what constituted good care by performing a type of efficient care work, characterised by selective compliance with the patients' needs, which allowed them to reduce their emotional labour. The example below, taken from my field notes, is from a feeding situation with a patient who was anxious. It could take up to half an hour to feed the patient one slice of bread without scaring him, and communication was crucial.

> Without saying what is happening, the auxiliary nurse puts three pieces of bread on the fork and pushes it into the patient's mouth. The patient screams and trembles all over his body. The

> auxiliary nurse turns to me and tells me that it is important to stuff the food in the patient's mouth while he is screaming. The meal takes five minutes. The patient eats the whole slice of bread but is terrified.

Efficient care work is another way of dealing with time constraints and the devaluation of the auxiliary's competence. Pressing the food into the patients' mouths or cleaning the patients without saying a single word allows the work to be completed more quickly. Instead of protesting, the workers responded to rationalisation by disengaging, a strategy that created an emotional distance between the workers and their work. When an alarm was beeping from a patient's room, it could be ignored, if another auxiliary nurse (regardless of their being available) had responsibility for that patient. Lee-Treweek (1997) describes a similar strategy where the care workers treated the patients as objects: care work is treated as an ongoing production process where the objects are cleaned and fed to a strict time regime. As Lee-Treweek (1997) observes, whilst caring for people takes time, ordering bodies to time and chore constraints allows the work to be less upsetting and done more quickly. In order to understand why care workers act with indifference to their patients, previous studies have argued that care work is ambivalent work. It does not only involve affection and other- centredness, but it also evokes the necessity to deal with dirty work and hard manual labour (Twigg, 2000). In order to get the job done, care workers may withdraw their emotional labour (Dahl, 2009; Lee-Treweek, 1997). Although the management did not approve of the auxiliaries who performed efficient care work and, in some cases, viewed their behaviour as neglect, the managers did not punish or sanction them. For the workers that did not enact efficient care, this type of disengagement was seen as threatening the caring self and the care ethics of auxiliaries, contrasting with what I previously described as the auxiliary nurses' 'detailed knowledge' of the patients' needs. While 'detailed knowledge' comprises person-centred acts, 'efficient care work' can be seen as depersonalised (Lee-Treweek, 1997).

In my ethnographic material, there exist a relationship between the enactment of efficient care and marginalisation. A common situation for the auxiliaries who performed efficient care work was that they had short, part-time and/or temporary contracts and balanced their working life between two or three different jobs. Thus, I would suggest that one interpretation of efficient care is to view it as a response to precarious work. These practices of disengagement were only evident among workers who had a fragile affiliation to the organisation or shared a vulnerability attached to their visa conditions. To cope with the work, these auxiliaries redefined their role as carers by providing depersonalised care detached from emotions and personhood (Lee-Treweek, 1997). Precarious work contexts provide poor conditions for gaining the knowledge necessary to comply with individual patients' needs. As previous studies have observed, positional power in the workplace may influence the repertoires workers use to cope and resist their work-related problems (Behtoui et al., 2017). It was the workers that were most disadvantaged in the organisation, first-generation immigrants, who enacted efficient care. However, given that this study builds on short-term ethnographies, more research is needed to interpret the different meanings of efficient care and the intentions of these workers.

Discussion

In order to get the job done, the auxiliaries use three different strategies in response to devaluation and poor working conditions. By speaking up and defying the management, nurses and doctor, they attempt to resist the formal professional hierarchy to provide what they see as decent care for their patients; by bending the rules they mitigate management's demands and reclaim the time for their patients; and they disengage and reduce their emotional labour through efficient care. These responses are distinct in their character and unequal availability to different groups.

As predicted, it was only the auxiliaries from ethnic and racial majorities who engaged in overt resistance. As other studies have illustrated, those who are the most disadvantaged and would gain the most from changing the situation are the least likely to exercise resistance, such as by speaking up (Behtoui et al., 2017; Travis & Mor Barak, 2010). However, in this case, as the study's analysis illustrates, the auxiliaries' attempts to change their conditions by speaking up were not welcomed and were largely ignored by their authorities. Furthermore, there were very few examples of overt resistance in the nursing homes. Although overt resistance such as 'speaking up' is often considered the best way workers can change organisational control (Hirschman, 1970), it was principally auxiliaries' engagement in covert resistance that defied and mitigated the demands of management in the nursing homes. In contrast to the much more confrontational and risky business of speaking up, the findings indicate that care workers that are positioned in the bottom of the care hierarchy, like auxiliaries, engage in subtle everyday forms of resistance. Moreover, both auxiliaries with ethnic and racial minority and majority backgrounds enacted such covert forms of resistance. Thus, the association between resistance, ethnicity/race and power inequality is weaker when it comes to covert practices of resistance. This may suggest that the strategy that proves to be the most useful in diminishing management control in the nursing homes is equally available to natives and immigrants. This form of everyday resistance was available to different groups at the workplace and created a 'tacit' collective agreement and shared culture of disengagement toward management demands.

Disengagement through efficient care, however, was not a strategy that created bonds between different groups of workers. As with the strategy of speaking up, coping through efficient care reflected an ethnic and racial hierarchy at work. The data from the ethnography indicate that there existed tension between the workers: in particular the auxiliaries who engaged in overt resistance felt threatened by efficient care work. Future research should explore in further detail how differences in the way workers handle their challenges at work influence workers' solidarity and communities of coping.

Conclusion

A key argument in the literature on care ethics is that care relations are different from other systems of social relations because they operate under an ethic of other-centredness (Lynch et al., 2021; Williams, 2018). Care is seen as a specific disposition, a way of being, defined by a commitment to the needs of others (Tronto, 2018). This implies that care cannot be completely commodified or withdrawn (Lynch et al., 2021). Yet debates

in the care literature have pointed to the problems in care ethics of naturalising and idealising care, stressing the need to recognise care work as manual labour and bodywork (Lee-Treweek, 1997; Twigg, 2000), as well as the consequences of new forms of governance such as rationalisation and NPM in health care occupations (Vabø, 2006). These perspectives underscore the importance of being aware of the ambivalence of care work, its other-centred character and simultaneously try to avoid overly strong ontological claims about the caring self (Dahl, 2009). One main argument underpinning this theoretical perspective is that resistance in care work seems to be implausible, when care work is understood as altruistically motivated and a unique practice of other-centredness (Lee-Treweek, 1997). Building on the perspective on care work as ambivalent work, this study demonstrate that care workers resist and negotiate the rationalisation of care work both by enacting a defence of autonomy for their patients (Brown & Korczynski, 2017) and by acting with indifference to the patients' needs through efficient care. This theoretical lens, which includes insights from both the sociology of work and the literature on care ethics, is important to acknowledge the coexistence of different motives and work relations in care work. By stressing the need to acknowledge the coexistence of negative and positive experiences and multiple projects of the self in precarious work contexts (Manolchev, 2020), I have shown how care workers are not passive recipients of rationalisation but deploy a repertoire of different resistance and coping strategies that both protect and undermine the caring self. Consequently, the study offers only partial support for the thesis of the caring self that argues that care workers will not withdraw their care in response to rationalisation (Brown & Korczynski, 2017) and neoliberal capitalism (Lynch et al., 2021). While enacting the caring self, care workers also provide efficient care – that is, careless care – to their patients. Thus, the study also draws attention to how the relative powerlessness of older people, the patients, is produced in complex ways within the current political economy.

On a general level, this study stresses the need to address how power differences between workers influence their strategies of coping and resistance. A key insight from the sociology of work, is that lack of positional power not only influences the pay and monetary rewards, it may also constrain individuals' pleasure in work relations and their choice of strategy (Acker, 2006; Behtoui et al., 2017). Although previous research has described how care workers resist work-related problems through strikes and public protests (Mulinari, 2018; Rogalewski, 2018), my fieldwork offered no examples of collective mobilisation among the workers and very few examples of overt resistance. This can be interpreted as a reflection of auxiliaries' subordinated position in the professional care hierarchy: they are doing the 'hands-on' care and suffer from societal misrecognition (Elstad & Vabø, 2021). As pointed out in the literature on everyday resistance, the powerless do not have the opportunity to resist openly, instead they mitigate demands through their everyday acts (Fleming & Sewell, 2002; Scott, 1985). Building on this insight, the study shows, on the one hand, how everyday struggles and the hidden transcripts of care work are critical for understanding labour agency (Anwar & Graham, 2020). Regardless of immigrant status and racial background, care workers bent the rules by refusing to wash dirty clothes or quantify their care tasks through registration. Although these hidden acts did not change the structures they resisted, it enabled them to carve out spheres in which they gained autonomy and some extra time to care for their patients. As

Manolchev (2020) observes, such soft forms of resistance should not be dismissed as harmless substitutes for 'real resistance' but underscore workers' ability to construct meaningful 'selves' within precarious contexts. On the other hand, the study shows how marginalisation is caused by the intersection of social inequalities: the devaluation of female-dominated work and increased rationalisation in combination with immigrants' vulnerable position within care work and the global economy (Williams, 2018). The most vulnerable care workers responded to rationalisation by withdrawing their care. An important task for future research, as well as policy development, is to acknowledge such intersections of social inequalities when addressing questions of the survival of the caring self and its potential as a site of resistance to the ethics of indifference and carelessness in market-driven societies.

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