Reproducing Care:
Changing Geographies of Nursing Work in the United States

by

Caitlin Renee Henry

A thesis submitted in conformity with the requirements for
the degree of Doctor of Philosophy
Graduate Department of Geography and Planning
University of Toronto

© Copyright by Caitlin Renee Henry (2017)
Nurses provide essential care to people in their most vulnerable times and perform myriad tasks that support the healthcare system as a whole. In spite of their essential role, nurses in the United States have been subject to devaluation individually and systemically, through underinvestment in nurse training, understaffing of facilities, and a lack of recognition for the work that they do.

This dissertation is a qualitative study of nursing work in the US, focusing on nurses’ experiences of their jobs since the 2008 financial crisis until 2014. I base my argument on interviews I conducted with 37 nurses working in New York City and St Louis, Missouri. I also analyzed a variety of texts including media stories, union publications, and discussion boards, as a complement to nurses’ own stories.

I examine three means of managing nursing work: the restructuring of the built environment of health services, the lengthening of the working day, and the changing modes of measuring and counting nursing work. I demonstrate different ways and scales at which nurses’ work and working conditions are changing during a dynamic period of restructuring in US health care. By drawing on interviews with nurses working in the New York and St Louis metropolitan regions, complemented with secondary textual analyses, I examine how broader changes to the political economy of
health care, specifically the built environment, shift length, and ways of measuring work, impact the mundane and everyday aspects of the nursing job.

Through these three means of governing nursing work, I add texture to theories of social reproduction. Social reproduction, or the reproduction of people and of everyday life and institutions, includes historically feminized work that sustains life, such as nursing work. Health and health care work, however, are under-theorized in the social reproduction literature. This dissertation contributes to feminist geography by foregrounding nursing work and the workplace of the hospital. While there is a rich literature in geography on the global migration of nurses and on the gendered dynamics of work, few scholars have engaged with the everyday experiences of nurses in their most common worksite. Furthermore, health geography has paid scant attention to the crucial roles that health care workers play in the making of health. Therefore, in this dissertation, I contribute to these literatures by focusing on the workers, how they and their work are regulated, and their subjectivities in relation to their work as it is restructured.
Acknowledgements

My research would not have been possible without the generosity and support of my family: Uncle Joe Neufeld for setting me up with a place to live in New York, my mom for helping me make connections with nurses in St Louis, and many others for both research and personal support – Elayne Dix, Marianne Neufeld, Ray Neufeld, Tom and Eleanor Neufeld, Greg Neufeld. And to all my family who sent me emails of support in the week before my defense. Thank you to my parents, Maggie and Mike, and my brother, Tim, for providing encouragement, moral support, and a safe haven when I need to escape from the drudgery of the diss. My mom gave me the inside scoop on nursing for most of my life and always helps me pick myself back up when I’m down. Most of what I know – and most of what follows here – I learned from her.

Thank you to my committee and additional readers for all of the feedback, engagement, encouragement, and healthy skepticism over these past 6+ years: Matt Farish and Emily Gilbert, and Michelle Buckley, Mark Hunter, and Margaret Walton-Roberts. And to my supervisor, Rachel Silvey: my cheerleader, engaged critic and mentor, generous hugger, and most enthusiastic reader of my work; I am so deeply indebted. Thank you, also, to many faculty members who constituted my shadow committee: Mike Ekers, Andre Sorensen, Deb Cowen, Judy Han, Raj Reddy, Sharlene Mollet, and Alana Boland (I’ll see you on the squash court!), as well as the faculty in the Center for Global Social Policy with Ito Peng.

And of course, a big thank you goes to all of the nurses who generously shared their time, thoughts, experiences, emotions, and opinions with me in interviews.

My reading group was one of the best experiences over my time as a graduate student. Thank you to Martine August, Dan Cohen, Martin Danyluk, Kanishka Goonewardena, Prasad Khanolkar, Brett Story, and Laura Pitkanen. The texts we read and discussions we had are reflected in my dissertation’s weird reference list and my meandering and promiscuous way of thinking.

I’ve learned a lot over my time at UofT, and much has been through union service. Thank you more than I can say to those who fought the good fight with me. Some of you pretty much saved my life in the hard times and were so life-giving all along, especially Sara Suliman, Ashleigh Ingle, James Nugent, and Amy Buitenhuis. And three years later, in the strike, Deltas Forever: Joe Curnow, Rebecca Bartel, Anjali Helferty, Maddy Whetung, Kevin Edmonds, Omar Sirri, Abe Singer, and Victor Lorenz. Similarly, friendships made through politics teach you a lot, and I’m grateful to all the friends I made working on the UofT General Assembly and all that you taught me: Faraz Vahid Shahidi, Alex Conchie, Zexi Wang, Vivian Endicott-Douglas, Will Nakhid, and Johanna Lewis.
Thanks to my housemates over the years at the Wright House, Jen Ridgley, Patrick Vitale, Simon Vickers, Annie McKenzie, and Katie Mazer. You provided support, compassion, laughs, and so much good food. I am so grateful for the community we have created and sustained together over the years.

Thank you to a great network of friends outside of the university for keeping me grounded: Kat Snukal, Andrew Kohan, and Marta Chudolinska in Toronto; in New York, Francesca Hays, Ana Djordjevic, Pedja Bilinac, Varuni, Joey Neufeld, Luis Gallo, Edward Djordjevic; Chad Watkins and Lindsey Schaffner in St. Louis/Belleville; Maria in Seattle.

Over this time in academia, I’ve benefited more than I’m worthy of from the friendship, encouragement, and collaborations with in ways small and big: Kim England, who got me into researching nurses initially and continues to shape my academic work; Caroline Faria made me a geographer in the first place back in 2005; Brit Gilmer, Josh Akers, and John Paul Catungal, who, without, I never would have even made it through my MA to do a PhD; Paul Jackson for our discussions on health and social reproduction, global health, and dogs; Lisa Freeman (#FemFrontlines for life); David Seitz for the invaluable support in teaching, especially during the death threats against feminists in the fall of 2015; and to the many more including Yui Hashimoto, Ann Bonds, Magie Ramirez, Tish Lopez, Carmen Teeple Hopkins, Raili Lakanen, Ozlem Aslan, Jaby Mathews, Jacob Nerenberg, Emily Reid-Musson, Jeff Biggar, Charles Levkoe, David Roberts, Nick Lombardo, Annie Bartos, Ayesha Basit, Sanchia DeSouza, Elizabeth Lord, Elsie Lewison, Cynthia Morinville, Lia Frederikson, Rebecca Osolen, Alex Marques, Shiri Pasternak, Heather McLean. And, crap, I’m sure I’ve forgotten many more of you.

Everyday, I am amazed by the support and love of those closest to me: my long-time housemate, rabble-rouser, co-dependent, Katie Mazer; Patrick Vitale for support, laughs, homegrown arugula, and an always compassionate ear. Jerry and Whitney Neufeld-Kaiser for being the best of friends to me, giving undying support and laughs, and being the greatest travel buddies and cousins. And to Nick McGee for keeping me calm, letting me rant, making me laugh, and much much more.

I’m so lucky to have landed in such a vibrant and political department. Reflecting on the dynamism in the department, from my time as GGAPSS president to annual trivia nights to Intersections speakers to long discussions at pub nights, I don’t think I would have finished my PhD if I were in a different department.
# Table of Contents

Chapter 1: Introduction 1
Chapter 2: Hospital Closures: The Sociospatial Restructuring of Labor and Health Care 46
Chapter 3: Time and the Social Reproduction of Health Care 83
Chapter 4: The Abstraction of Care: What Work Counts? 114
Chapter 5: Conclusion: Towards a More Just Geography of Nursing Work and Good Health 144
References 162
Appendix 1: Participant Biographies 183
Appendix 2: Interview Guide for Nurses 189
Copyright Acknowledgements 192
List of Figures

Figure 6: St John's Queens Hospital, fall 2013. 62
Figure 7: Closed Hospitals and Residents of Color by Census Tract (2010) 66
Figure 8: Closed Hospitals and Household Income by Census Tract (2000) 67
Figure 9: Closed Hospitals and Household Income by Census Tract (2010) 68
Figure 10: Free-standing emergency room 72
Figures 11 and 12: The new condominiums replacing St. Vincent’s Hospital 73
Chapter 1
Introduction

Nurses provide vital labor that sustains and reproduces health care systems. Yet, their work, which is feminized, suffers from chronic undervaluation that manifests in decades of stagnant wages and underinvestment in resources and training programs (Aiken 2007; Buchan and Aiken 2008; Mignon Duffy 2010; Kingma 2006). This dissertation investigates three different ways that nurses’ jobs in the US are managed in the everyday. With the downsizing of hospital systems and the implementation of the Affordable Care Act, health care in the US is undergoing significant changes, and these affect the geographies of health access, health services, and health care work.

This dissertation analyzes the everyday working conditions of hospital nurses, contributing to feminist political economy and feminist geographic literature on care work. I understand nursing work as part and parcel of the reproduction of health care institutions, of patients’ health, and of the nursing profession. Feminist geographers have developed a rich literature on care work, and my dissertation contributes to this body of research by focusing on nurses specifically. Nursing work, as a combination of skilled medical and care work, offers unique understanding of the intersection of skill, work, and gender. Furthermore, a geographic approach offers insights into the relationship between the spaces of work and the work itself. This dissertation brings
together an analysis of the changing and uneven geography of hospitals with an analysis of the hospital as worksite for nurses. Drawing on research of hospital nurses in New York City and St Louis, Missouri, I bring a geographic lens to nursing work, focusing on what this specific type of worksite can reveal about nursing work and commodified social reproduction.

**WHY NURSES? GUIDING QUESTIONS AND CONTEXT FOR THE RESEARCH**

Nurses are the backbone of the modern American health care system. They constitute the largest group of health care workers with 3.1 million registered nurses licensed in the US and 85 percent of those are presently working in the profession (AACN 2016). The total number of all ranks of nurses currently working in the United States, from the lower rank of licensed practical nurse (LPN) to higher ranks of nurse practitioner (NP) and nurse anesthetists (CRNA), is closer to 3.7 million (DPE 2016). They are the workers who have the most face-time with patients. As one nurse, Krista, said in an interview, “A lot of patients are afraid to talk to their doctors. I don’t think doctors are scary...I think nurses break it down for patients. They feel secure with the nurse, because when they’re in trouble, they always yell, ‘Nurse!’ They never yell, ‘Doctor!’ They always want the nurse for everything...They feel comfortable talking to us.” Nurses are often the workers whom patients trust most.

Nursing is a distinctive labor sector in several ways and attention to nurses contributes to understanding the intersection of gender, race, work, and value. Nursing is a combination of professional caregiving and skilled medical work, making the job
challenging to measure and value. Nursing is one of the most feminized professions. Not only are roughly 90 percent of nurses in the US women (USDHHS 2010), but also, only women were permitted to join the profession well into the 20th century (Glenn 2010; Reverby 1987).1 Seen by the profession, and through widespread popular assumptions about gender, as a suitable job for women because of its nurturing and caring requirements, i.e., women’s ‘natural’ abilities, nursing is one of the few professions that has long provided women with stable work. These forces contributed to making the profession almost exclusively made up of women. The gendering of the profession was thus self-reinforcing. The gendering allowed the devaluation of nursing for much of the 20th century, based on historical feminization of particular types of work that nurses perform, i.e., nurturing care work and intimate body work (see Mignon Duffy 2010).

Additionally, with approximately 75 percent of nurses being white (HRSA 2013, 23), the profession also has a fraught racial history, built on a tradition of morality, purity, and femininity that made nursing an acceptable type of work for – and a job nearly exclusively for – white women (for more detailed histories, see Glenn 1992; Hine 1989; Reverby 1987). Thus, the stable job was predominantly a white woman’s job. In recent decades, nursing has become more diverse, as more women of color have joined the profession.2 Additionally, nursing is becoming a more secure job through the

---

1 Nursing schools and the nascent American Nurses Association, the main professional body of nursing, ensured nursing was a women-only profession through informal and formal means, such as only training women to become nurses.
2 Although nursing was the first health profession to desegregate in 1949, it has struggled to better reflect the national population compared to other health professions. That said, nursing has become much more diverse since the mid-20th century when it was almost exclusively white (and segregated, see Hine’s 1989 history of Black nurses in the US). Nursing programs at community colleges as well as some (very limited) scholarships for nurses (both for minorities and those willing to work in
increase in unionization, with roughly a quarter of nurses in the US belonging to a labor union (Cobble 2010; DPE 2016; Semuels 2014). Nurses today are “the new auto workers” (C.H. 2014), as nursing is one of the few labor sectors with growing unionization rates in the US. In the past fifteen years, nurses and their unions have situated nurses as leading champions of good jobs and good health for all.

Finally, I conducted research in the context of a chronic shortage of nurses. For decades, administrators, health economists, and the nursing profession have been at odds over what constitutes adequate staffing levels. Importantly, however, actual staffing levels have often, though unevenly across spaces, failed to meet any of the ideal levels set out by these parties (Aiken 2007; Buchan and Aiken 2008; P. Buerhaus et al. 2002; P. Buerhaus, Auerbach, and Staiger 2009; Dall 2007; Dotson, Dave, and Cazier 2012; Kingma 2006). Facilities across the US have struggled to staff with enough nurses to provide safe and high quality care for patients. State and federal under-investment in nursing education meant too few nurses received training throughout the 1980s and 1990s to both reproduce and grow the nursing workforce at a sufficient rate to fill all of the vacant jobs. For working nurses the job was challenging, with high patient loads, declining resources in the workplace, and wages that remained stagnant or were slow to increase. Nurses have always been essential to the health care system and people’s access to health services. Yet, federal and state governments, educational institutions, underserved areas) has made nursing education more affordable for some. Also, desegregation, affirmative action, and targeted mentoring programs created more education and work opportunities for racialized nurses. With more employers requiring education beyond an associate’s degree, hospitals are providing education grants for their nurses to complete their BSN. Two nurses I interviewed were in such a program. Racialized nurses are considerably more likely than white nurses to have education above an associate’s degree. For an extensive discussion on diversity in health care workforces, see the Sullivan Report (2004).
and health care facilities have chronically, and unevenly across spaces, undervalued nursing work.

Nurses are a distinctive labor sector, as well as a workforce whose labor underpins the US health care system. Health care and nursing are activities that very much happen in place; they are material, relational, and interactive. Therefore, nurses’ work can add texture to geographic analyses of the body, landscapes of care, and the ways space and place shape people’s lives. A geographic approach to nurses’ labor can bring into a single analysis the everyday working lives of nurses and the broader political economic forces that shape the uneven geography of good working conditions and adequate care provisions.

**Guiding Questions and Concerns**

When I initially began my research in New York, I wanted to understand how and why what I understood as the chronic shortage of nurses persists and how the shortage impacts nurses’ job. I wanted to understand why, given that nurses are such essential parts of the health care system, a shortage could persist over decades. How could such important work warrant such underinvestment? In the field, as I began interviewing nurses, I revised my driving questions. Instead of strictly focusing on the shortage, I immersed myself in the everydayness of nurses’ jobs (I discuss this further in the methods section below). I focused on how the drastic changes I saw happening around me in my research sites impacted the daily work of nursing. I followed three key aspects of nurses’ work, examining the restructuring of hospital real estate space that has prompted a growing number of hospital closures (Chapter 2), the heightened
management and governance of nurses’ work time (Chapter 3), and the documentation of the tasks increasingly expected during nurses’ workdays (Chapter 4). These are each dimensions of the structuration of nursing work. By focusing on these aspects, this dissertation shows how these means of governance matter in the everyday of nursing work. In other words, I researched the conditions under which nurses’ labor was being restructured in the context of a long-standing undervaluation and exploitation of nurses.

This dissertation, therefore, focuses on three changes in the management of nursing work in hospitals in two US cities. The changes are happening at multiple scales and are coming from multiple sources – from nurses themselves, health care administrators, government committees, governors, and insurance companies, to name a few. Put simply, in this dissertation, I focus on how changes to the time, space, and measurement of nursing work impacts nurses’ practice and patient care. Each of these changes struck me as curious while doing research. The length of their shifts was a major concern for nurses and how they felt about their jobs. Why did nurses actually seem to want a longer working day? In my neighborhood and across the New York metropolitan area, I watched as hospitals closed and nurses and communities fought these closures. Why were hospitals closing in great numbers around New York City, and what did this have to do with nurses? In interviews I listened to nurses complain that the quality of care they are able to provide fails to meet their ideals, and that they feel the burdens of increasing amounts of paperwork and rising numbers of patients for whom they are responsible. How do staffing levels and documentation rules and norms impact nurses’ work, and what do forms of measurement obscure and reveal about the
work nurses do? Each of these issues, as I demonstrate in this dissertation, is part of broader changes in the practice and spaces of nursing work.

These empirical questions relate closely to my theoretical questions about social reproduction. How can work that underpins the entire health care system be so undervalued as to threaten the quality and availability of healthcare services? What is the relationship between the under and/or de-valuation of nurses and the incredible profitability of health care in the US’s hybrid public-private system? How are health and health labor commodities? How is health work social reproductive work? What does commodified social reproductive labor reveal about the valuation of reproductive work, relationships, and spaces more broadly? These questions animate this dissertation.

**Research in the Era of Health Care Reform in New York and St. Louis**

I conducted my research over ten months in 2013 and 2014, primarily in New York City, but with a smaller complementary two-week research stint in St. Louis, Missouri. This was an interesting time for American health care. During 2013 and 2014 the Affordable Care Act was coming into full effect. The national economy was still recovering from the economic crisis of 2008, and the recovery was uneven across the country, even though the crisis had officially ended (Greenstone and Looney 2013; Rampell 2010). Discourses of inequality had become popular. In fact, in the 2013 New York mayoral election, voters elected a candidate who campaigned primarily on addressing income inequality and fighting hospital closures in the city (McManus 2014).

---

3 This is not a comparative study, but a study of hospital nursing in two distinct but complementary US cities.
The Affordable Care Act (ACA), the largest overhaul in health care and health insurance since the creation of Medicare and Medicaid in the 1960s, came into full effect in January 2014, in the middle of my time in the field. As I conducted research in New York City, I watched the federal and state governments advertise new insurance plans and improved standards for existing plans for millions of people. In November of 2014, amidst the government shutdown, the federal insurance marketplace website crashed, testing people's patience for the new program (Humer 2013).

The ACA expanded access to both public and private insurance for millions of people in the US. It eliminated common discriminatory practices in insurance plans, such as excluding pre-existing conditions and charging women higher rates than men (Glied 2014). The ACA and its rollout also shed light on the entrenched landscape of health inequalities, at macro and micro scales, across the US. Twenty-one states rejected federal money that would expand Medicaid coverage, an insurance plan for poor people and children administered by each state (which also varies in quality and access by state) (Whitehouse.gov 2015). This left 4.3 million people caught in the “coverage gap”: people too poor to afford the new government subsidized private insurance plans but not poor enough to qualify for Medicaid under pre-ACA requirements. For states that accepted the federal funding and for millions of people able to access the subsidized and improved plans on the insurance marketplaces, health care became more accessible. Though full of faults, the ACA made a bit less uneven what had been a greatly uneven geography of access to health care services and insurance.

For health care facilities, the ACA created many unknowns. Nurses I interviewed said their administrators were nervous, unsure of how the expansion of insurance
would impact an already financially unstable hospital system. As I address in more
detail in Chapter 4, a central worry for administrators and health care staff was how
new requirements for Medicare reimbursements would impact hospital budgets, and in
turn, quality of work and care.

Additionally, and importantly for my two research sites, inequality had been
growing in both New York and St. Louis (Berube and Holmes 2016). New York ranks
among the most expensive places to live in the US as well as a city with stark inequality
(Berube 2014). St. Louis is a deindustrialized city that felt acutely the effects of the 2008
recession which followed decades of industrial decline and persistent racial
segregation.

My primary research site was New York City. New York is a city of extremes. It is
the center of global finance, a destination for immigrants from around the world, and
one of the densest cities in the country. Residents live in gross inequality, meaning that
some of the richest and most impoverished people in the US share the same city (see
Berube 2014). New York, as Massey (1994, 155–156) explains, has a “uniqueness of
place” developed out of its “distinct mixture of wider and more local social relations.” It
is unique and also, to some extent, reflective of the world. As Sassen (2000, 80)
explains, global cities like New York “allow us to specify a geography of strategic places
at the global scale;” in other words, because of its location in the global economy, New
York especially speaks to both the local and outward to the global. The inequalities in
New York City are examples of the “localizations of the global”. As Sassen (2000, 83)
explains, “the implantation of global processes and markets in major cities” has
internationalized parts of the economy, “[imposing] a new set of criteria for valuing or
pricing various economic activities and outcomes. This has had devastating effects on large sectors of the urban economy.” These impacts are unevenly felt, disproportionately affecting women and people of color as well as social reproductive labors both paid and unpaid. The work of care in New York sheds light on both global and intimate impacts of capitalism and neoliberal economic politics.

St Louis served as a smaller complementary research site in the broader research project. St Louis is a very different city from New York in the size of its economy and population; it is more similar to other mid-sized US cities. The political economic situation in St Louis is emblematic of the long-term urban crisis that many cities in the US have faced over the 20th century (C. Gordon 2008; K. Jackson 2006; Sugrue 2014). Today, it is a city still visibly struggling after deindustrialization and the 2008 recession. Inequality and segregation are stark. 4 High rates of poverty and a population of mostly racialized residents characterize the small St Louis City, north in St Louis County and across the Mississippi River in the East St Louis, Illinois area. Very wealthy suburbs surround the city to the south and west and working- and middle-class suburbs sit east of East St Louis. These suburbs also have significantly higher proportions of white residents than the cities of St Louis and East St Louis.

The health care landscapes in New York and St Louis differ greatly. New York has a rather extensive network of eleven public hospitals, while St Louis has none. In St Louis, as in many cities and states, for-profit care dominates; many mid-sized cities like

---

4 For an extended discussion of the geography of demographics in the St Louis metropolitan area over the 20th century to early 2000s, see Gordon (2008).
St Louis have few-to-no public hospitals (see Kaiser Family Foundation 2013).\textsuperscript{5} In this dissertation, I use interviews with nurses in St Louis as a complement to those of nurses in New York. The research in New York constitutes by far the bulk of the data I use. Because of their similarities and differences, New York and St Louis are good complements as research sites. The pairing of these sites offers a unique window into the reproduction of health care work and reveals the differences, similarities, and continuities of the uneven geography of health care work and quality health services in the post-recession US.

While I build my arguments on research in New York and St Louis, the geography of this dissertation is of and in hospitals in the United States. The workplace as a geography is central to my research. All of the nurses I interviewed work in hospitals or outpatient clinics that are operated by hospitals. Grounding an analysis of nursing work in the space of the hospital is logical and makes historical sense. Nurses were essential to the establishment of the modern hospital, with student nurses serving as inexpensive or, often, free labor for the nascent institutional system of hospitals (Hine 1989; Reverby 1987). Hospitals, today, continue to be nursing institutions, as patients are admitted only when they need nursing care (S. Gordon, Buchanan, and Bretherton 2008, 12). Though hospitals are not the only place where nurses work, they

\textsuperscript{5} There are three types of hospital ownerships in the US – state/local government, non-profit, and for-profit. For-profit hospitals dominate in the southern states, while non-profit (and to a lesser extent state/local government) facilities are predominant in northern and northwestern states (Kaiser Family Foundation 2013). In New York State, 86% of facilities are non-profit and the remaining are state/local government facilities. No for-profit hospitals have operated in the state since 2008. See also McLafferty (1982; 1986) and Chapter 4 for more on the decline of for-profit hospitals.
are the predominant employer of nurses, with nearly two-thirds of nurses working in inpatient and outpatient hospital services (HRSA 2013, viii).

As McDowell (2009, 1) explains, workplace analyses are especially useful for analyzing interactive service work. She explains that, “through the lens of the workplace, the emphasis is on the sorts of embodied interactions that take place in everyday exchanges between the three sets of actors involved in these exchanges: workers, managers, and clients/customers.” For health, the workplace is a key site where the interaction between nurse and patient happens and also where government regulations and funding are put into action.

The following three chapters approach the geography of hospitals in different ways. In Chapter 2, I address the intersection of nurses’ work and the uneven geography of hospitals in New York. Using New York as a case study for analyzing the impacts of state-driven downsizing of the hospital system, I investigate the impacts of the changing geography of hospitals on people’s access to good jobs and to health services. In Chapters 3 and 4, I go, as Marx (1981, 279) might say, into the “hidden abode” of the hospital. As Fraser (2014, 61) argues for, these chapters work to “fill in [the] background conditions of possibility” of health care and nursing work. Background conditions, for Fraser, constitute the social relations that underpin capitalist production and exploitation, and “social reproduction is an indispensible background condition for the possibility of capitalist production”. Thus, the hospital is

---

6 As a comparison, of licensed practical nurses, the rank below registered nurses, less than a third work in hospitals. Over the past decade, the proportion of LPNs working in hospitals has declined, and the real numbers of RNs working in hospitals has increased.
an apt site for investigating nursing work, one of the “background conditions” of health and health care.

These latter chapters address the worksite itself, analyzing how changes in shift length (Chapter 3) and in modes of measuring and documenting nursing work (Chapter 4) shape nurses’ work in the hospital. These two chapters address issues happening across the US, rather than changes that are specific to New York or St Louis hospitals. My scale of analysis is therefore the workplace, both of nurses’ workplaces and within their sites of employment. While I focus on the workplace, work is not bounded strictly by the shift or the facility. For example, in Chapter 3, I address the question of work-life balance and spillover. For nurses working 12-hour shifts, work time and the energy and emotions their work demands regularly spills over into time off and at home. As literature on work-life balance has long argued, a clean break between work and non-work life rarely exists (J. Keene and Quadagno 2004).

Additionally, the spatial organization of labor in hospitals mirrors that of the heteronormative nuclear family households. Specifically, hospital spaces and work performed there are structured in ways that reflect the gendered hierarchies of professions. Medicine is masculine and historically dominated by men, while nursing is its feminine other, dominated by women. Nurses have more contact with patients, carry out doctors’ orders, and are more visible and spend more time on the floor or at the nurses’ station, while doctors have historically been in charge of running the entire hospital and making the bulk of decisions around patient care (Glenn 1992; Hendrich et al. 2008; Sweet and Norman 1995). Similarly, hospital birthing rooms show how the lines between public and private are blurred alongside the lines between production
and reproduction (Fannin 2003). Hospitals try to recreate the home in birthing rooms, bringing the domestic into the public sphere of the hospital through the process of reproduction. In direct response to homebirth advocates who were critical of the sterile hospital birthing atmosphere, facilities transformed birthing rooms into “newly ‘personal’ environments” to match medicine’s new “philosophy that no longer views childbirth as pathological. Birth is now so natural...that it belongs at home” (2003, 513-514, emphasis original). The new birthing center “situates the birthing woman within both domestic and institutional space...masking [the] technological sophistication behind the mundane trappings of domesticity” (2003, 518). Therefore, the home itself becomes commodified in the name of reproduction in order to capitalize on the profitability of childbirth in America. In my own research, many of the nurses I spoke with specialized in labor and delivery. They spoke of a similar trend happening now in which hospitals are marketing themselves as state-of-the-art mother-baby centers, competing for customers with other facilities in the New York region.

THEORETICAL UNDERPINNINGS

Two theoretical intersections underpin this dissertation. The first intersection is health and social reproduction. I argue that approaching health through the lens of social reproduction offers specific insights. The second intersection is that of feminist political economy and labor geography. In the next section, I outline both of these intersections, explaining how this dissertation contributes to these bodies of literature.

I approach the dissertation research from these theoretical angles for a few reasons. As a feminist geographer, I first and foremost approach the work and
restructuring of nursing from a feminist perspective. I have found theories of social reproduction and literature on care work to be the most useful because of their insights into the commodification and feminization of reproductive work. Second, as I explain later, health geography has paid scant attention to labor, leaving me to develop engagements elsewhere with other literatures, specifically the feminist theories and literatures mentioned above. Finally, because I initially came to study nurses through the care work literature, my engagement with questions of labor are filtered through that body of scholarship.

**Health and Social Reproduction**

Importantly, nursing is social reproductive work, and this dissertation contributes primarily to feminist political economic theories of social reproduction. Social reproduction refers to the biological reproduction of the species as well as the everyday work and institutions that contribute to the reproduction of everyday life (Bakker and Silvey 2008b). The term refers to “a structured set of practices that unfold in dialectical relation with production, with which it is mutually constitutive and in tension” (Katz 2001b, 711). Social reproduction captures the work, relationships, and institutions that, in part, underpin the productive sphere. This includes human reproduction and raising children, but also other forms of paid and unpaid care work, social services, and institutions such as schools and churches. Social reproduction also encompasses health care workers and institutions, such as hospitals and long-term care

---

7 Fortunati (1995) explains that reproduction reproduces the worker, enabling him [sic] sell his labor power. The reproducer’s relationship to capital is mediated by the worker.
facilities. In this dissertation, I aim to refine social reproduction as an analytic tool for health and health care work.

For Marx, social reproduction was a narrow set of spaces and labors (Strauss and Meehan 2015, 6–8). Marx understood reproduction as dependent upon production, and he understood consumption as central to reproduction. His conceptualization of social reproduction limited the concept to the (re)production of the labor force. Feminists have expanded and developed the concept considerably from Marx’s initial narrow definition.

Marxist feminist research has been central to expanding the concept, using it as an analytical tool for research on “how we live” (K. Mitchell, Marston, and Katz 2003, 416). “Long after the workday expires and the shop floor is shuttered, these crises” – which they identify as rooted in global political economic restructuring – “hemorrhage into the spaces of life’s work” (Strauss and Meehan 2015, 3). In other words, spaces of work and spaces of life bleed into each other, and analyzing the work and spaces of social reproduction is essential to a nuanced understanding of the impacts and processes of global political economics. Feminists have broadened the umbrella of ‘work’ to include paid and unpaid work involved in reproduction as well as address the continuities and differences in social reproduction across contexts (Bakker and Silvey 2008a, 3–4). In other words, the spaces, labors, resources, and relations of social reproduction are at the center of important struggles over the quality and conditions of everyday life.

---

8 See Bakker and Silvey (2008a) and also Strauss and Meehan’s introduction to their (2015) edited collection for a more detailed genealogy of social reproduction and how geographers have taken up the term.
Geographers have paid special attention to the spaces and scales of social reproduction and to the ways that social reproduction is “secured through the shifting constellation of sources encompassed within the broad categories of the state, the household, capital, and civil society” (Katz 2001b, 711). They have drawn attention to reproductive work done in the home (England and Stiell 1997; Giles, Preston, and Romero 2014; Pratt 2004); the reproduction of the state (Kofman 2012; Oswin 2010; Silvey 2008); gendered and racialized reproduction (Braedley 2010; Parker 2015); and the intersection of social reproduction and public space, from practices of reproduction (Fannin 2003; Fredericks 2015) to uneven capitalist investment in reproductive public spaces (Harvey 1978; Katz 2001a; Loyd 2014). Geographers have found the foregrounding of the politics of social reproduction in analyzing inequalities and political economic processes to be fruitful and insightful.

Like any concept, social reproduction has its limits and its critiques. Some have critiqued social reproduction for reifying a binary with production (Gibson-Graham 2006b; Strauss and Meehan 2015). Encapsulating so much of daily life, social reproduction can seem to capture almost everything. While social reproduction is a somewhat nebulous and overly broad concept, feminists have used the concept fruitfully to analyze the materiality of ‘women’s work’, or the feminized, paid and unpaid work historically relegated to women (Federici 2004; Fortunati 1995; Meehan and Strauss 2015; K. Mitchell, Marston, and Katz 2004). Feminists and feminist geographers have demonstrated how the feminized work, spaces, and materials of social reproduction have been devalued economically (Federici 2004; Glenn 1992; Pratt 2008), and made to appear as non-work (Fortunati 1995).
What I find useful about social reproduction, though, and what keeps me using it as an analytic, is the way that it foregrounds the necessities of life, such as material goods, emotional labor and care work, relationships, housing, education, and health care. Also, the concept focuses attention on how the (re)production of those necessities happens unevenly across time and space, within and across scales, crosscut by identity and structural privileges and oppressions. As Strauss and Meehan (2015, 2) argue, as a tool for analysis, social reproduction,

potentially facilitates the exploration of both precarious work and precarious life as mutually constitutive conditions of subordination and oppression, while recognizing – as Butler does – that all bodies, all social and ideological formations, are reproduced through human labor and are therefore precarious to a degree. The concept of social reproduction...is also a lens for focusing on the unequal distribution of conditions of flourishing that render some bodies, some workforces, and some commodities far more precarious than others. As economic restructuring has intensified demands for time, labor, and value extraction ‘at work,’ we recognize that recent crises – economic, political, and environmental – have also reconfigured the conditions and possibilities for life’s work.

Strauss and Meehan emphasize precarity in part because of the contingency of life in late capitalism. With the increased privatization of life’s needs via neoliberal economics and policies, the necessities of life become unevenly distributed, accessed, and experienced. The tools, resources, and institutions of social reproduction become harder to access for many people. Social reproduction is a lens for examining how inequalities are relationally produced and contested (Bakker and Silvey 2008a, 5). As an analytic tool, social reproduction also demands and envisions new possibilities. Katz (2001b), in her now classic piece argues that social reproduction unveils wrongs and demands recourse. She states that social reproduction shines light on the “havoc wreaked on [material social relations] by a putatively placeless capitalism” and requires
“[addressing] questions of the making, maintenance, and exploitation of a fluidly differentiated labor force, the productions (and destructions) of nature, and the means to create alternative geographies of opposition to globalized capitalism” (2001b, 709).  

Social reproduction, as Katz explains, appears to be everywhere at once. Indeed, this is one of the limitations of the concept. Yet, Katz (2001b, 718) argues, this “ubiquity,” of having a “mushy consistency and an almost infinite number of locations...makes [social reproduction] so important to redress in the wake of...assault on its forms and practices”. The ubiquity of social reproductive work, institutions, and materials lays bare the political economic changes over the past few decades around the world. A social reproductive lens enables an analysis of the changing geography of production and reproduction, of the uneven material conditions of everyday life.

Social reproduction is particularly useful for analyzing nurses and their work. Nurses help people through the life course, from pre- to post-natal care for pregnant women and new mothers, through to the later stages of life with long-term nursing home care and hospice. Nurses provide essential public health education and are central to preventative health care, working on bodies in very material ways. Finally, nurses, as the largest segment of the health care workforce, are essential to the reproduction of health care institutions and the workforce. They maintain, repair, and assist people in times of sickness and injury, as well as helping in biological reproduction.

Importantly, health and health care institutions often appear in the list of examples of sites and institutions of social reproduction (for examples see Harvey  

---

9 See also Bakker and Silvey for a detailed discussion of social reproduction in light of this “global neoliberal restructuring” (2008a, 4 and Chapter 1).
Few scholars, however, have fleshed out how and why health falls under the umbrella of social reproduction or the implications of taking such an analytical approach to health (Connell and Walton-Roberts 2016; Henry et al. 2015; P. Jackson and Henry Forthcoming; P. Jackson and Neely 2014; Loyd 2014). This dissertation takes the position that approaching health—the institutions and systems, the work of health, and health as a process and state of being—from the lens of social reproduction offers unique insights for understanding the uneven geographies of health work and, by extension, health care services. Good health is foundational to everyday life. If people are not healthy, do not have healthy environments to live in, or have no health care workers to care for them, then people cannot take care of themselves and their communities. The reproduction of society depends on having healthy (enough) people and institutions. Because of this, the politics of health and health care have been central to social justice movements (for example, see Loyd 2014). Furthermore, the often-quoted portion of Katz’s (2001b, 711) definition of social reproduction—“the fleshy, messy, and indeterminate stuff of everyday life”—speaks directly to health. Health is a bodily and material state of being and arena of struggle. Questions of health encompass bodies from the abject, sick, and messy to the hygienic and clean to the pregnant. Diagnoses, pain, and care are all fleshy, messy, and indeterminate at once. If social reproduction is the fleshy and messy stuff of

---

10 This part of Katz’s quote is over-used as a quick definition of social reproduction. Overall, I think that it does not explain much about social reproduction, except when thinking about health. In the rest of her definition, she explains that it encompasses biological reproduction both inter-generationally and in the everyday through the acquisition of basic needs and the reproduction of the labor force “at a certain (and fluid) level of differentiation and expertise”. Social reproduction “is also a set of structured practices that unfold in dialectical relation with production, with which it is mutually constitutive and in tension.” For the full quote, see page 711 in Katz (2001b).
life, then health, being very fleshy and messy, presents an insightful avenue to explore those very qualities, politics, and social relations.

Loyd (2014, 14–15) understands health as a matter of social relations, contested at many scales, and full of possibility. She explains that health is “more than an absence of unfreedom, but positively animates what we might understand as freedom…as an individual and collective bodily self-determination.” For Loyd, health is first the embodiment of socially produced norms, harms, and privileges. Second, the discourse of health, she explains, “marks people's desires for well-being, flourishing, bodily integrity, and self-determination” (2014, 14). Health, and the struggles over it, brings together short and long-term needs and social justice strategies. This includes simultaneously the meeting of everyday needs and the necessity of a healthful, socially just, and freer new world order.

By Loyd's definition, the work and workers of health are part and parcel of the individual and collective struggles, successes, and manifestations of health. Health workers are political agents empowered with helping to positively animate the freedom that people individually and collectively achieve. Health takes center stage in social reproduction, freedom, and political struggles. This dissertation demonstrates the usefulness and importance of considering health as part and parcel to social reproduction; health is simultaneously a commodity, state of being, service, and social relation. I hope that this dissertation contributes to Loyd’s understanding of health, with health care workers being central actors in that struggle.

---

11 Scholars of care have also highlighted how power dynamics between caregiver and care recipient can be negative and/or abusive. At the very least, the power balance between the two parties must be negotiated. For examples see Milligan (2005; 2009).
**Feminist Political Economy and Caring Labor Geographies**

Work is what connects the two theoretical intersections that underpin this dissertation. It provides the pivot from health and social reproduction to feminist political economy and labor geography. Health care workers are central to the provisioning of health care services and the reproduction of health care institutions. Yet, health care work and workers remain understudied in health and medical geography (see Andrews and Evans 2008; Connell and Walton-Roberts 2016; some exceptions of note include Bondi 2004; Brown 2003; England and Dyck 2012). Since Andrews and Evans (2008) called for more attention to health care work, little has changed. In their recent review piece, Connell and Walton-Roberts (2016, 1) lamented that while medical geography has expanded to become a “more broadly based health geography,” the sub-discipline lacks the same attention to workers and the everyday (re)production of health services and institutions. Geographies of health, they suggest, need to better incorporate labor and feminist geographies in their analyses of the contemporary period of health transformation and globalization.

Therefore, while I contribute to health geography in this dissertation, I do so tentatively, as I have often found fewer resonances with my work there than as compared to literatures on feminist political economy and on care work and labor geography. In fact, Andrews and Evans (2008) point to feminist theories on care work, economic geography, and literature in nursing studies as key literatures for the study of labor in health. Connell and Walton-Roberts (2016) echo this call, with a focus on labor
and feminist geographies. Similarly, Jackson and Neely (2014), in heeding calls from other health geographers for more engagement with critical theory and geography, argue that Marxist-feminism is one theory that can bring a more explicit and nuanced engagement with political economy in health geography.¹²

In geography, most attention to nurses has come from feminist geographers researching and theorizing care and social reproductive work. This body of research has situated nurses within a global devaluation of and squeeze on social reproduction (Raghuram, Madge, and Noxolo 2009; Walton-Roberts 2012; Yeates 2004a). Nurses are but one example of the intensified extraction of reproductive labor in global capitalism that also includes the paid and unpaid work of domestic workers, nannies, teachers and librarians, various social service workers, as well as families and communities. Much of this labor falls to poor and precarious women, racialized people, and people from and in the Global South (Enloe 2004; Federici 2004; V. Lawson 2007; Nagar et al. 2002).

Of the care work literature on nurses, most scholars have approached nursing work and the workforce by focusing on migration. Nurses, also part of the global squeeze on social reproduction, are not only in short supply in the US. Much of the Global North is has too few nurses to fill staffing vacancies, and countries have recruited or “poached” (R. Nelson 2004, 1743) nurses from abroad to fill such care deficits.¹³ This

¹² Health geography has not ignored feminist theory, however. Some notable examples of feminist interventions in health geography include Bondi and Burman (2001), England and Dyck (2012), and Parr (2003). There is a separation, though, between the sub-discipline of health geography and geographers who address health questions. See Jackson and Neely (2014) for discussion of these two (generally separate) bodies of work.

¹³ A care deficit refers to the lack of care provisioning available in a society (Hochschild 2000; Raghuram 2012). Care deficits are multi-scalar, existing in the household and community as well as society more generally. Care deficits include both paid and unpaid
international recruitment, scholars have shown, exacerbates the stress on already fragile health care systems in the Global South (Kingma 2006; Mackintosh, Raghuram, and Henry 2006; R. Nelson 2004). Scholars have focused on the dependency across Global North countries on foreign-trained nurses who often come from the Global South (Choy 2003; Kingma 2006; Kofman and Raghuram 2006; Mackintosh, Raghuram, and Henry 2006; Walton-Roberts 2012; Yeates 2004a) and on the politics and experiences of migrant nurses (Dyer, McDowell, and Batnitzky 2008; England 2015; England and Henry 2013; Pratt 2008; Raghuram 2007). This scholarship highlights that the nurse shortage is global, uneven, and part of the inequitable squeeze on social reproduction.

In geography few scholars have approached the work and politics of nursing outside of the lens of migration (Brown 2003; McDowell 2009; Milligan 2005; Milligan and Wiles 2010). Broadening the research focus from migration to nursing work overall can care workers – from parents to domestic workers to health care workers. They can also refer to structures of caring. In other words, a structure such as a health care system may be inadequate for meeting health care needs. Thus, it leaves a structural care deficit. For example, the US is experiencing a care deficit not only in the shortage of workers to provide care, but also at a systemic level. This produces an uneven geography of care and health, such that the care deficit is a national crisis, felt more and less severely across space. At the same time, care deficits exist at broader scales when women, primarily from the Global South, migrate to the Global North to fill care deficits there. These flows are what Hochschild (2000) calls a global care chain (see also Parreñas 2001; Walton-Roberts 2012; Yeates 2004a; 2004b). Nurses, nannies, domestic workers, and other care and social reproductive workers make up these care chains. Thus, given the scope and geography of the global nurse shortage, care deficit is a useful term to understand the crisis. Deficits of care services and deficits of care workers are connected. In real numbers, the availability of workers is central to the existence or not of health care deficits. If there are no workers to provide care, people experience a care deficit. If there are no institutions or structures, then the work of providing health care becomes difficult. As Farmer (2014) succinctly explained in the 2013-2014 Ebola crisis in West Africa, “without staff, stuff, space, and systems, nothing can be done.” Yet, the existence of a deficit cannot be reduced to numbers alone. Rather, the availability of workers and institutions of care need to be considered alongside the political economic conditions that govern people’s access to health care and health jobs.
uncover the mechanisms, actors, and social relations that manage the provisioning and qualities of health work and services. This can add nuance to the rich analyses and insights of the nurse and care worker migration literature. Such an approach contributes to not only complicating the nurse migration literature, but also geographical literature and theories on work more broadly.

Nurses fit well in the care work literature, for reasons more complex than just the work that they do. Care work is a type of social reproductive work. If social reproduction encompasses all of the work done to sustain life, care work describes the interpersonal and relational, often nurturing, work done for “meeting personal needs or contributing to personal development” (Mignon Duffy 2010, 15). This includes a broad range of work such as nursing, teaching, domestic work, and cooking. Understanding care work as under the umbrella of social reproduction keeps a feminist political economic analysis at the center of studies of such work. This approach situates care work within the broader political economic context, focusing on the global and the intimate and their mutual constitution. Also, this approach addresses the racialized and classed hierarchy within care and reproductive work that Glenn (1992; 2010) and Duffy (2007; 2010) so sharply outline.

The care work literature has, in particular, demonstrated the ways in which different types of femininity are naturalized and mobilized for different types of work. For example, England and Steill's (1997; and Stiell and England 1997) research on nannies in Toronto and Rosenbaum's (2014) on domestic workers in Los Angeles show how normative expectations of femininity, place, immigration status, and race influence the experiences of nannies and domestic workers. These norms also reflect both
employers’ understandings of themselves and of which women (from where) they believe are the best fit as their children’s nanny. Raghuram’s (2007; 2009a; 2012) work on migrant nurses in the UK investigates the intersection of race, gender, and work, revealing experiences of racism ranging from outright to more passive expressions such as language classes to alter immigrant accents.

Nurses are social reproductive workers for whom care is a central part of the job they perform. Understanding nursing’s relationship to gender and race can add nuance to the rich care work literature. For example, nursing’s history and the legacy of Florence Nightingale, a founder of modern nursing, demonstrate the potency of normative gender expectations in work. Nightingale based her ideas on a belief in women’s abilities to “restore health in both homes and hospitals...Nightingale’s model for nursing revitalization, and the hospital’s reordering, was built on an uneasy alliance among concepts drawn from the sexual division of labor in the family, the authority structure of the military and religious sisterhoods, and the link between her moral beliefs and medical theories” (Reverby 1987, 41). The development of nursing was both built on and facilitated by its own feminization.

Nightingale and her disciples believed that nursing was exclusively women’s domain. A woman’s character was central to her nursing; her capacity for nursing skill

---

14 Nursing was empowering for women because it offered them paid work, education, and some authority. Nurses were subordinate to doctors, as a profession and within individual facilities. While they did not want to challenge male authority in the health care and hospital system, nurses did seek to establish nursing as “a female hierarchy that was equal to, but separate from, that of the men” (Reverby 1987, 42). As Reverby (1987, 42) explains, “the nurse was to be loyal to the physician, but not servile”. Nightingale’s ideas toe the line of subservience. Nursing was to be its own sphere; nurses were supposed to have trusting, but not necessarily dependent, relationships with (male) physicians, or as Nightingale explains, “the independent sense or energy of
was determined by her character (1987, 49-50). Nightingale’s ideas of nurses as young, virtuous, self-sacrificing, and morally upstanding permeated the profession’s identity well into the 1970s.\textsuperscript{15} These character qualifications worked to preserve the profession for predominantly middle-class white women, as nursing identified them as embodying a particularly ideal type of femininity for the profession (Glenn 1992; Malka 2007; Reverby 1987). Identity and work tasks operate in an iterative relationship. ‘Womanly’ nurses performed feminized duties of health care, such as nurturing, cleaning and hygiene, and maintaining an orderly unit, which kept nursing a feminized realm distinct from medicine. Yet, this preservation was in tension with the actual dirty work of nursing, as McDowell (2009, 163) explains. The feminine angel image invisibilized the fleshy, bodily, and messy work. The emphasis on caring as central to nursing work sanitized and naturalized nursing work to be suitable work for middle class women. They could stay, or become even more, respectable by doing nursing work. Providing care for others, McDowell explains, “is associated with women’s ‘natural’ talents of empathy and sympathy, able and willing to perform tasks of social reproduction and bodily care that are often associated not only with the body but with the private, the personal and the intimate realms of embodiment”. When Nightingale and her contemporaries characterized nursing as maternal, loving, and the natural work of women, the dirty work of nursing became more palatable or invisible; the dirty work could be ignored when the maternal work was emphasized (see S. Gordon and Nelson responsibility.” Thus while nursing was set up as distinct with its own realm of responsibilities, authority, and expertise, their obligation to carry out doctors orders sustained the power hierarchy between nursing and medicine.\textsuperscript{15} This legacy persists today. For example see calls to abandon the angelic identity and for troubling the Nightingale hangover (S. Gordon and Nelson 2005; S. Nelson and Gordon 2006).
Nursing was then an honorable way for middle class women to enter waged labor.

Feminist political economy brings attention to gender and other identities, in addition to class, “as emergent domains of inequality and conflict under capitalism” in “the study of the relationship between economic and political processes” (Sheppard 2009, 547–548). Feminist political economy draws attention to that which is often rendered non-essential but is vital to everyday life (McDowell 2009; Nagar et al. 2002). A feminist political economic analysis asks what counts as work, what work is worth, what relationships animate the work, who does that work, and where and when she does it. For example, overlapping like a Venn diagram, care work and feminist political economic analyses demonstrates how the relationships and work of care and intimacy are not only vital to the reproduction of everyday life, but how these relationships animate life in all sorts of contested and complicated ways. Such work draws attention to the intimacies of globalization, and how local and intimate scales are in a mutually constituted relationship to macro scales (Mountz and Hyndman 2006; Pratt and Rosner 2012).

Nursing’s gendered history and present necessitate a feminist analysis. Pairing theories of care work and a feminist political economic analysis situates this particular type of work in a broader context. Such a combination of analytics balances a focus on the specificities of care work and the larger processes that shape work. In other words, the pairing brings a gendered lens to the politics of work, while situating care work within those broader politics.
FEMINIST APPROACHES TO RESEARCHING NURSING LABOR

Methods

My research is based predominantly on interviews and textual analysis. The interviews with 21 nurses in the New York metropolitan area are foundational to each of the chapters and appear throughout the dissertation, driving my engagement with critical theory. Interviews with sixteen nurses in St Louis complement the New York data. My total sample size is 37 nurses.

I use various textual analyses to complement the interviews throughout the dissertation. Different texts serve slightly different purposes, and I explain the particular methods in-depth at the start of each chapter. In Chapter 2, a media analysis was the most effective way to track hospital closures. Since there is no comprehensive government tracking or database of hospital closures, media reports were a useful form of record. For this chapter, I developed a method for cataloging media reports on hospital closures, complemented with New York State Department of Health records, to track the changes in the geography of hospitals. In Chapter 3, I draw on public discussion boards and an editorial piece in the *American Journal of Nursing* (Underwood 1975) to complement the interviews and expand the scope of the argument. This situates the move to the 12-hour shift with nurses in national (or even international) conversation about the working day. In Chapter 4, I draw on nurse union organizing materials, industry publications and studies, and federal and state laws regulating

---

16 I have provided a cast of characters in the Appendix, with a brief biography of each of the interviewees from both New York and St Louis.
staffing and insurance reimbursements. I use these texts to triangulate and complement nurses’ experiences with methods of measurement.

Interviews with nurses are foundational to my arguments. As I explained above, I interviewed a total of 37 nurses living and working in the New York and St Louis metropolitan areas. Using a snowball sampling method, I began my interviews by drawing on personal contacts I have in both regions. After interviewing each of my initial contacts, they each connected me with between one and five other nurses. All of the nurses worked in hospitals.

Although drawing on personal contacts to start my sampling generates a particular selection, the sampling worked out such that I was able to interview a rather wide array of nurses. The demographics of my New York sample mirror the racial and gender demographics of the national nursing workforce (USDHHS 2010). Nationally, roughly 75 percent of nurses are white (CHWS 2008, 4). The majority of interviewees identified as white, two as South Asian, one as African American, and two as Latina. The gender breakdown matched the national gender split of 90 percent of American nurses being women. In my sample, two of the 21 interviewees were men. Two of the nurses were migrants, one trained in India and one was from Peru. Nurses worked in a variety of specialties, including women’s health/labor and delivery, emergency care, the

---

17 Except public figures, all names of interviewees are pseudonyms.
18 In the New York metropolitan area, that percentage is just over 50.
19 In this case, migrant means people working as nurses who immigrated to the US as adults. This can include trained nurses who migrated, lower-ranked nurses who migrated then trained as RNs in the US, and migrants who trained in the US to become nurses. Generally, the last category is not included in literature on migrant nurses, since the sending country did not train the nurse. I argue they are worth including in this category since, as they migrated as adults, the sending country still invested considerable resources in raising and educating the person before emigration.
operating room, intensive care and stepdown, and med surge.\textsuperscript{20} They were also at a variety of stages in their careers. Five were early stage, ranging from close to finishing nursing school to having two years of experience. The majority (11) were mid-career. Five other nurses were around retirement age; some had recently retired or reduced their work to part time, while others were considering retiring in the next few years. I found these interviews with late-in-career nurses particularly useful for a few reasons. These nurses had seen the changes to their work and workplaces for over 40 years and offered important insights into the major changes in health care and nursing – from the restructuring of insurance reimbursements to the demand for increased education for nurses to the introduction of more technology, more regulation, and more paperwork in health care. The nurses worked in four of the five boroughs (none from Staten Island) and both Nassau and Suffolk Counties, which make up the suburbs of Long Island, and Westchester County, directly to the north of the city. They lived around the city and surrounding counties.

In St Louis, I interviewed 16 nurses, and all work in hospitals or clinics run by hospitals. All of my interviewees also live in the St Louis metropolitan area. Seven were white, six were African American or from sub-Saharan African, and three were Filipina. Two of my St Louis interviews were with men. Three of the interviewees were early stage nurses, all having recently graduated from nursing school and in the first year or two of working. Nine interviewees were mid-career, and four were finishing their careers or had recently retired. Ten nurses were migrants, ranging from being trained abroad to coming to the US specifically for nursing school to retraining as nurses once

\textsuperscript{20} A stepdown unit is one step below an intensive care unit. Med surge is general nursing. It is analogous to internal medicine for physicians.
having immigrated. My personal contacts in St Louis had more connections with migrant nurses, thus I have a disproportionate number in the St Louis sample. Primarily for this reason, my St Louis sample is more diverse than the national nurse demographics. This diversity strengthens the sample, providing a wider lens for viewing the politics of nursing work as it intersects with gender, race, class, and immigration status.

I conducted interviews both in person and over the phone, and in places that were convenient for the nurses (their home, my home, and in private rooms at their workplace). Interviews lasted between 40 minutes and two and a half hours, with most lasting about an hour. During these semi-structured interviews, I followed an interview guide that covered questions about their work history, everyday experiences at work, their observations about the nurse shortage, and their sense of trends in their profession.21 From these interviews I wanted to gain a sense of their everyday work experiences, how that everyday had changed over their careers, and what their personal relationship was to their work. I wanted to hear about the nuts and bolts of their workdays as well as the emotional work and attachments they have to nursing, health, their patients, and the health care system. The purpose was to glean an iterative understanding of the daily practice of nursing and the political economic trends in the profession and health care more broadly. These interviews constitute oral work histories of nursing.

Aside from nurses themselves, I wanted to complement nurses’ stories with the work that their unions were doing. Despite months of attempts, I was unsuccessful in

21 The interview guide is in Appendix 2.
conducting one-on-one interviews with the leadership of the New York State Nurses Association (NYSNA). After being passed around the organization for months, trying to set up an interview, they finally told me they were unable to find the time for an interview. I thought I would win in our little game of persistence; I did not. Thus, in lieu of an interview, I attended a public talk\textsuperscript{22} by the executive director and president, in which they discussed the organization’s shift in the late-2000s/early 2010s from a professional association with bargaining rights to a trade union. Additionally, one of the nurses I interviewed was a former staff member at NYSNA, and he was able to provide additional insights into the organization’s recent changes.

Though my group of participants reflects the demographics of the nursing workforce, my sample size of 37 nurses is not one that I would call representative. Although with the complementary textual data, I can draw some generalizations and trends regarding nursing work in these two cities. The interviews do, however, speak to Lawson’s (2000) call for letting subjects’ stories speak for themselves. I let the nurses’ stories drive my engagement with critical theory. Similarly, Walton-Roberts and Pratt (2005) argue that though a smaller sample size can limit generalizability, in-depth interviews that trace personal histories can offer intimate insights into the ways individuals and processes at multiple scales interact. Nurses’ testimonies, work histories, dissatisfactions, emotions, and successes speak to the intimate, everyday engagements with the different forces operating on the health care industry and nursing labor.

\textsuperscript{22} Panel at Left Forum, 2013, on health care union activism (Sheridan-Gonzalez 2013)
For Pratt and Rosner, the intimate is “a politicized sphere of overdetermined meaning that feminists can explore and use as a basis for thinking about globalization” (2006, 21). The intimate shifts focus away from the local in order to “[employ] terms that are not defined against one another but rather draw their meaning from more elliptically related domains...the intimate forces our attention on a materialized understanding of the body when we theorize on a global scale” (Pratt and Rosner 2012, 11).

Intimacy and the intimate encompass much more than the private and the personal. As Pratt and Rosner (2012, 3) explain, “intimacy does not reside solely in the private sphere; it is infused with worldliness.” The intimate offers a new scale on a new map that accounts for the intimacies operating at different scales. It emphasizes the mutual constitution of macro and micro processes and relations. The intimate is a necessarily both a material and emotional sphere that

    comes in close and supplements the visual with a host of other sense experiences: sound, smell, taste; the ways bodies and objects meet and touch; zones of contact and the formations they generate. Through its participation in the tactile, the intimate functions not as an opposite to the global but as its corrective, its supplement, or its undoing. (Pratt and Rosner 2006, 17)

Thus, not only does the intimate shine light on the mutual constitution of the global and the local but also disrupts any possibility of seeing a hierarchy or boundary between the two. It “takes us onto a different map or perhaps entirely beyond the visual register of map reading” (2006, 17). Intimacy “[aims] to expose the patterns that recur when gender, sex, and global imaginary combine” (Pratt and Rosner 2012, 2).

Nursing work engages directly with the intimate and intimacy. Nurses discussed the fatigue of commuting long distances, making their work schedules compatible with
their partner’s, desires for stimulating work, and the stress that follows them home after working with a tough patient. They discussed the intimate monitoring of patients, such as watching vital signs in surgery, or the delicate conversations they had with victims of domestic abuse or drug addicts who came to the ER for a meal. They explained the very intimate body work of nursing such as changing bandages on wounds, lifting and moving heavy bodies, or moisturizing a diabetic patient’s vulnerable skin. They talked of the mundane and small, but ever important, tasks involved in non-direct care, such as sterilizing surgical tools or coordinating discharge plans for patients and their families. Each of these tasks is intimate and personal for both patient and nurse. Each tasks also reflects the broader political economic context that influences who does which work and how.

Mountz and Hyndman explain that “the intimate involves a proximity that renders tangible the intimacies and economies of the body” while connecting intimacies across space and place without flattening the difference and context (2006, 450 and 447). In other words, the intimate reads the macro policies that are written into bodies and materials, as well as the personal stories and actions that drive, shape, and resist macro-scale politics. The in-depth interviews, while limited in generalizability due to sample size, offer a richness and depth that comes from digging deep in nurses working lives and histories. These interviews specifically explore the intimate scale and intimacies of nursing work. Thus, analyzing the intimacies of life and nursing work foregrounds the labors, politics, and relations of life’s work in analyses that operate at multiple scales. It means not asking nurses’ stories to be ‘representative’ of all nurses
but rather, for their stories to push, respond to, and reshape critical theory, research methods, and the assumptions that guide our analyses.

**Feminist Theory on the Politics of Research**

As feminists have argued, it is important to understand the methods by which we fill our research gaps because “research is a process not just a product” (England 1994, 82). Feminist geographical research is necessarily political. As Staeheli and Lawson (1994, 97) explain, feminist geographers “focus on connections between sexuality, race, class, and gender, the construction of identities in and through space...[and open] up gender relations and patriarchies as crucial structural forces in society.” They argue that we must “recognize the partiality and situatedness of all knowledge” in order to place ourselves “in between;” this is an approach to research that sees individuals’ perspectives as partial but also valid and “acknowledges that we cannot fully know and understand the positions and experiences of people in different subject positions” (1994, 99; see also England 1994). Researchers must consider how their positions as well as their participants’ subjectivities influence the research and the research process. Thus, feminist geographers have argued against understanding research and the researcher as objective; instead, they demonstrate the ways in which a researcher’s positionality and biography always influence their work.

In her 1994 piece on reflexivity and feminist research, England argues that that not only does the researcher’s biography affect their engagement in the field, but also, the relationship between researcher and participants shapes fieldwork and analysis. My biography is certainly present in this dissertation, and it would be an impossible task to
separate myself from my research. My mother is a nurse, and my grandmother was a nurse at two of the now-closed New York hospitals that I discuss in Chapter 5. A few of my interviewees are friends of my large extended family in New York City. One of the more senior nurses I interviewed, Carol, even treated my grandmother for a broken arm in the 1960s.

I was initially hesitant to use my personal connections, however, in doing my research. I wanted to maintain some distance and not make things ‘too personal’. I did not attempt faux impartiality, but I was aware of the ways in which my personal connections, particularly to a few of my interviewees, could impact the power dynamics in the interview. I was wary of interviewees feeling pressured to participate or to answer questions. Yet, interviewing skilled, middle class workers is a different situation from doing research with more oppressed populations (for discussions on the politics of this research, see Gilbert 1994; Kobayashi 1994; Swarr and Nagar 2010). A different power dynamic exists when both interviewer and interviewee are well educated and hold considerable cultural capital. Few researchers have addressed the politics of researching ‘up’ or laterally (notable exceptions include Aguiar 2012; Ho 2005; Nader 1974; Peck 1998). These scholars have shown that researching middle class people and elites fills out our analyses of the workings of global capitalism. They present different perspectives and at different scales, revealing the network of logics that underpin everyday understandings of labor, value, and neoliberalism. In my case, by researching skilled workers, I approach neoliberal ideologies, workplace reforms, and immigration changes from a perspective that complements the rich analyses on lower-waged, lower-skilled, and less privileged workers. Furthermore, as a graduate student interviewing
mostly middle class workers with stable employment, I am, in a sense, researching up, though not with the traditional agents of global capitalism. That said, the hierarchies and boundaries between classes are complex. In some ways, nurses embody more powerful positions than me because of their job security and middle-class wages. Yet, in other ways, we have similarly limited power in our respective institutions. And yet still, I hold a certain power in being the researcher, tasked with writing up their stories. I am accountable to the nurses, responsible for fairly and accurately representing their words, even if they never read the articles I publish. The complex relationship I have to my interviewees requires careful negotiation, which I discuss below. I offer my analysis of nurses as a complement to this methodological literature, expanding the notion of who such agents of capitalism are to include, at least in some ways, middle-class, skilled, social reproductive workers.

**Feminist Methods in Action: Dilemmas in the Field**

Feminist methodological approaches have provided some guidelines for my research. Specifically, they underscore the importance of being aware of the power dynamics between researcher and researched. Feminists insist that “reflexivity play a central role” in research, and that scholars attend with care to “the consequences of the[ir] interactions with those being investigated” (England 1994, 82). In my own research, this feminist methodological principle manifested in my own fear of pressuring people to participate through personal connections. I used a few strategies to help mitigate the potential uneven power dynamics with my interviewees. I began each interview by clearly explaining their rights to answer or refuse to answer any
questions, as well as pose questions to me. I also established a friendly and professional rapport to help interviewees feel at ease. While I understand that such a friendly rapport could in fact exacerbate uneven power dynamics, I tried to set a tone that would make interviewees feel welcome to participate, comfortable refusing to answer, and able to raise other issues that they wanted to discuss. For example, if an interviewee seemed to feel uncomfortable with a question, I reminded them that they need not answer it and that we could move on. The use of semi-structured interviews also contributed to setting up this rapport and sharing the guiding of the interview with the interviewee. By using a flexible structure in the interviews, nurses could assert some authority in guiding the conversation. At the same time, such a structure helped me try to cover all of the topics I wanted to discuss while also keeping discussion open enough for new issues and questions to arise.

I made additional efforts at reducing the power differentials. In questioning whether or not ethical research is even possible, Patai (1991, 137) argues for feminist research with goals that “ought to be the generally human ones”. In my interviews, I tried to be as accommodating as possible in scheduling and sought to meet nurses in places that were convenient and comfortable for them. As I noted earlier, interview sites included their homes and mine, public places, and private rooms at their place of employment. Additionally, many nurses themselves have experience doing research. Indeed, more than one of the nurses I interviewed had done interviews for other researchers. Their familiarity with the process meant they were also generally familiar with their rights as participants and made conversations on informed consent easier.
My personal background and investment in the subject gave me some legitimacy in the eyes of the nurses. After all, “the world is an intersubjective creation and, as such, we cannot put our commonsense knowledge of social structures to one side...The researcher cannot conveniently tuck away the personal behind the professional, because fieldwork is personal” (England 1994, 81 and 85). We also, then, cannot put our lifetime of knowledge on our research topic to the side. Telling nurses about my own connections to the profession and New York helped to establish common ground and a sense that both of us were contributing to the interview but in different ways. My familiarity with the profession meant that in many interviews, despite the fact that I had introduced myself as a daughter of a nurse and not a nurse myself at the start, nurses would ask me to verify multiple times during the course of the interview that I was not a nurse.

It was also my personal connections to nursing and to some of the nurses that helped move my snowball sampling along. As I stated earlier when I started my research, I did not want to draw on personal contacts. I wanted to ‘do it on my own’. Yet, after trying multiple methods of reaching out to nurses – from going through professional associations to handing out fliers outside of hospitals – I was at a dead end. I was left with few other options. Drawing on these more personal contacts was a way to connect with interviewees. Additionally, the personal connections added more accountability both for the interviewees and for myself. The hectic pace of life in New York was, I believe, one of the roadblocks I had faced earlier in setting up interviews. Nurses seemed more willing to take time out of their busy lives if a mutual contact had introduced us.
Furthermore, my position as a graduate student with limited funding greatly shaped my research. While New York and St. Louis are fitting sites for researching nurses and health care, I also chose these sites because of the personal supports that I had in each place. My extended family lives in New York and my uncle provided me with a place to live while I conducted research. In St Louis, I stayed with my immediate family. Without these supports, I could not have even done the research. The precarity of graduate students in the contemporary university also shapes engagement with interviewees. When I was struggling to recruit nurses for interviews, I considered offering monetary compensation as incentive. Yet, a meaningful amount of money was not feasible for me. I considered offering nurses $30 or $40, or roughly an hour’s pay for their time. Yet, the middle class wage was too much for me to afford. Instead, I had to rely on a different incentive: personal contacts to vouch for me. Overall, my precarious position in the academy shaped not only where I could do research, but also the ways I could go about conducting my research.

Feminist geographic methods require that researchers understand their positionality, acknowledge and account for different subjectivities, and commit to developing knowledge aimed at cultivating social justice. As Kobayashi explains, academics must use their critical analytical skills not only on themselves (i.e., self-reflection) but also in a way that combines social change and scholarly critique (1994, 78). Thus it is a combination of acknowledging and accounting for our positions as researchers in this world and our obligations to social justice that guide feminist research.
In this spirit, I let my interviewees guide my research and my engagement with critical theory. Discussing the theoretical potential of migrants’ stories, Lawson (2000) argues that in order to understand the complex questions generated in studies of capitalism, research requires in-depth interviews with the subjects of capitalist intervention themselves. She argues for letting these subjects’ stories drive our engagement with critical social theory, and highlights the potential of in-depth individual interviews for the development of theory. These stories demonstrate that access to work, social support, and government assistance are not only shaped by the intersecting relations and statuses people move in but also offer “a rich account of the social and cultural costs of neoliberal development” (2000, 174). Drawing on in-depth interviews, Lawson shows how individual stories “have theoretical power beyond simply their own unique stories...[They] bring to the surface the contradictions of capitalist growth, which can only be spoken of by” the people on the ground (2000, 186). Their stories challenge dominant discourse as well as raise questions for researchers. It is the ways the stories from research participants challenge dominant discourses of capitalist development and growth, neoliberalism, and modernity that can guide researchers’ engagements with social theory. For my research, nurses’ everyday work stories challenge mainstream, theoretical, and economic characterizations of nurse shortages and surpluses. As I argue in the remaining chapters, their stories push theory to account for the contradictions of capitalist accumulation and the needs of social reproduction and health.
ROADMAP OF THE DISSERTATION

This dissertation examines three changing aspects of nursing work and the nurse workforce – time, space, and modes of counting work. Each of these elements is part of the broader restructuring of nurses’ everyday work lives. The geography of nurses’ workplaces, changes to the length of the working day, and different ways that nurses’ work is documented, quantified, and valued are all methods for managing nurses and their work. These are changes and methods that come from multiple scales, ranging from state and federal regulations to health care administrations to nurses, both the profession and individuals. The following chapters examine how these changes are happening and what the implications are for nurses’ everyday work lives, and by extension, patient care and the broader provisioning of health care services and work.

In Chapter 2, I trace the implications of changing capitalist investment in the built environment on health care provisioning and the nursing workforce. I argue that when spaces of work close, jobs disappear. This is not a new or novel argument. Yet, I extend this idea to social reproductive spaces and work. What this chapter adds to this argument is that when spaces of social reproduction and social reproductive work disappear, serious implications for health, economies, and communities arise. In other words, hospital closures are, intentionally or not, a form of managing the nursing workforce. Closures have the effect of managing the workforce in particular ways that support and depend on the skill bifurcation of nursing and the changing landscape of health services.

In Chapter 3, I interrogate what the change from the eight to the 12-hour shift does for nurses’ work lives. Nurses I interviewed expressed ambivalent and
contradictory feelings on the longer shift length. I argue that the move to a 12-hour working day, with fewer working days per week, actually flattens expectations around working conditions. As a means of stretching short labor resources, the longer shift started as a tool for meeting staffing needs in the nursing shortage of the 1980s. As it gained popularity, nurses expressed (1) that they overall preferred working fewer days per week and (2) that they felt the longer shift contributed to burnout, mistakes, apathy, and fatigue that spilled into their off-work time. This produces a contradiction of aspiring to have more days off while lamenting the negative impacts on their work and their working conditions. I argue that this contradiction works to distract from underlying issues of the chronic nursing shortage. Instead of addressing the working conditions, the longer working day pacifies nurses without substantially or actually addressing the causes of the nursing shortage. Both this chapter and the next sit within a broader context of change in national and Anglo-western nursing and health care, although my analysis happens through the nuance of St Louis and New York’s specific contexts.

In Chapter 4, I argue that the ways in which nurses’ work is defined and accounted for impact their ability to practice their work. This chapter engages with various ways that state and federal governments, hospital administrators, and nurses attempt to quantify or document nursing work. Drawing on critiques of quantification and literature on a politics of the possible, I argue for adding an explicit politics of social reproduction to analyses of modes of abstraction. Such a focus, I argue, shifts attention to what gets invisibilized in dominant modes of accounting for nursing work: care.
Theoretically, social reproduction enhances analyses of a politics of measure by requiring more fulsome modes of measuring work.

In each of these chapters, I unravel management techniques that operate at multiple scales. These management strategies are not top-down methods from the state or hospital administrators. Rather, these are a mix of formal and informal, precise and non-specific management techniques. Sometimes, in the case of hospital closures, the management of the nursing workforce is not even a clear primary goal. For example, in chapter 4, I argue that one of the impacts of hospital closures is nurse union busting. While not the primary goal as outlined by the state commission leading closures in New York, hospital closures have the effect of eliminating unionized jobs for nurses. Thus, in effect, hospital closures are union busting by other means. Nurses have been key figures in fighting closures in New York, also shaping the landscape of health care workplaces.

Similarly, as I explain in chapter 3, both nurses and management favor the 12-hour shift. In some facilities, management has imposed the new shift structure, while in others nurses have been the group advocating for the change. And yet in other facilities, it has been a joint management-nursing venture to solve staffing and budgetary shortcomings. Together, the following three chapters demonstrate the utility and possibility of considering health from a social reproductive perspective. The chapters interrogate the ways nursing work is managed, and foreground a politics of good health and good jobs. It is impossible to fully understand the politics of health without a keen analysis of the workers who provide health care service and sustain health systems. Seen this way, good health and good jobs are mutually constituted. In sum, nurses’ work offers important insights into the politics of work, social reproduction, and health.
Chapter 2
Hospital Closures:
The Sociospatial Restructuring of Labor and Health Care

“St. Vincent’s plight has been portrayed by public officials and the media as a story of misfortune – a community losing a vital piece of its infrastructure and a centerpiece of its identity to a combination of mismanagement, the recession, and bad luck. The truth, though, is considerably more alarming. St. Vincent’s collapse is only the most visible symptom of an ongoing financial emergency facing the city’s five dozen remaining hospitals and threatening those they serve. In a sense, St Vincent’s is the Lehman Brothers of the local hospital industry: an institution whose dramatic disappearance, once unthinkable, raises dire questions about the viability of the entire system.”

Mark Levine, New York Magazine, 17 October 2010

In 2010, St. Vincent’s Hospital in Manhattan’s West Village closed its doors after 161 years in operation. Politicians, community members, nurses, staff, and doctors all rallied in the year prior to save the hospital, but, after slipping into $1 billion in debt, New York State opted not to bail out the facility but to let it close (Hartocollis 2010a; Levine 2010). This was not, however, an isolated case; the 20 other hospital closures in New York City in the past decade signal a comprehensive restructuring to health care in New York.

This chapter investigates New York City’s hospital closures and their implications for nurses and the neighboring communities. It analyzes connections between changes in the nursing profession and hospitals that have closed and

subsequently sat in ruin for years. Through tracing the stories of hospital closures and recent changes in the nursing profession, I argue that hospital closures reflect major health care restructuring in the context of economic retrenchment. These closures facilitate three mutually constituted restructuring processes in the urban built environment, the health care industry, and the nursing workforce, which happen through the devaluation of social reproduction under capitalism.

This chapter investigates the uneven and changing geography of hospitals in New York City. While I draw specifically on the case of hospital closures in New York, the findings are applicable elsewhere in the US, as many locales are downsizing their hospital systems. In this chapter, I analyze how the changes in the geography of worksites and health care sites impacts both service delivery and the availability and geography of good jobs for nurses. Thus, this chapter works at a broader scale than the next two, which go inside the hospital. Geography is particularly appropriate for analyzing hospital closures because access to health care and work are spatial concerns. Where a hospital is located is a significant factor in a person’s access to care in both emergencies and in the everyday, Similarly, how far a nurse lives from her job affects her work and personal life, and, as I discuss further in this chapter, when a hospital closes, it impacts a nurses’ ability to reproduce herself in myriad ways.

The New York hospital crisis is still unfolding. A media analysis, complemented with interviews with nurses and site visits to closed hospitals, was an effective way of capturing the ongoing process. Many of the closures attracted considerable media attention. I tracked coverage of each of the closures since 2003 in major New York publications, borough newspapers and blogs, and industry publications for real estate
and finance. In lieu of a comprehensive government record of closures, these accounts helped to trace this history of hospital closures in New York. Therefore, these provide context. I also analyzed with New York State and City Department of Health documents on the closures and those from the Berger Commission. For these documents, I performed a discourse analysis, coding for how these state agencies and department justified closing hospitals, how they characterized the role of hospitals in communities, and how they defined and discussed needs. Finally, I tracked changes to closed hospital sites through site visits in 2013 and 2014. As many of the sites sat empty after closure but changed ownership repeatedly, I visited closed hospital sites to document the conditions of the buildings and changes to the site as redevelopment progressed.

In addition, I draw on the interviews I conducted with over 20 nurses working and living in the New York metropolitan area. Their testimonies capture the changing working conditions and expectations of nurses amidst an era of health care restructuring and crisis. They speak to the intimate and systemic impacts of hospital closures and the changing investment in the built environment.

After setting the context for hospital closures in New York City, I bring David Harvey’s (1978; 2010; 2014) work on capitalist urbanization together with feminist theories on social reproduction (Katz 2001b; K. Mitchell, Marston, and Katz 2003). Integrating these theories of social reproduction demonstrates the implications of capitalist investment in the built environment on social reproduction. Taken together, these theories provide a useful framework for understanding how social reproduction – the reproduction of bodies, everyday life, and capitalist social relations – is part and parcel of the built environment and the work that happens in it. I then outline each of
the three restructuring processes under way in New York’s health care system, showing how each is implicated in the others. In conclusion, I point to how these restructuring processes ultimately signal a restructuring of social reproduction that threatens access to good health and good jobs.

THE STORY OF HOSPITAL CLOSURES

New York City has lost twenty-two full-service hospitals in the past decade, and many others struggled to remain in operation through the 2008 recession. Brooklyn, Manhattan, and Queens have felt the brunt of the closures, losing a total of eighteen since 2003, eleven of which closed post-2008. This means that nearly all of the city’s closures have been in the three most populous boroughs. Queens in particular is underserved. When the borough lost three facilities in the winter of 2008-2009, residents already travelled further for care than New Yorkers in most other parts of the city (Reddy 2010). Parkway, the final for-profit facility in the city, closed in November 2008, and Mary Immaculate and St. John’s Queens Hospitals closed the following March (B. Benson 2008; Einhorn, Kadinsky, and Goldsmith 2009). Queens was already underserved; residents travelled further for care than New Yorkers in other parts of the city (Reddy 2010). Then-Mayor Bloomberg argued that more ambulance service to Queens could compensate, but borough residents, nurses, and councilmembers knew

---

24 The analysis begins in 2003 – the year when hospitals began to close in significant numbers in New York City. The first three years saw eight hospitals close in the city, and an additional four closed in the surrounding counties. I focus primarily within the boundaries of the city but pay attention to the surrounding counties: Nassau and Suffolk Counties on Long Island and Westchester, Putnam, and Rockland Counties directly to the north of the city.
better. With thousands of lost jobs and already over capacity hospitals, graffiti on the boarded-up St. John’s Queens make an apt plea: “Please don’t DIE on your way to another hospital” (Einhorn, Kadinsky, and Goldsmith 2009, no page).

Brooklyn has also been hit hard by closures. Since at least 2012, community members have been fighting to protect two more Brooklyn facilities. Long Island College Hospital (LICH) in Cobble Hill and Interfaith Medical Center in Bedford-Stuyvesant have both struggled financially for years. Interfaith acts as a safety net, serving 160,000 predominantly underinsured and low-income patients of Bedford-Stuyvesant (Goldberg 2014b). It closed its sister facility in 2003 in an effort to save itself, but it finally filed for bankruptcy in late 2012 (Ford 2013). In June 2014, Interfaith emerged from bankruptcy court as a very different facility. After over a year on the verge of closing, Interfaith is understaffed, and patients have turned to other more stable facilities for care (Goldberg 2014b). In its post-bankruptcy life, Interfaith must regain the trust of the community, showing that they are stable and open for care after over a year of uncertainty.

When near closure in the late 2000s, LICH’s doctors engineered a partnership with the State University of New York (SUNY) (Hartocollis 2010b; Concerned Physicians of LICH no date). The deal was meant to preserve the facility, but less than two years after the 2011 merger, SUNY began closing units, diverting ambulances, and searching for a buyer for the property. Members of the LICH community took SUNY to court and were able to guarantee that even if SUNY sold the property, the space would have to remain a medical facility of some sort. SUNY essentially balked at and ignored each court ruling to continue operations, and after returning to court dozens of times,
SUNY finally closed and sold LICH in May 2014 (Hartocollis 2013; Frost 2014; Goldberg 2014a). Like many hospitals before LICH, the new property owners will convert the space into residences and an urgent care center.

New York’s hospital system has a very uneven geography. The eastern side of Manhattan, known to some as “Bed Pan Alley” (Lambert 1994, no page), has one of the highest densities of hospitals in the country with nine facilities. In comparison, Manhattan has 27 hospitals, yet Queens has only eleven hospitals and 800,000 more residents (NY Department of Health no date; United States Census no date). Manhattan has 4.7 beds per 1,000 people, but other boroughs have considerably less capacity. The Bronx has 2.5 beds, Brooklyn has 2.2 beds, Staten Island has 2.4 beds, and Queens has 1.7 beds per 1,000 people. Hospital closures have had a noticeable impact on admissions and emergency room wait times. As a nurse at the Queens Hospital emergency room explains, per shift, her regular patient load nearly doubled after three Queens hospitals closed during the 2008 financial crisis (Reddy 2009, no page).

These closures mean a loss of services, jobs, and community anchors. As each facility prepares to end service, affected communities and workers have made explicit the connections between hospital closures, community viability, and gentrification. As I will discuss later, many hospitals have become residential spaces, and community members, aware of this trend, protest with signs saying, “Condos Rise, Brooklyn Dies” and “Please don’t DIE on your way to another hospital” (Keep Brooklyn Hospitals Open for Care no date, no page; Einhorn, Kadinsky, and Goldsmith 2009, no page). In the fight to keep LICH open, New York State Nurses Association (NYSNA) Executive Director Jill Furullo stated, “Communities are being left behind. When you close a hospital you close
20 percent of community-based clinics” (Frost 2013, no page). Thus, the community hospital is an important access site for health care services. The fight against closures and gentrification constitute a single struggle, as the condominiums and apartments that replace hospitals are part of a bigger process of dispossession in the neighborhood.

Hospitals are closing for many reasons. Improper management is part of the problem. St Vincent’s and Parkway Hospitals are perhaps the most egregious examples of mismanagement, with St. Vincent’s falling $1 billion into debt, and Parkway’s CEO being convicted of bribery, from an attempt to bail the facility out of the red (Levine 2010; Chan 2012). Yet, this is by far not the only – or even the central – cause of hospital failures.

Nearly all hospitals in New York City operate at break-even or negative profit margins (Weinberg 2003; Levine 2010; Ford 2013). Insurance is an important factor. Medicaid in New York State is one of the most expansive systems in the country, providing coverage for three million city residents (Kaiser Family Foundation no date; NY Department of Health 2013a). Medicare and Medicaid do not reimburse for all of a patient’s expenses, leaving hospitals to absorb the remaining costs (Weinberg 2003). Additionally, approximately 1.2-1.4 million city residents are uninsured, and the Affordable Care Act only cuts that number by about a third (Cadogan et al. 2010, 6; Blavin, Blumberg, and Buettgens 2013, 7). Hospitals stay in the black by finding the right combination of patients with private insurance, state coverage, and without insurance. Payments from the privately insured help hospitals cover losses from the un/under-insured. With roughly half of the city’s residents without private insurance, many hospitals struggle to find a balance of payment schemes.
The balance of payment schemes is also racialized, gendered, and classed. Hospitals located in poorer neighborhoods especially struggle to break even, as Medicare and Medicaid predominantly serve socio-economically disadvantaged women, children, and people of color (NY Department of Health 2013a). Furthermore, patients on Medicare and Medicaid have lower health literacy than patients on private health insurance (Baker et al. 2002; Scott et al. 2002). They are less likely to use preventive health care services and are generally in poorer health than people with private insurance. Even in areas like New York with more robust social safety nets, uninsured Americans have less access to services and higher rates of unmet medical needs than the privately insured (Cunningham and Kemper 1998; Kirby and Kaneda 2005). The hospital and emergency room, not clinics, have historically served as primary service spaces for the un/under-insured. And health research shows that hospital closures negatively impact patients’ overall health status (Bindman, Keane, and Lurie 1990; Buchmueller, Jacobson, and Wold 2006; Bazzoli 2012). Patients lose service providers, facilities are further away, and more often than before the closure, people are denied services. Additionally, New York’s previous wave of hospital closures is an example of the racialized and classed impacts of hospital closures. In the closures of the late 1960s to early 1980s, McLafferty (1982, 1671) found that “the racial composition of the neighborhood is an important predictor of hospital failure,” as closures happened predominantly in areas of higher poverty and larger populations of people of color. Closures also happened in neighborhoods with the lowest socio-economic status, and those served by smaller community hospitals (S. McLafferty 1986, 1083). In other words, the hospitals with the most vulnerable patient populations are also those who
struggle the most to find a mixture of patients and payment plans that can allow the facility to survive financially. Hospital closures threaten the health of those at most risk.

The uneven geography of hospitals can also facilitate closures. Like other businesses, hospitals compete for customers (i.e., patients). The glut of hospital beds in locations like Bed Pan Alley make for more intense competition over patients in an already tough financial environment. So while some communities lack hospitals altogether, areas with too many services are also in risky positions; these facilities face close and stiff competition that also put the longevity of facilities at risk. The uneven geography makes for an overall very precarious health care system.

Additionally, New York State has facilitated the recent closures in two ways. First, the state deregulated reimbursement rate negotiations between hospitals and insurance companies. In the 1980s, the state was much more heavy handed, treating the hospital industry more like a "regulated public utility" and making sure that reimbursement rates could guarantee hospitals’ survival (Levine 2010, no page). Governor George Pataki, however, introduced a deregulated, free-market model in the 1990s (Salit, Fass, and Nowak 2002; Dinallo 2009). Hospitals now negotiate the terms of reimbursement directly with insurers. This new system privileges large facilities and multi-hospital systems that are more powerful negotiators and better able to absorb lower reimbursement rates. Small and stand-alone hospitals often have to accept the rates that larger hospitals and corporations have negotiated which, for smaller facilities, are frequently unsustainable.

Secondly, over the mid-2000s the state embarked on a mission to reform the hospital and long-term care system in New York. The Commission on Health Care
Facilities in the Twenty-First Century – or the Berger Commission, named for its chair, Stephen Berger – aimed to “rightsize” the system, meaning “the possible consolidation, closure, conversion, and restructuring of institutions, and reallocation of local and statewide resources” (Berger Commission 2006, 59). As I address later in more detail, this was state sanctioned downsizing by another name.

At the same time, the health care workforce is changing. Since the mid-2000s, the health care industry was feeling the pre-emptive impacts of the 2008 recession and the restructuring of insurance reimbursements. As I’ve explained, hospitals began closing in noticeable numbers during this period. Yet with the 2008 recession, not only did more hospitals go under, but also the remaining facilities stopped or slowed their hiring, even to fill long-standing staffing needs. Thus, with more hospitals financially unstable or closing, employment opportunities have declined. Now, hospitals mostly hire only the most experienced nurses, and new graduates and migrant nurses struggle to find work (K. Evans 2009; Kurtz 2013); my interviewees corroborate this. Hannah, who recently started her first job, and Katherine, who is finishing school, both explain the stress, fear, and luck involved in the job search.

It’s very hard as a new graduate, because the hospital has to invest a good amount of money to train you. I think like 8 months I looked. I had a connection at this hospital, which is, in my opinion, why I got this job. I think a large part of it was that I knew somebody at the hospital. (Hannah)

I’m terrified. But I feel like I’ll be ok...like I could walk into an interview and relate to a person. It’s still scary. I’m more scared of the timetable. Some people it takes 9 months to find a job. What are you supposed to do in the in between? (Katherine)

These statements would be unthinkable a decade ago and is a reversal of what the nursing labor market was for decades. Before the early 2000s, hospitals complained of
not having enough willing nurses to fill staffing positions. As the economy turned sour, hospitals closed and/or had little money to hire the staff they had previously been seeking. Jobs for nurses dried up as a wave of new nurses graduated, no longer easily able to land a secure job. But nurse shortages and hospital closures are not discrete phenomena; rather, they are constructed crises, and investigating them more closely shows how these intertwined processes are instrumental in the overall restructuring of health care.

SOCIAL REPRODUCTION AND THE BUILT ENVIRONMENT

Feminist theories on social reproduction (Katz 2001b; K. Mitchell, Marston, and Katz 2003; Mignon Duffy 2010) and Harvey's work on urbanization under capitalism (1978; 2010; 2014) provide a useful combination for understanding the relationship between hospital closures and the nursing labor supply. On one hand, Harvey’s theories on urbanization and investment in the social reproductive built environment help to explain hospital closures and turnover in the built environment. On the other hand, feminist theories of social reproduction help in understanding the relationship between the feminization of care work and nursing shortages (Yeates 2004a; Raghuram 2009b).

Harvey uses social reproduction to refer specifically to the reproduction of labor power and the “wide range of social expenditures” and physical infrastructure related to this process (1978, 108). What he calls the social reproductive built environment is infrastructure that is an unappealing investment for capitalists. Investment here comes out of need, as capitalists must “fashion an adequate social basis for further accumulation” (1978, 108). In other words, capitalists have to provide the
infrastructure – the social reproductive built environment – for the labor force to reproduce itself. This infrastructure, though, is also an opportunity to absorb surplus capital and avoid crises of accumulation. Capitalism needs a landscape that can help capital produce, reproduce, and expand (2010, 86). Yet, this built environment can become outdated and act as a roadblock to further accumulation. At this point, capitalists “revolutionize” the infrastructure (2014, 146). In this case, hospital closures are part of revolutionizing the landscape.

Feminists, of course, have a more comprehensive understanding of social reproduction, emphasizing bodies, emotions, and social relations. Important for understanding the relationship between capital investment and social reproduction, feminists have shown how social reproduction has inequality built into its essence, as production’s “other”. Through both feminization and being non-productive work, paid and unpaid social reproductive labor is under and devalued (Glenn 1992; Mignon Duffy 2010). By being the “natural” work for women, social reproductive labor is thus not work. Its feminization as non-work facilitates the devaluation, even when waged. Though feminization happens in different ways, impacts across occupations are similar. Often, this work is undervalued economically and socially, jobs are precarious, and at times, workers are subject to abuse, manipulation, and violence (Raghuram 2007; Silvey 2008). Similar to other feminized work, nursing has been devalued in particular ways. For example, wages remained stagnant from the 1970s into the late 1990s, finally rising in the face of an acute labor shortage (Duffy 2010).

These two approaches to social reproduction are not discrete definitions. The latter does not preclude the built environment, and a rich understanding of the former
helps emphasize the ways in which social reproduction is both a social and a *spatial* process. Feminists have demonstrated the spatiality of gendered processes and social reproductive work. For example, feminist geographers have addressed the ways in which space and the built environment is gendered (McDowell 1983; Hanson and Pratt 1991). They have also explored the geography of the gender division of labor (Nagar et al. 2002; England and Lawson 2005). This work shows the importance of space in social reproduction. Yet, as the built environment reflects a division of productive and reproductive spaces, bodies, and activities (McDowell 1999), social reproduction theory needs a better appreciation of capitalist investment and accumulation in the built environment. This is a missing link between these different definitions and theories of social reproduction that can explain the interconnections between hospital closures and geographies of nursing labor. The theories need more integration. Mitchell, Marston, and Katz (2003, 418) explain that “how we live *in space* constitutes us as contemporary subjects in life’s work” or social reproduction. The particular spaces or built environment that we *produce*, however, also constitutes us as contemporary – and *healthy* – subjects. The missing link – an integrated analysis of these two approaches to social reproduction with attention to capitalist investment – is key to understanding how social reproduction happens, as a process, act, and set of relations that is rooted in and produces the built environment. Thus, Marxist analyses of investment and turnover in the social reproductive built environment need to integrate a deeper understanding of life’s work, just as theories of life’s work need to more fully incorporate the ways in which capital moves through the social reproductive (and productive) built environment. Merging these two literatures together brings to the fore the bodies and
work involved in social reproduction as well as how capitalist interest or reluctance to invest in the built environment enables or inhibits social reproduction.

Consider the following statements from nurses I interviewed:

One of my friends had to work 15 more days [at St. John's Queens Hospital] and she would have gotten all of her retirement benefits. Nobody ever though it would close! The St. John's clinic [closed earlier and laid off nine of the 13 nurses]...One was a pediatric nurse and they told her she could go back to the hospital and they would train her to work with adults on the floor, but the hospital closed within a month. And the clinic still had this patient basis; patients in the clinic make appointments a month in advance. A lot of them were kids who needed inoculations. It was horrible. Nobody thought it would come to that. At the last minute, they thought someone would come in and save them but reimbursement rates have been terrible...St. John's was what was considered valuable real estate, but nothing's happened with it. (Connie, RN)

It’s like a rat race. You drop your patient off, you give report, you put orders in, and you’re running to see your next patient...I’ve noticed our volume has increased. Long Beach Medical Center closed because of Hurricane Sandy. It was destroyed. With that closing, we saw a jump in volume, which of course [management] loves because it’s a business. However, doing that number of cases means longer days. They need to make changes, which I don’t see happening as quickly. They need to hire more operating room nurses. That’s not happening....There’s fewer hospitals, the amount of people hasn’t changed, so of course the numbers are going to go up. And of course workload, stress load – if I was to say, are the OR nurses happy? Not at all. There’s a lot of grumblings. (Sandra, Certified Registered Nurse Anesthetist)

Connie and Sandra’s stories demonstrate my argument: through the case study of New York City's health care system, I argue that spaces, turnover, and investment in the built environment are essential to social reproduction. When hospitals close – when the spaces of work and health care provisioning go away – nurses lose jobs, workload increases, and patients lose access to care. In other words, the life's work of social reproduction not only makes the built environment, but also depends on the built environment to happen. Systemic hospital closures could not happen without a restructuring of both the nursing workforce and the health care provision landscape. At
the same time, the persistent devaluation of nursing work, in terms of stagnant wages and increased workload in the past four decades, enables these closures. Together, each of these restructurings reflect broader global political economic dynamics, specifically the persistent subordination of reproductive processes to productive ones (see Federici 2004). Finally, these restructurings illustrate the mutual constitution of the built environment, health care provisioning, and nursing employment.

Health is particularly apt for making this claim. As I discussed in the introduction to this dissertation, Health is more than a single aspect of social reproduction or a lens for analysis. It is a very special element of social reproduction. Social reproduction – and especially health – is foundation to life and has long been a matter of struggle, central to social justice movements (for example see Loyd 2014). Since it involves both the reproduction of the population and the production of new commodities (e.g. pharmaceuticals), health demonstrates the fraught binary of production and reproduction (Fannin 2003; Armstrong and Armstrong 2006; McDowell 2009; P. Jackson and Neely 2014). Nursing is a complicated form of social reproductive work, as it brings together the skilled practice of health care and the nurturing, relational side of social reproduction. It also touches on all three aspects of social reproduction. Nurses deliver babies and help repair workers while, as I have argued, serve as the backbone of the entire health care system. With social reproduction and health being so foundational, health care workers – those who’s job it is to ‘make health happen’ – are central to that process. If they disappear, the very presence of social reproduction and practices of good health are under threat.
In what follows, I outline each of the three ongoing restructurings in New York’s health care system. I show how each process is unfolding and the role each plays in the other two restructurings. Through these restructurings I illustrate the missing link between these two approaches to social reproduction.

Reconstructing Space

The first restructuring is spatial. In this process, the built environment itself is restructured, with large spaces opened up for reinvestment and redevelopment. Hospital closures follow a common pattern. After the facility closes, it sits empty, often trading hands of buyers or sitting in bankruptcy court. Dormancy can last a year or two, for example in the case of St Vincent’s (Hughes 2013). It also can last many years, such as Parkway in Queens which closed in 2008 or St. Mary’s in Brooklyn which closed in 2005, both of which only began redevelopment in 2014 (Brownstoner 2014; Budin 2014). Often, a property bounces around from one owner to another, and maybe to another, until finally, someone buys it for a considerably higher price than the original buyer paid.

At least ten of the former hospitals have become housing – a few at market rate and rental, but mostly higher-end condominiums. For example, St. Vincent’s will be home to designers and celebrities when construction finishes (Hughes 2013). Others sites continue to provide medical services. St. Mary’s will become a nursing home (Brownstoner 2014). Two sites have become drug treatment facilities or outpatient
Having recently started renovation almost five years after closing, the windows have been replaced on the front of the building along Queens Boulevard in Elmhurst/Rego Park, Queens. (Author Photo)

clinics (Berger Commission 2006; Mogul 2013). Residences, though, are the most common form of redevelopment. In this turnover process, the line between productive and reproductive is constantly blurred, as hospital sites move between these two spheres. For example, the hospital property as hospital is a designated space of social reproductive infrastructure. On closing, it goes on the market as real estate and then a space for reinvestment via construction (read: productive). Finally, as in most cases, it becomes housing, falling back into use as part of the social reproductive infrastructure. Recall the case of St. John’s Queens that Connie spoke of earlier. After closing in 2008,
the building sat empty on a main street in Queens until a third owner finally began to redevelop it into mixed residential and retail space in late 2013.

These are enormous properties with particular types of buildings that are expensive to tear down or convert, and theories of property transaction could explain the long turnover times. In this chapter, I am concerned for what this turnover and redevelopment means for the work that happens in these spaces. The built environment – the physical spaces in which industry operates, workers earn wages, people receive care – is deeply implicated in this and the other two restructuring processes I address next. Through hospital closures, though, the built environment can turn over. The closures open up large plots of potentially profitable land for reinvestment in productive industries or for new investments in the social reproduction infrastructure, as I outlined in the hospital-real estate-housing process above. The devaluation of the built environment frees up that space for reinvestment, and an abandoned hospital is an ideal site for “renewed accumulation” (Harvey 1978, 116). It occupies a large piece of property, and the building itself retains a use value as a potential new hospital or other large facility. Furthermore, letting it sit vacant manipulates property values – both devaluing the property (Smith 1979) and enabling renewed accumulation through, quite often, high-end condominiums.

**Restructuring Industry**

The second restructuring involves the health care industry and the ways in which patients receive health care services. Broadly speaking, hospitals close and
services are centralized to larger hospitals with larger catchment areas. In some areas, urgent care centers (UCCs) have been opening to fill the care deficits left behind.

As I mentioned earlier, New York State formed the Berger Commission in the mid-2000s to review and offer recommendations for improving the state's acute and long-term care services. The Commission included lawyers, business owners, consultants, marketing experts, health care administrators, and a bishop, but no labor representatives. It recognized that health care services were wildly uneven, with minimal-to-no services in some areas and “excess” and “unnecessary duplication of services” in others (Berger Commission 2006, 1). The Commission, therefore, aimed to “rightsize” the system across the state. As the report states,

The Commission reaches a stark and basic conclusion: our state’s health care system is broken and in need of fundamental repairs. Today, New York is struggling to maintain a 20th century institutional infrastructure in the face of mounting costs, excess capacity, and unmet needs for community-based alternatives....Absent intervention, the Commission believes that the future of our state’s health care system is bleak. Unless we act decisively, further facility closures and bankruptcies are almost certain to occur. Moreover, the facilities that close due to market forces alone may be the ones most critical to preserving access. Without intervention, our providers will spiral further into debt and be forced to make difficult decisions to cut services and lay off workers. (2006, 4)

Solving these problems, the Commission argued, “[would] require difficult, perhaps unpopular decisions and strong leadership from our elected officials and others” (2006, 6). The Commission argued that New Yorkers “cannot deny our reality” and “must overcome our reliance on outdated institutions” to “demand a 21st century health system that is more flexible, leaner, stronger, and more affordable than the one we have today” (2006, 6).

The Commission recommended shrinking the entire New York metropolitan hospital and long-term care system, closing or downsizing twelve hospitals in the city
and an additional two in surrounding counties (2006, 9-16). The rightsizing would save the state’s health care system considerable money. As the report argues,

The closure of a facility has many advantages including the removal of fixed operating costs, forgone capital expenses, elimination of duplicative services within the market, increased efficiency at remaining institutions and opportunities for lease, sale or conversion of the facility’s property…. Additional savings are realized by forgoing renovations on aged physical plants…. Furthermore, the benefits of these eliminated costs accrue indefinitely. (2006, 59-60)

Not only is money saved through simply closing, but it is also saved and recouped through selling the property. Furthermore, this “elimination of systemic redundancies could save money without compromising access to care” (2006, 57). A strong argument can be made that two specialty cancer hospitals in Brooklyn is financially inefficient for meeting overall health care needs. Yet, these are not the redundancies that the Berger Commission’s recommendations address. Most of the recommended closures and rightsizings involve full-service community hospitals, predominantly in middle to lower-class neighborhoods in underserved Queens and Brooklyn. Community hospitals, which provide emergency and other basic health care services, are not “redundant” services. The Commission acknowledges that the market is disproportionately affecting “the [facilities] most critical to preserving access,” but many of its recommendations downsize or close these very hospitals.

These recommendations do compromise access to care. Both the recommendations and the actual closures predominantly involve community hospitals in the most populous parts of the city – areas that are also gentrifying and have populations of predominantly people of color. As Figure 7 shows, fourteen hospitals have closed in or near neighborhoods of at least 60 percent residents of color.
Gentrification tells a similar story of dispossession (see Figures 8 and 9); overall, the city is becoming wealthier, and hospitals have closed in the areas with the greatest increase in wealth since 2000 – midtown Manhattan, central Brooklyn, western Queens, and northern Staten Island. Poorer residents are doubly dispossessed, forced from their neighborhoods via gentrification and losing health care through hospital closures.
Furthermore, many of the now-closed hospitals were not in the recommendations, but have helped accomplish the Commission’s goals. The distribution of recommended “rightsizings” would have resulted in a similar loss of beds per borough. The 2008 fiscal crisis came at a convenient moment for politicians who were advocating the closures.
Rather than using government mandates, the state could just let facilities close under the rhetoric of austerity and tough financial times. As St. Vincent’s closed in 2010, the state health commissioner’s spokesperson explained that “there is just not enough money anywhere given the state’s finances to allow it to keep this hospital going, or any hospital in a similar situation” (Hartocollis 2010a, no page).
At its foundation, the Commission’s analysis ignores the daily and intimate work of social reproduction. This is not entirely surprising given the absence of labor representation on the Commission. For example, the Commission ran models to see if surrounding hospitals could absorb patients from facilities proposed for closures. This model measured a facility’s feasibility as an alternative service site by testing travel times from residence to hospital for people in the new catchment areas (2006, 70). A closure was acceptable if a patient could reach the new hospital in a comparable time to their current facility and if the new facility was able to accept an increased capacity (all determined by the number of vacant beds). The model does not address workload or staffing levels to deal with more patients, and it assumes operating always at full census, leaving no flexibility in patient load or cushion for times of high need. In interviews, nurses complained of heavy workloads. When they have fewer patients, the day is easier, and they can provide better care, but most often, nurses are overworked and understaffed. They strive to meet the needs of their patients but are often only able to do so by sacrificing their own wellbeing and the overall quality of care. This means cutting corners on the emotional labor – the conversations with patients, small observations, eye contact – and working for nearly twelve hours straight. In interviews, nurses explained they have little time for bathroom breaks, often do not eat or drink anything over their twelve-hour shifts, and the quality of care suffers.

The patient to nurse ratios can get very unsafe...the quality of the care is less. You’re rushing around. Someone simply asks you for a cup of water and you never get it for them because you totally forget. And who is going to get them a cup of water when there are people needing medication anyway. It would be nice to not have to run around like that and have enough nurses to be able to address what these people actually need, even if it is just a cup of water. (Hannah)
You don’t have time because of your workload. If you have a high acuity patient in one room, you can’t tell your other patient, ‘well I can’t be with you because of this other patient.’ But sometimes the other patient is more important or they need more care, so staffing affects quality of care. (Krista)

Furthermore, hospitals run on staffing levels worked out by human resources departments and executives that aim to run as financially efficiently as possible, and nurses know that increasing staff is an often-arduous process. As Donna explained, when staffing was an issue at her previous job, she explained,

[The administration] didn’t keep up with the volume and give approval for staffing increase in time. By the time they would finally get an increase census would have changed again. It was such a slow process to prove that you need more staff...you never really had what you needed...you never felt like you were ahead of the game.

Staffing needs and staffing allotment are a challenging match to make.

Finally, the Berger Commission Report suggests a new means of health care service delivery. Repeatedly and vaguely, it pushes for more home and community-based alternatives to nursing home placements and hospital services (2006, 73-75 in particular). This prompts a few questions: what is both less expensive and more efficient about home-based care? What exactly are community-based alternatives? Are community hospitals not community-based services? Though the Commission is not specific as to what it means by “community-based alternatives,” urgent care centers (UCCs) are perhaps one of these “alternatives”.

UCCs first began appearing in the United States in the 1970s, but numbers have grown rapidly in the past ten years. According to the Urgent Care Association of American (no date), UCCs are increasing by over 300 facilities per year, and over 9,000 UCCs exist nationwide. A UCC is like an emergency room without the trauma center, treating many patients quickly for about $155 per visit (Creswell 2014). UCCs in New
York are almost impossible to comprehensively track, and anywhere from twenty-five to hundreds operate in the city (NY Department of Health 2013b). There is significant evidence, however, that they are on the rise in the city. Besides their growth nationwide, nurses in interviews frequently referenced them as helping to alleviate ER traffic and as a replacement for family care doctors. Joan discussed their increasing popularity:

In the past year, there’s been such a crazy inundation of those – I call them Doc-in-the-Box – those stat-med, first-med places, and I feel that’s helping to decompress the ER as well. If people used the ER for what it was intended for there would definitely be a lot less wait. It would be a lot quicker of a system, you know, a lot more streamlined.

Additionally, UCCs are a pacification strategy, as politicians and redevelopers have tried to calm resistant communities by promising to replace hospitals with UCCs (Goldberg 2014a). In the case of St. Vincent’s in Manhattan, politicians promised to replace the hospital with an urgent care center in the community. Lenox Hill Hospital of Manhattan’s Upper East Side no operates a freestanding emergency room25 adjacent to the former St. Vincent’s new condominium project (Figures 10, 11, and 12).

---

25 This is basically just another name for an urgent care center. The facility does receive some ambulance services, but is not equipped for traumas.
In the recent fight over LICH, a judge ruled that regardless of who purchased the site, some medical services must continue to be provided there (Vertuccio 2014). Out of the ensuing battle over redevelopment, the winning bidder has stated they will open an urgent care center in the hospital’s place. But Susan Raboy, spokesperson for Patients for Long Island College Hospital, asks a pertinent question: without the related services

---

26 This was as much a pacification strategy as a means of saving face for the redeveloper, as the bidding process was highly contentious – and very ugly – for over a year. The LICH emergency room has continued – though with occasional interruption over the fight against the closure – to operate, even after the hospital formally closed in May 2014.
that a community hospital provides, “what good is urgent care if you don’t have a hospital to go to?” (Vertuccio 2014, no page).

Nationally, hospital corporations, insurance companies, and finance companies are who most commonly own UCCs; they are also of interest to private equity investment firms (Creswell 2014). Health insurers looking to ‘streamline’ services to their policyholders own some of the largest chains. For example, in 2010 Humana Health Insurance purchased Concentra, America’s largest urgent care company operating over 300 facilities in 38 states (Concentra no date). Concentra’s former owner, the private equity firm Welsh, Carson, Anderson, and Stowe then proceeded to buy Solantic (now called CareSpot), a for-profit UCC chain started by Florida governor
and businessman Rick Scott (Solomon 2014). Tenet Healthcare, one of the nation’s largest for-profit hospital systems, launched its own UCC system, MedPost, in May 2014 (Tenet Healthcare 2014).

In what Forbes Magazine (Solomon 2014, no page) calls “drive-thru health care”, UCCs, often, are not meeting needs. While UCCs may be convenient for many patients needing quick but non-emergency care and fill some of the care deficit left by a shortage of primary care physicians, their lack of regulation across the country has implications for who can actually access their care. Since most do not accept Medicare and Medicaid, they are free to refuse services to those without private insurance (Creswell 2014). Therefore, not only are UCCs limited by the scope of their services, but also by being private and for-profit, they limit who can access the care. In New York, with the shift from hospitals to UCCs, the for-profit health sector is growing. All hospitals in the city are either public or non-profit hospitals. Very few for-profit facilities survived the closures of the 1960-1980s (see McLafferty 1982). During this period, for-profit facilities – which were generally smaller, lesser-used service providers – had trouble remaining competitive in an era of hospital crisis. UCCs present a new opportunity for private, for-profit health care corporations to enter the city’s market. Rather than being part of the system in crisis as for-profit hospitals were, UCCs are part of the ‘solution’ to the crisis. Yet they are only a solution for some residents, for some communities, and for some health care needs. Thus, UCCs do not fill gaps left behind by closed community hospitals; rather, they can create a more uneven geography of health care services.
Restructuring Labor

The third restructuring process deals with labor – a restructuring of the nursing workforce. In many ways over the past 40 years, nursing is and has become a more stable and accessible job, particularly for those whom the profession has historically discriminated against. While union membership rates have been in decline in the US since the 1970s, nursing has seen significant growth in unionization recently.

Unionization nurtured its roots in labor strongholds like California and New York, but in recent years, unions have successfully organized in places as politically far and wide as Illinois, Missouri, Pennsylvania, and Texas. Currently, over 20 percent of US nurses are unionized, and most of that unionization happened since the late 1980s (Cobble 2010; Joanne Spetz et al. 2011). New York has some of the oldest, largest, and increasingly powerful nurse unions in the country, and nearly all of the nurses I interviewed are or had been union members in at least one job over their careers.

Unionization has real impacts for nurses at work. As Jocelyn explains, unionized nurses have greater voice in hospitals.

Hospitals that are doctor-driven, the nurse has no say. Like a nurse is not supposed to take any verbal orders. Everything has to be written. And at doctor-driven hospitals, the doctors give you verbal orders and you have no choice. And if something goes wrong, it’s your word against the doctor. So you know who’s going to win. It’ll be the doctor. But in other hospitals, where it’s union, the nurse has a voice.

Part of this unionization success has been thanks to the cycles of nursing shortages in the late 1980s and late 1990s-2000s. As facilities were desperate for staff, nurses had greater bargaining power as a group within the workplace. With the recession and increased hospital closures, the nurse shortage became a job shortage.
Hospitals had less money and were no longer able to afford to hire more nurses. Also, as hospitals closed, fewer facilities existed to hire nurses, making closures central to this shift in labor supply. As Harvey (1978, 125) explains, “the greater the labor surplus and the more rapid its rate of expansion, the easier it is for capital to control the struggle in the workplace.” This does not clarify why unions are still successfully organizing under the current conditions of job shortage; to understand those successes, we must consider nurses’ struggles over working conditions and quality of patient care. But Harvey’s argument does point to why unions and communities have been so unsuccessful in preventing hospital closures. Closures are union busting by another means. They are part of capital’s response to nursing’s increased leverage – a way to control the job market and to thus control the labor supply. Indeed, it is telling that NYSNA, the largest nurse union in New York State, has been leading the fight against closures. The spaces of employment are key to the labor struggle for nurses, whether the issue is unionization or the existence of jobs, since nursing cannot be automated or outsourced.

The first two restructuring processes are instrumental in the changes to the spatiality of nurse employment. Hospitals are the main employer of registered nurses (RN). Federal law only requires that long-term care facilities have eight hours of RN coverage per twenty-four-hour period, and these facilities staff mostly with licensed practical nurses (LPN) and assistants. UCCs, doctors’ offices, and other clinics also rely primarily on techs or medical assistants and nurse practitioners (NP), though they do use some RNs. Nurse practitioners, according to the Bureau of Labor Statistics (2012; 2014), are one of the fastest growing occupations, expected to grow by 34 percent by 2022. New York State has the highest number of NPs in the United States, and the New
York metropolitan region has the highest employment level of NPs of any metropolitan region in the country (Bureau of Labor Statistics 2014). In interviews, over half of the nurses expressed interest in or were already pursuing an NP degree. There is a trend in the profession to skill up.

Health care facilities are also using fewer RNs overall to save money (Weinberg 2003). Early in her career, Krista worked in nursing homes and eventually moved to a hospital in Brooklyn; she has watched staffing change over her career.

Ten years ago, a lot of RNs were working in the nursing homes. It’s not so right now. It’s more Licensed Practical Nurses. Because they had LPNs in the hospital and there’s less LPNs now in the hospital. The thing now is to have just RNs in the hospitals.

Similarly, Jocelyn explains the geography of the nursing hierarchy.

If you go to a private doctor’s office, there’s no nurses there. If you go to these urgent care centers that are popping up everywhere, there’s no nurses there. It’s doctors and medical assistants, ok? Now in the hospitals, they have regulations so you have to have nurses in these clinics... You will see nurse practitioners in the private doctors, but you will not see RNs.

The type of health care facility thus directly relates to who works there.

Additionally, as nursing has professionalized, RNs have taken on more managerial roles and emphasized the technical and higher skilled aspects of their work. Aides and technicians, who earn two-thirds less than RNs, perform the less-skilled and more intimate bodily tasks (see Weinberg 2003 for an excellent ethnography of this change; BLS 2012). Furthermore, employers increasingly require nurses to have a bachelor’s degree; while until recently, registered nursing never required a four-year degree (Pérez-Peña 2012). Jocelyn’s employer, for example, recently began to require RNs to have a bachelor’s degree.
When I graduated, you didn’t even need a bachelor’s; all you needed was an associate. I had to go back to school if I wanted to stay in my job. I think in a few years it’s going to be the same thing. They’re gonna want nurses to be nurse practitioners, and we’ll have to go back to school. It’s the trend that I’m seeing.

Nursing, then, is changing in ways that involve education, training, and space. Fewer employment spaces for RNs exist, both RNs and NPs becoming more difficult to obtain, and the health care industry is relying increasingly on technicians and aids to perform the work RNs used to do. This changing geography of services has impacts on the nursing hierarchy that are reminiscent of its history of segregation. Though nursing has been a stable and respectable job for women, as a middle-class profession, it has been an unobtainable profession for many (Reverby 1987; Duffy 2010). Nursing’s history is one of a racialized and classed hierarchy that protected the most prestigious positions of registered nurses for white women of middle class background (Reverby 1987; Clark Hine 1989; Glenn 1992). From the late 19th century into the post-war era, most nurses were white, middle class women – women who supposedly embodied “natural” qualities of moral, clean, and nurturing women. As women of color began to enter nursing, a skill hierarchy segregated the profession. Registered nurses were almost exclusively white and middle class women, while the less educated LPNs and nurses’ aids or technicians were women of color and of lower class. The legacy of this racialized, classed hierarchy still exists, but in recent decades, registered nursing has become more diverse, more closely reflecting national demographics (BLS 2013).

Presently, a bifurcation of the nursing workforce is beginning, built on nursing’s historical and racialized hierarchy. One stream of nursing is increasingly high-skilled, highly trained, and well paid, while the other is low-skilled, requires much less education, and is poorly paid. The restructuring of the spaces of employment – the
places where patients receive care and nurses go to work—facilitates this process, because some work spaces favor RNs, while others favor technicians, and still others NPs. The workforce begins to match the ‘revolutionized’ landscape.

CONCLUSION: FOR GOOD HEALTH AND GOOD JOBS

This chapter has shown how the three restructuring processes are intertwined. Changes to the built environment impact service delivery and the geography of the job market. Changes in the delivery of health care services shape what spaces and workers are needed. Changes to the nursing job market impact service delivery and the landscape that provides those services. These restructurings have the potential to make health care increasingly inaccessible in two ways.

First, the uneven geography of health risks becoming more uneven. Victoria, a nurse for over 50 years, has seen a lifetime of changes. She explains the care deficit in Rockaway, a peninsula community in Queens. Only one hospital remains for Rockaway’s nearly 120,000 residents, a third of which receive public assistance (NYC Department of City Planning 2014). She explained that neighborhood health care is in crisis:

As far as the community is concerned, we have a problem. My husband had a situation about a year ago, and we had to call 911. The paramedics say they were taking him to St. John’s [Episcopal]. Peninsula was closed already. I’m not taking him to St. John’s. So they suggest Beth Israel, but I know these hospitals, and they mean Kings Highway in Brooklyn [owned by Mount Sinai-Beth Israel Hospital System]… It’s even worse! But those are issues that the everyday family deals with. They wouldn’t know what I would know…If I wasn’t there, who knows what would have happened. That’s the scary part of getting sick when you live in Rockaway. And that’s just one community!
In Brooklyn, Krista expressed personal and professional concern over the many hospitals that have closed.

It becomes kind of tight finding jobs and doing overtime or anything like that. They closed a few hospitals in Brooklyn a few years ago and a lot of nurses and other staff came to Downstate Medical Center and they were accommodated. But you know, LICH, that was my hospital. I prefer to go to LICH. My pediatrician is at LICH. My OB-GYN is at LICH. I don’t want it to close. I don’t think hospitals should close. People get sick. People are always gonna be born. They’re gonna get sick. They’re gonna need a check up.

Victoria and Krista’s stories demonstrate how hospital closures are implicated in the uneven geography of health care provisioning. Renaming a facility via buyout or merger may obscure poor quality of care. Fewer facilities means longer travel times to services. Patients less familiar with the health care system or without a strong advocate are at a serious disadvantage. Fewer hospitals mean fewer job opportunities for RNs. When hospitals close, people have reduced access to health care services, and communities lose jobs and a social and economic anchor. Neighborhoods are in crisis.

Second, nursing is changing and can become less accessible through a restructuring of the profession. Nursing is becoming either a harder job to attain (e.g., as an NP or RN) or is becoming a lower-skilled, lower-paid job (in the technician or aide), which means the loss of a stable job opportunity for women. Furthermore, nursing’s segregated history provides a useful lesson. A new era is beginning in which the very nature of nursing is changing and potentially regressing along a racialized, classed, and gendered hierarchy. Although nursing is not exclusively “women’s work”, there is something important to hold onto in a job that has been a source of secure livelihoods for women for so long – especially when it is becoming a better job through increased unionization, better pay, more attention to safer staffing levels, and more
accessible to low-income women and women of color. This threat is intimately connected to the built environment and processes of accumulation. Hospital closures are the mechanism that can make this happen; having fewer spaces where registered nurses work can mean fewer good jobs. Furthermore, as Fiona and Krista’s stories also remind us, nurses are city residents, too. They need health care and jobs to reproduce themselves. Not only are communities threatened by closures, but also are nurses’ ability to socially reproduce themselves and their families. Thus, a health care system is at risk.

American health care is in a time of transition. With the Affordable Care Act (ACA) and the aging population, new care needs are emerging and met in new ways, and this is neither the first time nursing or the built environment has revolutionized nor the first crisis of American health care. The built environment reinvents itself through devaluation roughly every twenty years (Harvey 1978). The development and subsequent decline of hospitals maps onto these cycles, from the birth of the hospital in the late nineteenth century to their expansion in the 1920s and later in the post-war era and then to the beginning of their decline in the 1970s (Rosenberg 1979). Between 1967 and 1986 New York City lost 37 percent of its hospitals (S. McLafferty 1982). This was another period of “openly articulated state government policy of ‘shrinking the system’” (Pomrinse 1983, 575): i.e., other moments of revolutionizing the social reproductive health landscape.

What is particular about this cycle of crisis is the starting point. Arguably, health care is at a worse point than it was in the previous wave of hospital closures. Even though the ACA is expanding health insurance coverage for millions of Americans,
spiraling costs, growing economic inequalities, and the uneven geography of health care services mean the ACA is a small piece of a giant messy puzzle. Conditions in New York City are stark; the Brookings Institute lists the city as having the sixth highest rate of inequality in the country (Berube 2014). Indeed, New York witnessed the birth of the Occupy Movement in response to inequality and the 2008 recession; the new mayor successfully ran on a campaign to fight growing socio-economic polarization.

These three restructurings demonstrate the importance of the built environment to the work and practice of social reproduction. Hospital closures – as a phenomenon that is spatial, industrial, professional, and social – represent the contradictions of social reproduction, from its devaluation to the inequalities in access to health. This case study highlights the ways in which health care, work, and spatial restructurings are mutually constituted. As production’s other, health as social reproduction is more vulnerable to devaluation and also disappearing. If capitalists have little incentive to invest in the social reproductive built environment, investing in social reproductive health care labor is similarly unappealing. As the ripples of hospital closures show, the restructuring of social reproductive work and services (i.e., health) is part and parcel of the construction of the built environment and risks remaking the landscape into one where good health and good jobs are less accessible.
Chapter 3
Time and the Social Reproduction of Health Care

Nurses – the arguable backbone of health care – have watched their jobs change dramatically over the past 40 years. Patient conditions are more acute, staffing is more limited, the distribution of resources is increasingly uneven, and paperwork and bureaucracy have grown immensely (Abramovitz and Zelnick 2010; Lipscomb et al. 2004). Time has also changed. Since the 1990s, health care facilities have moved away from the 8-hour shift, in favor of staffing nurses in 12-hour shifts. I argue that time and the restructuring of shift work in nursing is an important tool of health care reforms of the last few decades. In effect, the 12-hour shift flattens expectations and possibilities for improving nurses’ working conditions. It works to move the discussion away from working conditions and content to which length of shift works best for someone’s schedule. For the history of labor struggles, the length of the working day has been a focus of struggle, so when and how did a longer but less frequent working day become a victory?

In this chapter, after a brief discussion of my methods, I will present a brief history of the neoliberal shift in health care since the 1970s. Then, drawing primarily on interviews with nurses in New York and St Louis, complemented with conversations

posted on a popular public nurse online discussion board, I question what the
dominance of the 12-hour working day means for nursing. I examine what nurses are
saying about the 12-hour shift structure. Turning to Marx and Marxist feminists, I argue
that this restructuring of nurses’ work time is an important neoliberal tool that
distracts from struggles over improved working conditions and patient care. While sold
to nurses partly as a solution to staffing problems and a way to have greater flexibility
in scheduling, the shift in shift work obscures and invisibilizes problematic and difficult
working conditions.

This chapter, along with Chapter 4, analyzes the working conditions specific to
hospital nurses. It contributes to geography by both investigating a specific worksite as
well as the temporal conditions under which nurses do their work. Nurses perform a
type of nursing particular to the hospital and the unit they work in. The shift length
impacts the relational care work they perform, as nurses embody their work in
different ways over the shift and at home after work. Work-life balance is a spatio-
temporal concern, and an issue central to a nurse’s work schedule. As I discuss later,
nurses bring emotional work home with them at the end of the day. Commute lengths
and shift lengths often intersect, impacting how nurses experience their jobs and their
home lives. Thus, as I discuss here, nurses’ time is spatial in many ways.

METHODS

This chapter, like the two that follow, is driven by interviews with nurses. In
these New York interviews, I was struck at the ambivalence nurses had or
contradictions they expressed when discussing their shift length. Many nurses like the
12-hour shift length, but they also have complaints about how it impacts their work and lives. To help me make sense of these interviews, I turned to interviews with nurses in St Louis, conversations on a popular public nurse online discussion board, and a 1975 editorial in the *American Journal of Nursing*, that was written when 12-hour shifts were just starting to gain attention in the US health care system. These additional sources broaden the geographic scope of this chapter. The lengthening of nurses' working day is a national, and even international, trend, as I discuss later. The broader scope and greater diversity of voices helped me to flesh out what nurses were expressing in interviews.

The interviews provide the bulk of the data, and I complement these with an analysis of a public nurse discussion board. I analyzed 25 discussions from 2004 to early 2013 in which nurses voiced their opinions on 12-hour shifts. Discussion board topics were all similar, asking fellow users about their opinions on shift length. Most discussions had between 10 and 60 participants, and the vast majority of participants only posted one (and sometimes two) comments. The anonymity of online discussion boards presents limitations for the research. For example, unlike in interviews, I am limited to the single or few comments a participant posts. Also, though I cannot filter participants by characteristics such as race, age, specialization, gender, and location, many participants offer some of these details or the discussion itself is among nurses in a particular location, specialization, or combination of the two. Also, these discussion board conversations are among colleagues, but are also public so others people can join the conversation, and this changes the relationship a researcher has with the

---

28 Quotes from interviews are indicated with pseudonyms while discussion board quotes are indicated with footnoted citations.
participants. These public discussion boards, however, constitute a useful and important site for understanding how nurses view their jobs. They provide a window into discussions that colleagues have with one another — discussions that are different from that of the researcher and the interviewee. Given the popularity of the website and the evident emotion with which nurses discuss their shifts, these discussion threads provide important complementary information on the issues nurses face within shift work.

In both the interviews and the discussion boards, I coded the nurses’ comments on shift length according to what feelings they expressed towards the 12-hour shifts, favorably, unfavorably, or ambivalently, and then coded them for themes that qualified nurses’ like, dislike, or ambivalence. I identified three to four categories for both what they like and dislike like about the shift length. Finally, I identify three main areas of concern that the lengthening of the working day raises.

I also draw on an editorial piece from 1975, published in the *American Journal of Nursing*. This is one of the earliest discussions of the 12-hour shift, and it is one that appears in a major American nursing publication. As with the additional interviews and discussion boards, the editorial piece helps to situate the debate over shift length within national scale labor politics since the 1970s.

**THE SHIFT IN SHIFT WORK**

Beginning in the 1970s and 1980s, federal and state governments cut spending to health care services and worker training while private (and importantly, for-profit) facilities grew in numbers and in territorial coverage (McGregor 2001; Quadagno 2006;
Stoesz and Karger 1991). This shift had implications – and as I argue here, was made possible through particular changes to the job – for how facilities operated. These spending cuts to services and health care worker training were part of a broader deregulation of the health care system and health insurance agreements that opened doors for the private market to control a greater percentage of the industry. More private and for-profit providers and parties entered health care.

Over these last three decades of the twentieth century, reforms also exacerbated the nurse shortage (see Kingma 2006). During the 1980s, restructuring cut funding to nursing education and health care facilities (Maskovsky 2000; Navarro 1993; Weinberg 2003). The combination of these reforms made nursing a harder job to train for, a more difficult job to perform, and a less desirable job to have.

First, funding cuts to education and facilities had a significant impact on the nursing labor supply (Buchan and Aiken 2008; Kingma 2006). Cuts to education meant that nursing programs could admit fewer students. This resulted in fewer new nurses graduating each year. Additionally, spending cuts changed the everyday working conditions for nurses as well. As facilities had less money, resources, from supplies and space to workers and salaries, became scarcer. Facilities ran with the bare minimum of both supplies and staff. As a result, nursing became a more stressful job with greater responsibility. Nurses’ salaries had also stagnated for decades (J. Spetz and Given 2003). As a more affluent, more health literate national population began to demand more and better services, health care itself changed and health care work became more challenging. Patients’ heightened expectations further increased the responsibilities of already overworked nurses. This focus on patient satisfaction has become even more
pronounced in the past two years. As of 2012, Medicare, the national insurance system for elderly Americans, factors patient satisfaction into how much the program will reimburse facilities for services (Guadagnino 2012). This new requirement for reimbursements makes more precarious the already unstable financial footing hospitals rely on, which I address in more detail in Chapter 4.29

These changes facilitated two trends in the American nurse workforce: (1) nurses left the profession, burnt out from the hard work and insufficient compensation, and (2) fewer women wanted to enter the profession. In other words, fewer new nurses entering the job market each year combined with high rates of burnout and decreased interest in the profession meant that the American-trained nurse supply was increasingly insufficient to meet staffing needs.

This shift in the nursing workforce was part of the overall shift in the global workforce, from Fordist to post-Fordist production regimes, or, in other words, a shift from higher-skilled and often masculinized work to lower-skilled, lower-paid, and increasingly feminized work (for examples, see McDowell 1991; 2009; Salzinger 2003). The feminization of nursing manifested in the devaluation of their work, with stagnant wages, and an overall underinvestment in the spaces, training, and materials of nursing (Duffy 2010).

Duffy (2010, 76) explains that aside from a set of cost cuts and privatization, neoliberalism in the late 20th century US was “an ideological commitment to

29 The Baby Boomer generation has also had a significant impact on the health care system. The growth in population and the resulting demographic shift has meant that the US has a larger population demanding health care services. Boomers will also place greater demands on the system because they are living longer and with chronic health concerns that come with aging. For greater discussion on the impacts, see the report by the American Hospital Association (2007).
proscribing the limits of public responsibility for care” which “changed the landscape of paid care”. The everyday practice of health care changed. This process involves a regimentation of the work and the working day, with clearly drawn boundaries between tasks. I address this division of tasks in more detail in chapter 4, but it is worth noting here. Facilities and regulators increased bureaucracy and paperwork, outlining all of the tasks nurses do. Yet, this list was incomplete, because much of the non-technical tasks such as conversing with patients and families and using soothing voices are not on the list. Duffy explains that nursing’s tasks are difficult to draw boundaries between, as “technical knowledge and relational competence are both important and can overlap considerably” (2010, 77). Technical or clinical knowledge often needs the complement of relational care work in order for nurses to complete their jobs. For example, Duffy offers the situation of nurses “[chatting] with patients about their pain level while taking their blood pressure”. These two activities, the technical activity and the relational caring activity, together give nurses a more fulsome evaluation of patients’ state and progress. Neoliberal policies and ideology changed the daily work of nurses, and I argue that the restructuring of time was an important tool in making that happen. The division between what I later, in Chapter 4, refer to as care and clinical work was a way of rationalizing some work as necessary and some as not. This is important in an era of fiscal precarity and staffing shortages, because changing the job requirements can change staffing requirements.

---
30 By neoliberal economic reforms and restructuring, I mean what Sparke (2009, 290) describes as the “pro-market practices of governance and free-market fundamentalist ideologies”. In the case of nursing and health care, these neoliberal economic policies meant economic governance models that justified administrators and governments cutting spending and resources to nursing education and health care facilities (especially via the restructuring of both private and public insurance reimbursements).
The move to the 12-hour shift was part of this changing of the nursing job. The longer shift became popular with health care administrators in the 1990s. Today, it dominates hospital nursing. Part of its growth in popularity can be attributed to the nurse shortage of the 1980s and 1990s, as facilities searched for ways to increase efficiency of services and use of resources (Reid, Robinson, and Todd 1994; Todd, Robinson, and Reid 1993).

The move from the more standard eight-hour shift to the 12-hour shift has its roots, though, in the 1970s. Hospitals in particular were in search of cost ‘effective’ measures to compensate for a lack of resources and (increasing and prolonged) staffing shortages. A 1975 testimonial published in the American Journal of Nursing offers insight into the change in shift structure. In her short piece “What a 12-Hour Shift Offers”, registered nurse Alice B. Underwood argues that, just like what her own pediatrics unit has done, nurses everywhere could meet staffing needs and deal with increased patient loads by reorganizing some of their key resources: themselves and their time. As the overworked nurses on the unit approached their breaking point – working eight and nine days in a row with additional, acute patients – Underwood explains, “we were ready to ask for additional staff, but first took a look at our own resources” (1975, 1177). Instead of questioning the increased responsibility in the everyday amidst insufficient resources, the nurses on Underwood’s unit changed to a 12-hour shift structure. While their managers were hesitant at first, they let the nurses try the new shifts. Underwood explains that the nurses enjoyed the sequential days off while managers appreciated the leaner total staff that the unit now required.
For employers, the 12-hour day has a few advantages over the eight-hour day. One advantage is fewer transition periods between shifts and fewer overall staff members. With only two staffing changes in a day, one changeover period – a time when two shifts overlap, when nurses hurriedly give reports on patients, and when little-to-no time is spent on patient care – is eliminated. Thus, the half-hour overlap in shifts is eliminated, saving money on paying two shifts at once and keeping nurses working on patient care and paperwork. Needing fewer nurses on the payroll means personnel costs decrease and facilities can try to use the new shifts as a way to deal with chronic staffing problems and shortages. Additionally, employing fewer nurses overall saves facilities from paying for benefits.

For nurses, ‘full-time’ can mean two different things. First, full-time status can mean working three 12-hour shifts per week, meaning a 37.5-hour per week (the shifts actually last 12.5 hours, including a half hour transition period). While this is a decrease in what counts as full time per week, nurses are generally paid hourly, which means a decrease in pay from five eight-hour shifts per week. Nurses may make up those lost hours by working an additional shift one week in a month, meaning working four shifts, or eight hours of overtime, every fourth week. The second style of scheduling would be three days the first week of a pay period, and four shifts the second week of the pay period. This system naturalizes four hours of overtime in every two-week pay cycle. Many of the nurses I spoke with talked of working at least one extra shift, or four shifts total, every other week.

What the lengthening of the working day offers nurses and patients is somewhat ambiguous, and early research was ambivalent about its effects. Some scholars argued
that the longer working day did negatively impact patient quality of care (Geiger-Brown et al. 2012; Todd, Robinson, and Reid 1993). Patient care suffers as nurses fatigue, showing the greatest fatigue in the second half, and even more so in the last hour, of the 12-hour shift. Others, however, found that the quality of care in an eight-hour shift is no different from a 12-hour shift (Mills, Arnold, and Wood 1983). Only working three days a week offers more time to recuperate after long shifts. Also, the longer shift allows nurses and patients more time to build a better rapport, which means the emotional labor and caring of nursing work could be potentially stronger in a 12-hour shift.31

Yet, more recent research on the 12-hour shift as well as research on shift work more generally paints a different picture (Rogers et al. 2004; Lockley et al. 2007; Geiger-Brown et al. 2012). Rogers et al. (2004) examined the relationship between shift length and errors. They came to two important conclusions. First, even when scheduled for 12-hour shifts, nurses generally worked overtime on those shifts, working anywhere from 13 to 16 hours at a time. Over 80 percent of nurses in their study reported leaving work after their shift’s scheduled end, and in general work schedules are “unpredictably prolonged” (207). Twelve hour shifts are not just 12 hours long; they are often 13, 14, 15-hour shifts. Second, frequency of errors and near errors begins to increase when shifts last over eight and a half hours, and greatly increases when over 12.5 hours.

Therefore, with the majority of hospital nurses working 12-hour shifts, when studies suggest that errors happen after ten and 12 hour of working, and when nearly

---

31 With patient stays becoming shorter over the past few decades, nurses build relationships with patients over a day or two, rather than many days. With 12-hour shifts, nurses can stay with patients through the majority of their stay. For example, a nurse might work two day shifts in a row, spending most of the daytime hours of a patient’s stay with them over their 48-hour admission.
half of all nurses work for more than the 12 hours of their shift, there is serious cause for concern about the quality of care and quality of work for nurses scheduled for long shifts. Furthermore, Geiger-Brown et al. (2012) and the Joint Commission (Lockley et al., 2007) – the main health care facility accreditor in the US – importantly point out that patients are not the only ones at risk during longer shifts. Nurses themselves are at greater risk of injury on longer shifts.

**NURSES SPEAK ON THE 12-HOUR SHIFT**

In this section and the next, I will present an overview of what nurses in my study are saying about 12-hour shifts. Then I will turn to Marx and Marxist feminists to ask what these comments explain about the 12-hour shift. I will argue that their comments demonstrate that the extension of the working day is an important tool in the neoliberal toolbox that distracts from issues such as overwork and overtime.

In my interviews and analysis of discussion boards, nurses express both enthusiasm and disdain for the 12-hour shift. Responses ranged from completely positive to completely negative. Overall, however, most nurses preferred the 12-hour shift over the eight-hour shift, which is consistent with other literature on nurses and 12-hour shifts (Geiger-Brown et al. 2012; Reid, Robinson, and Todd 1994; Stone et al. 2006). Indeed, one interviewee felt that the 12-hour shift was “the best thing that could have happened to nursing,” crediting it with attracting more new nurses to the profession over the 1990s and 2000s (see Goodin 2003; Kingma 2006). Yet, reading between the lines of enthusiasm and disdain is important. Nurses qualified their
feelings in a few common ways that reveal the work that the 12-hour shift does on nurses as a profession.

**What Nurses Like About 12-Hour Shifts**

Two dominant themes related to work–life balance were common among nurses who expressed a preference for 12-hour shifts: the potential for additional and consecutive days off and the potential for more flexibility in scheduling. A third reason commonly cited pertained to workload; 8 hours is simply not enough to do all the work required.

**Consecutive days off**

Many nurses explained that they loved having three or four days in a row. Krista explained the common reason why: the potential for regular long weekends and days spent in the workplace. She explains, “I prefer 12 hour shifts because you don’t have to be there 5 days a week. You don’t have to see people [at work] all day every single day. And you have your days off. If you plan it correctly you can plan a little vacation.”

Understandably so, an extended weekend is the envy of many workers. Yet, nurses complained that consecutive days off were not regular or guaranteed. This is especially true for newer nurses, who lack the seniority to successfully request their preferred schedules. Scheduling paid working days in a row, however, depends on the facility’s scheduling system and a nurses’ seniority. For example, one discussion board participant explains,
I have found that it is rare for a facility to have a scheduler that consistently upheld my request to not work 3 12's in a row...When I finally would have that day off after my third 12 hour shift, I would definitely not spring up out of bed with anticipation about how I was going to spend my marvelous day off...especially when I knew I was going to have to turn around and work in the next day or two.32

Nurses do not feel the benefits of more days off as well when they are split among single or paired working days. As new nurse Alyza explained, she and her colleagues often have their work days spread out across the week.

Many new nurse grads like the idea of 12-hour shifts but when you're a new grad, it's not like you get 3 days on in a row. You get one day on, one day off, two days on, two days off. It's a very hard schedule, because on your day off you're just trying to catch up on sleep. You're tired, so you just want to rest. It's not like a true day off where you can enjoy your time. If you can get two days on or two days off, it's a little better.

The experience of fewer workdays per week is very much unlike a long weekend for Alyza. Not only is she trying to catch up on sleep on most days she has off, but she also feels the impacts of her work across the entire week. Those non-consecutive days off factor significantly into nurses' fatigue and ability to recover. Shift work by its nature disrupts circadian rhythms, and this can increase the stress of maintaining a work–life balance (Gold et al. 1992; Klerman 2005). Nurses often explained that they devote almost an entire day off to recovering from work, leaving much less time to maintain balance between work and life.

32 ©Nurse. 1 March 2011. “12 hour shifts...3 is plenty” www.allnurses.com/general-nursing-discussion/12-hour-shifts-535337.html
**Flexibility**

As the work–life balance literature has well documented, flexibility in work schedules is a significant factor in employee satisfaction, productivity, and retention. For nurses, the flexibility in scheduling is a significant draw to the profession and an important factor in their satisfaction. Sophie, a migrant nurse from Kenya working in St Louis, explained that her schedule in Kenya was completely inflexible, but in the US, she has a lot of control over when she works. This has been one of the most important reasons for her job satisfaction. Similarly, Sandra, a nurse in New York explained that one of her reasons for changing to her current workplace was the flexibility in scheduling. In fact, recently, since she was too tired to spend time with her children after working 12-hour shifts, her facility allowed her to reduce her shifts from 12 to ten hours.

New nurse Alyza struggles with the on-again-off-again of 12-hour scheduling and praises the days when she can leave work early. While she explained that 12-hour shifts are fine, she really appreciates sometimes working only 10 hours because then she isn’t as exhausted. She can have “that extra hour where you can decompress before you carry on with your night”.

Nearly all of these comments on time off and flexibility also point towards an important part of shift work, nursing work, and the longer working day: fatigue, and more acute fatigue at the end of long shifts. Nurses are exhausted at the end of 12 hours of work, and especially after two and three long shifts in a row.
8 hours is not enough time

Finally, a third important reason nurses gave for preferring 12-hour shifts pertained to workload. Eight-hour shifts, they explained, were simply too short to complete all of the work required of them. In a 12-hour shift, however, they are able to better keep up. Though, as most nurses stay longer than their scheduled shift (Rogers et al., 2004), perhaps the 12-hour shift is still not long enough to cover all of the patient care and paperwork that nurses do. Nurses are expected to complete an overwhelming list of tasks, which I discuss more in Chapter 4. Sophie, a migrant nurse, was shocked when she first began working in the US at a hospital in St Louis.

I was surprised at the amount of responsibility that I had, that a nurse had. It was very overwhelming at first. I honestly did not think I would make it! ...Every year [documentation and paperwork] gets more...It's too much work. And I don't even know that it's the physical. I think it's more mental. You are held accountable for so much. It just makes it feel like it's a lot.

More time at work, nurses explained, allowed them to finish all of their work. Take for example, the multiple uses of overtime at Janie's facility.

There is turnover because of the shifts. My schedule works for me. It’s five days from 3-11 pm, and, even though I wish it was three 12s, I’m dealing with it. But a lot of my friends have left to go elsewhere for a job with 12-hour shifts and overtime. Overtime is a nice thing. I go into work at 2:45, and I sign up everyday for overtime. Management used to approve people for overtime all the time. Every hour over is [paid as] time and a half. So I would come in at 10:45, and you would make time and a half for those four hours and then your normal shift for eight hours. It really adds up in your paycheck. The day staff stays later to give us a dinner break. So at 2:45 when they’re shift ends, they stay until 6:45. So they get four hours of overtime. They used to approve it. If you signed up five days a week, you would get four hours each day. It really adds up! About a year ago, they took overtime away from us. Nobody could get it. We make a really great salary, but when you’re used to getting overtime, you factor it in to your life and budget. It’s not guaranteed, but they took it away. They are a lot more strict about approving overtime, so it’s scheduled overtime. And very occasionally, when I get off at 11, there will be still five ORs running and the night shift only
has enough to staff a certain amount. So they’ll ask people to stay from my shift and you’ll get overtime that way. I sign up six days a week, even Saturday [for overtime], but they really try to stay away from it. It’s a lot of money out of their budget. So my friends who left, they left for 12-hour shifts and for overtime.

Overtime serves multiple purposes: it relieves workload, it facilitates nurses supporting each other better at work, and it provides supplemental income. At Janie’s facility, there is clearly enough work to justify more hours being worked by nurses, as until recently, management regularly approved planned overtime. Janie is drawing a connection from workload and working conditions to shift length to wages. Nurses depend on overtime to supplement their regular income. Working overtime also provides more support on the floor to accomplish all of the tasks that need to be done. Nurses work together to ensure everyone gets a break. Finally, the shift structure is part and parcel of working conditions as Janie’s facility is seeing a lot of turnover as nurses leave for jobs offering 12 hour shifts and greater chances for overtime pay.

Changing the shift structure would do two things: (1) overtime would be far less common in the sense that Janie is used to as that extra time is absorbed into the regular working day, and (2) the extra staffing that Janie’s style of overtime provides would disappear. So while nurses mention that

Overtime is a different way of discussing shift length. As Janie explains, she wishes she worked 12-hour shifts, but until recently, she effectively already did. What is different from her situation compared to the standard 12-hour shift, however, is the staffing levels. With her overtime structure, more staff were around to do more work and support each other better. It is important to note that Janie frames her frustrations in terms of shift length, rather than working conditions. I will return to this point later.
What Nurses Dislike About 12-Hour Shifts

Nurses both for and against 12-hour shifts referred to similar drawbacks of the longer working day. These include exhaustion, overtime, time away from family, and apathy for patients.

Exhaustion

Flexibility and schedule control, as I mentioned above, are factors in fatigue, but nurses often complained or reported exhaustion after just one or two long shifts. On days off after long shifts, Krista explained that, “More than likely you’re home. Most of the time you’re sleeping all day, but at least you’re not there 5 days a week.” Importantly, even nurses who prefer 12-hour shifts explain that it is partially conditional on their workplace and lifestyle. Even while many explained that they preferred longer shifts, they emphasized the importance of a supportive work community and staffing levels and a work culture that ensured their ability to take breaks. In other words, preferring 12-hour shifts comes with many qualifiers.

Some hospitals [in New York] are unionized. In California they’re union so by law they are required a 15-minute break in the morning, 30 min lunch, 15 min break in the evening hours. In New York I would assume it’s the same, but sometimes [trails off]. There’s a list [of who needs breaks] but someone needs to regulate that list. And if there’s no one there to cover you then you have to cover yourself. (Alyza)

Alyza continued, comparing her experiences working in California, which has a strong union, to New York, which has a weaker but growing-more-powerful union.

It’s a fine balance between ‘I want to be there for myself so I can be there for my patients’ versus ‘I want to be part of the floor or unit so I’m not going to complain.’ As a new grad, that’s a fine line to figure out. But it’s also luck. If you’re on a floor with nurses who take care of each other then you’ll get your
break and be able to do that. I think it’s also easier at night. In the day patients are leaving for consults. I don’t know if having more nurses it would make things easier. I think if you legitimately had a charge nurse who did not have patients who could help and in addition you had a nurses’ aid and a float nurse to take over for people. Then that would help. I say that because that’s the model I saw that in my old hospital in California.

Similarly, Sandra credits the flexibility she has to being appreciated at work.

I’m very good at what I do, which helps when I have requests like I need to lower my hours. They're not saying to me well sorry you have to look for a new job. They were very accommodating, very understanding. It was one conversation with my boss who said “no worries!” Ok!

Sandra’s work environment influences how she can organize her shifts.

Katherine, a new nurse, expressed hesitation at 12-hour shifts because of the toll they take on a nurses’ body. In her clinical rotations as a nursing student, she observed significant differences across facilities.

What scares me is that the nurses on most floors won’t take a lunch break, will go 12 hours with barely drinking any water, not really eating. And if I don’t have a snack every 4 hours or if I’m dehydrated, I’m going to be a bitch. So that makes me nervous. By 11am on clinical days, I’m starving. Some floors seem to do it better. Because I’ll come back from lunch and other nurses will say she’s on her break and will be back in an hour. So that’s nice to see. But I had one instructor, she was like, “I love my job so much that I don’t pee during the day and I give myself UTIs on the regular because I’m not drinking enough water and then I’m holding in my pee.’ That’s not smart!

Alyza explained that she has trouble eating enough and staying hydrated at the outpatient clinic where she works.

The water thing is hard. I’m perpetually dehydrated. Luckily at work we have a water fountain, and my work is more relaxed than a hospital. But you’re also busy so you don’t notice it, but then you have to pee and you’re urine is disgusting and you’ll just put whatever in your mouth you can. So when you go home you just want to be good to yourself so you don’t really do anything. Maybe you’ll go to a yoga class, but you really just want your bed and to put your feet up.
**Time away from family**

Nurses complained that while the 12-hour shift structure benefits family life in some ways, it does mean often not seeing family on workdays. Sandra explained that she cut her hours back to ten per shift because she did not see her children after working 12 hours. They were already asleep, and she would even go days without seeing her youngest, an 18-month old. Sandra explained the impacts 12-hour shifts had on her family, and why she reduced her working days to ten hours.

S: I just did 3 12s, up until October 2nd, and then I started with 3 10s, and fortunately, for my job, you need 30 hours for the medical insurance, which is what I have and I need the medical for our family. But as an RN, I had to make up that 4th shift. I like 12-hour shifts, but now I feel them. I'll be 40 in two years, but I do feel like it's a long day now. And maybe it's a long day because I go home and I don't rest. I'm going, going, going. So right now, I'm very happy doing the 10s. But I feel like I'm giving back to my family, They need me here than those 2 hours at work. I need to be home for homework and studying for exams and just keeping the ship upright!

C: Do you work 3 shifts in a row?

S: Not anymore, I did when they were little. But now it's almost too difficult to be away from home for that long. When I was doing the 12s, I was getting home and I wouldn't see [my baby] for 3 days because she'd already be asleep, and I would leave for work and she was still asleep. So that's long time not to see her...Three days away? I need to keep my hand in this pot [at home]. I'll usually do 2 and then one off or two off and then do the 3rd. There's a way you can do it...and you have a week off without taking vacation, but right now, it's not so feasible with these guys [children]. If I was single, I'd be on that in a second. But it doesn't work so well now.

Even when nurses are able to be with their families, exhaustion impacts the quality of care they provide outside of work. A discussion board participant explained,

I'm torn. I like 12’s because we can self schedule and therefore I can save a lot of my vacation time, because I can arrange my schedule to where I get many days off in a row. On the other hand I work nights and rarely get quality time with my kids. I find myself tired and very snippy all the time.
I never want to do housework or cook, because I’m the only one who does it! My job is exhausting physically and mentally, so 12 hrs is more like 13 + and by then my back kills me! ...I would love to work 5–8’s! 33

Jocelyn, another mother of five, explained to me that at a previous job, she worked 12-hour shifts. Jocelyn is, as she explains, “not like the norm. The majority of nurses love 12-hour shifts. I’m like the few that don’t, that just hate it.” Too many consecutive shifts meant too much time away from her family. “When I worked 12 hour shifts, I remember one time telling my nurse manager, don’t put me 3 days straight because there’s no food in the fridge. Like sometimes when she put me three days straight she killed me. I said let me do 2 and have at least a day off in between. The manager tried to be accommodating.”

Nurses without children also saw the disadvantages of 12-hour shifts for family life, as a discussion board participant explained, “I can see how this schedule would be very difficult for someone with children (I don’t think I’d like it if I had children of my own), but many of my colleagues have kids and somehow manage to make it work.”34

Joan works the 12-hour night shift, from 7pm to 7am. It works well for her schedule and lifestyle.

My boyfriend is a police officer, and he works nights so it works out that we both work the night shift because that way we sleep late on our days off. We function more in the afternoon than in the morning. So it kind of works out, and I really like it. I feel it gives me more opportunity to do things during the day. I feel like I don’t have to miss as many things.

33 LoveANurse09. 1 March 2011. “12 hour shifts...3 is plenty” www.allnurses.com/general-nursing-discussion/12-hour-shifts-535337.html
34 OTAS, 1 March 2011. “12 hour shifts...3 is plenty” www.allnurses.com/general-nursing-discussion/12-hour-shifts-535337.html
Joan’s 12-hour shift schedule works well for her in large part because of its compatibility with her and her partner’s lifestyle. Overall, the 12-hour shift seems to work best for, or at least be the preference mostly of, younger nurses, those without children, and those in supportive work environments.

**Apathy**

Literature on 12-hour shifts often argues that the longer shift helps foster better rapport between nurses and patients (Gold et al. 1992; Todd, Robinson, and Reid 1993). This claim, however, is a bit tenuous. Nursing, as I argued above, is socially reproductive labor — labor that reproduces bodies physically, emotionally, and mentally. Its relational element is integral to both nurses’ identity and to the work they perform.

Mary, a migrant nurse who works 12s in St Louis explains that she has learned to detach and just do the job. She said, “There’s only so much you can do. That you can stretch yourself so much and get yourself all stressed out and the end result is the same. So I’ve learned to just kind of do what really needs to be done and let other people deal with the other stuff.”

The weight of caring for patients for longer shifts is heavy, and nurses can bring that emotional work home with them. Detaching is a coping mechanism for a challenging job, as Krista explains,

As nurses, we meet – I have probably taken care of thousands of people, and you take a piece of them with you. I still remember patients I had 10, 12, 13 year ago. We’re exposed to all of these issues and problems and situations more than a layperson would. I don’t know if that will make us crazy in the end or we’ll end
up angels. I don’t know! But there has to be something. You come across so many people and knowing who’s going to die, who has cancer or HIV, and even births and being around children. I wonder. When I get older am I going to be tormented. My sister [who is also a nurse] sees people being shot up and stabbed. It takes a toll on you. It makes you numb sometimes.

Krista cares deeply about her patients. She also recognizes that she needs to detach in order to be able to even do her job. At times, nurses become numb to what they are doing and the care they are providing.

**Overtime, informally**

Finally, consistent with Rogers et al. (2004), I found overtime work to be a common complaint, with both overtime and long commutes adding to the length of the working day. Nurses understand that the workday does not exactly end when they clock out. Commuting commonly came up as a qualifying factor in satisfaction with the 12-hour shifts and work more generally. Sandra previously worked in Manhattan, a considerable commute from her home in the suburbs of New York. She changed jobs after the stress of commuting before and after a long work day and the total time spent away from her family became too much.

I went [to work at Mount Sinai] for about a year, but commute with 5 children was too much. So I ended up, in the interim of working at Mount Sinai and being pregnant with my fifth, I did per diem at South Nassau to get foot in door...So I changed there. The commute is 35 minutes. Over an hour to Mount Sinai, sometimes hour and a half. My friend encouraged me. She said “you've gotta make your life simpler.”

Between the cost of tolls and parking and the stress of both commuting and being away from her family, Sandra’s extra long shifts were not worth the higher pay of a job in the city. She moved to a job in the suburbs of New York, closer to home.
Similarly, other nurses felt that a short commute enabled them to even do 12-hour shifts. Long commutes make long shifts untenable.

I try to work closely to where I live, but it hasn’t always worked. I worked in Elmhurst, that took me 2 hours. Huntington was like an hour away. But this is the closest – I got really lucky. Yeah, you can’t beat that. To me that’s important. The commute is huge, because I had such a horrible commute before that this is huge. Oh gawd!! It was like ‘I hope I don’t fall asleep driving home!’ And back then I was younger so I was able to do it, but as you get older you can feel those shifts – those 12, 16 hours. And so what if you have 4 days off, because 2 days you’re just vegetating, recovering. (Jocelyn)

I love working 12-hour shifts. I’m tired after 12 but I’m tired after eight too. It allows for more consistency in caring for the patient, and I LOVE having four days off a week. I don’t have a long commute though, I’m at work 10 minutes after I leave my house.35

The intersection of shift length (time) and commute length (space) demonstrate the spatio-temporal experiences of work life balance and job satisfaction. Commuting, just as fatigue and recovery, family life, and age, is an important factor in the satisfaction with the 12-hour shift. A short commute can make a long shift more feasible physically and for managing the needs a nurse has at home. A long commute paired with a long shift can make work-life balance impossible. These factors also greatly shape nurses’ abilities to do their jobs properly and maintain work-life balance.

**BEYOND PREFERENCE: WHAT A LONGER WORKING DAY MEANS**

Whether or not nurses prefer the 12-hour working day is a debate failed at the outset. A more insightful debate comes not from asking about preference but asking what work the 12-hour shift structure does, how it changes nurses' jobs, and why a

35 nurse cozmo. 6 April 05. “12 hour shifts too long?”
www.allnurses.com/general-nursing-discussion/12-hour-shifts-99931.html
longer working day seems to be a victory in working conditions. To answer this question and understand the nuances of these nurses' quotes, I turn to Marx's discussion of the working day and feminist theories on social reproduction. The 12-hour shift is a neoliberal tool that relied on principles of choice, freedom, flexibility, and control. The longer shift serves to distract from improving working conditions through pacification. In this final section I explore this argument through two aspects of time restructuring: workload and overtime.

None of this is to belittle the real benefits that nurses find in either 12 or eight-hour shifts. Workers have myriad needs and many researchers have shown that work flexibility and workers having a sense of control are important to job satisfaction, job performance, and work–life balance (S. Anderson, Coffey, and Byerly 2002; Barton 1995; Halpern 2005; Hochwarter et al. 2007; Jamal 1981; Keene and Reynolds 2005; Mennino, Rubin, and Brayfield 2005). The realities of shift work complicate work–life balance. In many ways, the 12-hour shift structure has the potential to offer that flexibility and choice. Flexibility with work hours and a worker's control over their work day—even if that control and flexibility are just a perception, rather than a reality—help to lower stress that workers experience (S. Anderson, Coffey, and Byerly 2002; Halpern 2005). Additionally, mental health has significant impacts on work and life satisfaction, as work-induced guilt affects satisfaction with both aspects of a worker's life and impacts job commitment (Hochwarter et al. 2007; Jamal 1981). Job and life satisfaction are also very gendered realities, as women often perceive greater control when home life is smooth (Keene and Quadagno 2004; Keene and Reynolds 2005). My intention here is to question why the 12-hour shift has become so popular
and why a working day that is 50 percent longer – albeit a bit less frequently – is seemingly an improvement in nurses' working conditions.

I am also not claiming that nurses are duped. Nurses see through employers' attempts to avoid dealing with serious issues such as understaffing, lack of resources, and workload. As one discussion board participant neatly put it: “12 hour shifts were created for the employer’s benefit. Less staff results in less benefits to be paid”.

Another stated that her unit was “threatened with 12 hour shifts” as a way to solve staffing issues cheaply. Another frustrated and tired nurse complained,

I just woke up, and, like every other day I have off, there was a voicemail from my boss asking me to work extra tonight. I feel guilty about not helping out because we have been so short lately, but I know it's not my problem — they need to staff appropriately.

Nurses see this situation as the complicated one that it is. Thus, exploring those complications helps to reveal how and to what ends workers’ time is structured.

**Time and Shift Work in Capitalism**

Marx (1981) argued that time is a construct that shifts with changes in working conditions. Control over time is a focus of capitalist struggle and a goal for both capitalists and of workers. The lengthening of the working day, according to Marx, is about capitalists’ intention to extract as much surplus labor value from workers as

---

36 Fiona59. 1 March 2011. “12 hour shifts...3 is plenty” www.allnurses.com/general-nursing-discussion/12-hour-shifts-535337.html
38 KaitRN. 1 March 2011. “12 hour shifts...3 is plenty” www.allnurses.com/general-nursing-discussion/12-hour-shifts-535337.html
possible. Time is crucial to growing capital, as “moments are the elements of profit” (1981, 352). Moments are when the capitalist draws out more value from the worker.

Time is a disciplinary mechanism that workers were forced to accept in the growth of industrial capitalism (Thompson 1967). It disciplines and controls workers to live and work within a regulated time structure, but this also provides a framework to use in struggles to limit the working day. Capitalists’ concern with labor’s time extends beyond the working day. In fact, according to Marx, capitalists are interested in managing the entire day. Time, therefore, is a central struggle in capitalism, extending beyond the working hours to concern the structure and use of the entire day’s time.

Additionally, as Marxist feminist scholars have shown, social reproduction – the productive labor that appears otherwise (Fortunati 1995) – complicates this further. In his discussion of time, Marx was referring to productive labor, but feminist theorists have argued for a focus on social reproductive labor as well. With the commodification of social reproductive labor, the economic exchange of social reproduction becomes more apparent or visible. Rather than being hidden in the home or mediated through the productive laborers who go in search of a market to sell their labor, ‘women’s work’ becomes a public economic exchange just like productive labor. Nursing is an important site of this exchange, as it is skilled labor, social reproduction, and interactive service work all in one.

What is important and different today is that the neoliberal discourse casts the 12-hour shift into an apparent victory for workers. Most nurses want the 12-hour shift structure. One nurse I interviewed explained how she was a leader in introducing the
12-hour shift in her workplace. After seeing her husband work 12s and having more
days off, she pushed for the same for nurses at her facility.

Neoliberal economics advocates for a growing, ‘freer’ market, a shrinking state,
and individualism. Choice and freedom are rhetorical tricks of neoliberalism. The 1975
American Journal of Nursing (Underwood) piece I discussed earlier illustrates this well.
Underwood explains that, in her facility, another result of the changes was
“improvement in staff morale (being allowed to try something we wanted)” (1975, 1178). She expresses a sense of freedom and control in the workplace. Nurses were
empowered to try their own ideas and restructure their own time, but they were
working within constraints. Instead of approaching management with a request for
additional staff, an idea that the human resources department arguably would have
resisted, the staff felt empowered because they were able to try a strategy that was
fiscally efficient for the hospital. Morale improved not because of increased resources
and staff, but because they were (very slightly) in control of time. Their ‘choice’ and
‘freedom’ to try the new structure made a lack of resources seem to disappear,
disguised under the reworking of time. Two important labor issues, workload and
overtime, show how the caveats and qualifiers nurses express are representative of a
reshaping of nurses' working days. Workload and overtime are also issues that work to
obscure, and the lengthening of the working day is an important tool in making that
happen.
Workload

The 12-hour shift serves to obscure the issue of workload in a few ways. First, it changes the discussion of workload capacity. As I noted above, nurses expressed a preference for the longer working day because eight hours were not enough to finish all they were required to do. The longer shift allowed them to finish, or at least come closer to finishing, everything they had to do on their shifts. Looking at the ways in which nurses talk about going back to the eight hour shift: that they would likely end up staying late and that eight hours would never be enough time. Jocelyn explains the impacts of the intersection of staying late and shift length at her previous job.

If you’re working eight hours and they need you to stay because the other nurse doesn’t come in in the evening, it’s a lot easier to do the overtime, because you’ve only been there eight hours. So you can give the four extra hours. Once they turned to 12-hour shifts, that’s when I noticed the increase in sick calls. And I guess it’s because you know it’s a very difficult floor, and maybe if you’re not even slightly feeling well, and then you gotta be there for 12 hours, and then god forbid you get mandated to stay there longer, you know?

With a longer shift length, Jocelyn saw more nurses calling in sick for shifts. When the nurse on the next shift fails to come to work, the nurse currently working must cover for her, at least until a replacement is found. When the shift is eight hours, Jocelyn explains that staying late is doable. When the shift is 12 hours long, staying late is quite difficult. Rather than question the amount of work, the discussion focuses on the time allotted to do all of the work. Here, time is still a matter of struggle, but it is not about reducing time in order to do less work. The issue is gaining enough time to do all of the work.
Second, and I address this in more detail in chapter 4, the longer shift works in tandem with the bureaucratization and segmentation of nurses’ working day to invisibilize the emotional labor that nurses perform in much of their tasks. Scholars of social reproduction and emotional labor have shown that the affective and relational elements of social reproductive labor are essential to the labor, and this is legitimate work that takes considerable energy (Hardt 1999; Hochschild 2003). In nursing, that interpersonal aspect of the job is essential to its identity (Reverby 1987; Mignon Duffy 2010; Glenn 2010). Even with the professionalization of nursing, the image of nurses as caring and compassionate persists (S. Gordon and Nelson 2005). Nurses, patients, lawmakers, health care administrators all believe in nursing as caring, both emotionally and physically.

Nurses complained that they had begun to care less about their patients. For nurses, this is a drawback to the longer working day. Skill is socially determined, it is no less important to call the emotional labor of nursing what it is: a skill and an essential part of the job made up of unquantifiable tasks and moments of relation between nurse and patients. ‘Caring about’ is arguably a skill in nursing. The exhaustion that comes from working for 12 hours and from performing all of the documentable and quantifiable tasks that the state requires of nurses leads them to cut back on what is not required by law, i.e., the emotional labor of nursing. A tension exists between finishing all of the documentable, quantifiable, legally required work and between doing all of the emotional and relational work that nursing as a profession requires and professes. Neoliberal goals of efficiency are in competition with common expectations of nurses. Nurses need more time with patients, but perhaps that can better happen through
decreased work load. The intense regulation of nurses cannot quantify the emotional aspects of the job, but since those aspects are so ingrained in nurses’ identities, training, and daily experiences, nurses begin to care less, work overtime, or both. In the end, neoliberalism exploits the caring that is inherent to nursing. Extending the working day to finish the work has become a ‘natural’ solution.

**Overtime**

Overtime constitutes two categories: additional hours of work and the spillover of work into home life. The 12-hour shift produces overtime in nearly every sense — from small lengths of overtime per shift to a naturalized few hours overtime per pay period to additional overtime shifts. First of all, the 12-hour shift makes a standard working day longer, and thus, by its dominance in nursing (and in hospitals in particular) the longer working day becomes naturalized. This becomes concerning when, as Rogers et al.’s (2004) study revealed, almost half of nurses report that they commonly leave their shifts after the scheduled end time, a statistic that nurses I interviewed and nurses on the discussion boards support.

Additionally, many nurses in interviews and on the discussion board explained that they often pick up extra shifts, working four or five long shifts in a week. Many explained that their ability to pick up extra shifts in a week was a clear benefit of the 12-hour shift structure, while some complained of being asked to work too much overtime.

Finally, and this echoes issues of workload, overtime manifests itself in the unpaid time outside of the workplace that involves recovering from the working day, commuting, and emotions that know no spatial or temporal boundary. Nurses need a
day to recover from the 12-hour shift, commutes make shifts an hour or two longer, and the exhausting emotional demands of caring for sick patients over those long days mean nurses have to detach themselves from the work. Interviewees explained that they have had to train themselves to care less about patients, so as to bring home less emotional baggage from work. This is a move that arguably changes both nurses’ identities and the type and quality of care that patients receive.

CONCLUSION: MAKING TIME FOR CARE

While the 12-hour shift structure may seem to provide many benefits for nurses' work–life balance and provide workers a better sense of control at work, the impacts of the 12-hour working day are ambiguous and complicated. A longer working day in a physically, mentally, and emotionally demanding job means a harder day’s work that takes longer to recover from. As I have argued, whether or not nurses prefer the eight-hour or the 12-hour working day is a debate that misses the point, because a longer working day is just that: a longer working day. This new shift structure serves to distract from important issues of workload that nurses, just like other workers, have struggled over for the entire history of the profession. A feminist Marxist analysis of the working day sheds light on the politics of the reworking of time and daily work, demonstrating the control over nurses’ time is a political struggle. In this case, the politics of time distracts from broader workplace politics. The reorganization of staff time overshadows the betterment of nurses’ jobs and working conditions, obscuring demands for more time resources, more staff, and more care.
Chapter 4
The Abstraction of Care: What Work Counts?

“The work, often unwaged or poorly paid, of those who perform care, is what many understand to be that which is the least technological, the most affective and intuitive...But strange reversals occur during times of serious illness. Or rather, what appears to be a reversal becomes clarification. Our once solid, unpredictable, sensing, spectacularly messy and animal bodies submit – imperfectly, but also intensively – to the abstracting conditions of medicine. Care becomes vivid and material.”

Anne Boyer (2015 in *Guernica*)

In reflecting on her experiences as a cancer patient, poet Anne Boyer (2015) describes how the work of nurses and assistants makes patients legible to medicine, doctors, and the health care system, through forms of measurement and documentation. The personal, individual, and qualitative become rational, general, and abstract. These feminized workers, however, maintain the personal side of the experience through the care and compassion they bring to their work. As she explains, “my urine is measured and charted by the same person who charms me with conversation. This is so that painful procedures will become less painful...The worker who draws blood tells a joke.”

Boyer's description outlines the tasks that make up nurses' work: a mix of care and clinical or medical work. Care is the qualitative, emotional work, while clinical skills are tasks easily quantified and listed on a patient's chart. One is hard to count, while the
other is regularly formally accounted for. These different tasks are intertwined, and yet the care work of health care can be subtle and even invisible, “[existing] in a kind of paradoxical simultaneity” (Boyer 2015) with clinical tasks. The data or clinical work gains permanence and visibility in documents and patient charts; the care work is fleeting, like a joke told while blood is drawn.

In this article, I examine the ways in which nurses’ work is measured and managed through documentation practices, hospital administration, and government regulations. I argue that, because nursing is social reproductive work, only part of the job comes to be seen as essential. Through various methods of accounting for nursing work, the clinical tasks comes to be understood as essential while care work becomes seen as excess or even invisible. This hierarchy creates a division between the tasks – care and clinical work – that constitute a single job: nursing.

I foreground social reproduction in my analysis, bringing those theories into conversation with Geoff Mann’s (2007) politics of measure and Miranda Joseph’s (2014) call to appropriate modes of accounting. Together, feminist political economics and critical engagement with measurement show how processes of abstraction and quantification can and often do miss the actual work of social reproduction. Furthermore, in bringing such literatures together, I show how making explicit the work, spaces, resources, and social relations of social reproduction not only reveals that which is often made invisible, but opens up new possibilities for how work and health are valued and counted.

Before I present my argument, a few preliminary clarifications are in order. First, nurses are not the only workers who provide a mix of clinical and care work in health
care or social reproductive work. Nonetheless, nurses, as the largest group of health workers in the country (S. Gordon, Buchanan, and Bretherton 2008, 12), do work offers a useful way to consider the ways in which social reproductive work is measured, managed, and struggled over. Second, care is a nebulous term, with many meanings. Most often in geography, care refers to tasks and actions that constitute caring for and the empathy and emotional labor of caring about someone or something. “[activities] in which humans engage to the end of living well in the world... also a way of thinking and a kind of approach to the world” (Tronto 2001, 71). For my purposes, it captures the emotional, intimate, and, often, fleeting work nurses do. When I refer to “patient care,” I am referring to nursing work in general; i.e., care plus clinical work. This brings me to my third point: I purposefully oscillate between considering nursing work from a labor and a patient care perspective. While my argument is based on research on and with nurses, not patients, their work is inseparable from patient experience. Because they perform their work on and with patients, they often describe their work and are trained through the lens of the patient. Put simply, patient care is nursing work. To touch down on one side or the other would be to inaccurately represent the work nurses do.

I base my arguments on interviews with nurses working in the New York and St Louis metropolitan areas. All of the nurses work in hospitals and in a range of settings, from the emergency room to the operating room and intensive care units to hospital-run outpatient clinics. As a complement to the interviews, I draw on nurse union publications, ethnographies, and nursing studies literature.

This chapter’s geography is the hospital workplace. The scale of the workplace, as McDowell (2009) explains, brings together macro and micro scales. It is a key site
where global labor processes, local politics, and the intimacies of everyday life intersect. The hospital is a site of substantial accounting and accountability, from documentation, regulation, and government inspections to scientific research and norms of rationality. Hospitals are also a site of work historically considered non-work (i.e., nurturance) and tasks that seem impossible to measure (i.e., care). Hospitals, then, offer an interesting space for considering the politics of measure and for messing with modes of accounting and accountability. Because of the type of spaces hospitals are, they demonstrate the importance of space and geography in analyzing modes of accounting. Nursing work happens in space and between bodies. Modes of accounting for nursing work are thus shaped by the type of space, i.e., the type of unit in a hospital, and the bodies who perform that work and receive care. Finally, hospitals are the main employer for nurses, as well as economic and social anchors for many communities. My interviewees’ insights, however, are broader than nursing or the hospital. Their experiences can contribute to understanding the broader processes that govern the provisioning of care and the valuation of work across spaces.

THE TROUBLE WITH MEASUREMENTS

Care and the Clinical

As I explained above, nurses’ jobs can be thought of as falling into two categories: care and clinical work. Janie, an operating room nurse, describes her work:

There’s two sides to nursing. There’s the technical side – that you know how to do everything and you’re good at what you do. I think that’s 50%. And I think the other 50% of nursing is social interaction. You need to know how to speak to people and to be social and likable. You need to know what you’re doing: what medications you’re giving and the dosing and know all of that. But you also need
to know how to interact with your patients. Because you if you don’t have bedside manner, they won’t even remember what you’re giving them. Leave your personal stuff at home. You need to bring your game. They’re in the hospital! They need to be cared for.

Janie explains that nursing is one part clinical skills and one part caring for patients. Clinical skills are abstracted tasks that are easily quantified and recorded on a patient’s chart. These tasks are abstracted because they are generalized tasks and protocol. A nurse records standardized tasks, actions, and practices that make up much of their practice. These include inserting an IV, passing medications, regularly turning patients, monitoring wounds, and sterilizing operating room equipment. By contrast, care is qualitative and particular. Care includes emotional labor, eye contact and gentle touches, listening to a patient or family member for a few extra minutes, a smile or nod of the head, helping a patient eat, designing care plans for each patient. Each person’s care needs are different in specifics, but general in their presence. Nurses rely on protocols and procedures that they tailor to meet an individual’s needs. Everyone needs care, but how that care happens is special to the person.

The line between care and clinical nursing work is blurry, though. As Janie explains, she works simultaneously in two registers and does so by the necessities of her job. Nurses build a caring rapport with patients as part of developing clinical relationships (Weinberg 2006). Good bedside manner is part of properly assessing a patient. Good clinical practice depends on good care practice, and vice versa. If the nurse is not comforting the patient, making them feel more at ease before surgery, much of the nurse’s technical skills will have lost their effect. Maintaining eye contact and assessing a patient are not simply two different tasks done simultaneously. They are utterly inseparable; one is not what it is without the other. A nurse cannot perform
one task without performing the other simultaneously. Care and the clinical constitute a package deal; each part is unintelligible without the other.

A Short History of Nursing in the United States

The care and clinical binary I identify has a long history in nursing, manifesting in different ways over time. Nursing evolved out of both a form of domestic service and the informal care that mothers, wives, and daughters provided to family members in the mid- to late 19th century (Reverby 1987). Women were seen as especially suitable for nursing work because of their proclivity to care and nurture. Near the turn of the century, nursing more or less coalesced into a single regulated profession across North America and the UK (Reverby 1987). This was largely due to Florence Nightingale, the lady with the lamp, whose philosophy on nursing emphasized morality and a nurturing, maternal femininity, while also outlining the foundation of modern clinical nursing practice.

With greater professional cohesion, nurses demanded more respect and power in the hospital (Reverby 1987). In an effort to escape subordination from mostly male doctors, nursing emphasized its special knowledge and skill set and developed the medical and scientific side of the profession. Nurses inhabited a dual identity: nurturing angels and skilled medical workers (S. Gordon and Nelson 2005; S. Nelson and Gordon 2006). Both care and clinical work are essential to nursing, but nurses gained power and respect as they professionalized and skilled up, emphasizing the clinical.

As nursing professionalized, a clearer hierarchy developed between care and clinical work. While nurses (RNs) spend the majority of time interacting with patients,
the tasks they perform have changed over time (Mignon Duffy 2010; McDowell 2009). Gradually, RNs have filled managerial roles and done the “higher skilled” tasks such as passing medications. The harder, less glamorous “dirty work” of nursing, such as cleaning bedpans and much of the intimate body work, has fallen on lesser trained and paid certified nursing assistants (CNAs) and licensed practical nurses (LPNs). This division of tasks has a racialized and classed history. In the early 20th century, leaders in the profession created these lower ranks of nurses to preserve the privileged whiteness of registered nursing (Reverby 1987; Hine 1989; Glenn 1992). With fewer educational requirements, lower ranks have been easier for lower class and racialized women to access. The racialized hierarchy persists with 75 percent of nurses being white (HRSA 2013, 23).

The increased distance of registered nurses from more and more direct patient care is part of an overall devaluation of the caring part of nursing work, in which clinical tasks become seen as essential and care work is categorized as excess. This devaluation has multiple implications. First, on a human resources level, the hierarchy of skills impacts what numbers and combination of types of nursing staff a unit will use each shift (S. Gordon, Buchanan, and Bretherton 2008). Second, and more broadly, the division and hierarchy of care and clinical work has implications for who can access nursing work. The more respected, higher ranked, more clinical work of nursing becomes harder work to qualify for, with more training required for the higher ranking of nurses. Lower ranks of the profession, licensed practical nurses and nursing assistants, are positions that are easier to access due to their lower educational requirements, but they are also less respected, paid less, and require more intimate and
more physically demanding body work. The skilling up of registered nursing and emphasis in health care on clinical work means clinical work becomes more synonymous with respectable, higher ranked nurses. The requirements have implications for not only who can afford to enroll in which programs, but also, which workers are then paid living wages and which work is respected. This has implications for how both work and worker are valued.

**What Measurements Can Miss: The Budget and the Chart**

While nursing has changed over the past century, nurses’ ability to do their entire jobs has become harder over the past few decades (Aiken et al. 2002; Buchan 1994; P. I. Buerhaus et al. 2007; Garrett 2008; Hayes et al. 2006). Many facilities have struggled to recruit and retain nurses, while often-difficult working conditions have contributed to nurses burning out and leaving the profession entirely. The governance and regulation practices that guide nurses’ everyday work lives, I argue, have also played an important role. Two examples of measurement, the hospital budget and the patient’s chart, illustrate my argument. They demonstrate, first, how the ways that work is evaluated and counted obscures the full conditions of nurses’ jobs. These examples also show how modes of measurement influence what counts as legitimate work.

In interviews with me, nurses expressed stress and frustration over high workloads and a consequent inability to provide the highest quality patient care. Regina an ICU nurse manager in Yonkers, just north of New York City, tells the tale. She spoke fondly of the early years of her career in the 1980s, when she felt she was able to spend
ample time with patients and families, providing high quality care with attention to
detail. This ended in the 1990s, with the hospital’s growing financial instability.

We went through a long period of time where there was a lot of financial
distress. The hospitals were losing a lot of money. The administration in this
hospital changed. We got a new CEO and a new chief nursing leader. It started to
go down that slippery slope. That was about 15 years ago. They laid off x amount
of nursing assistants. ‘Do more with less!’ ...Then you can’t provide that quality
care with that nurturing and caring for the patient that you really want to do.
That was really frustrating. ...When you become very busy, and you don’t have a
lot of time, you prioritize, as we’re trained to do, what you have to do. Because
life and limb come before the little extra time you might spend with the family or
reassuring the patient.

With tighter hospital budgets, Regina’s job *changed*. Nurses had more patients,
and fewer nurses worked on the floor each shift. Nurses were forced to focus on
absolutely essential tasks. A sharper binary emerged between care and the clinical, in
which parts of nurses’ work was rendered as less necessary.

The 1990s marked the beginning of financial troubles for hospitals around the
country, primarily because insurance reimbursement rates dropped (Salit, Fass, and
Nowak 2002; Henry 2015b). Tigher budgets and a chronic nurse shortage meant that
facilities operated with fewer staff to provide care. Nurses feel the effects of a tight
budget directly: units have less staff and fewer supplies, meaning fewer people to do all
of the work and each nurse then has less time to spend on each patient’s care (Norrish
and Rundall 2001). When understaffed, each nurse has less time to provide the holistic
care she was taught to practice. In such working conditions, a clearer, but inaccurate
and unnecessary, division between clinical and care work emerges. Many nurses I
interviewed had faced similar situations to Regina. With hospitals investing less in their
nursing departments, the nature of the job changes: rather than provide care as they
were taught, nurses are forced to do the bare minimum and make do with what staffing
and resources they have. Regina’s concerns are not primarily about hours or wages. She was frustrated with her entire work experience. Budgets, which are the products of decisions people make, have direct impacts on the work nurses can and do perform, on the care patients receive.

Regina found herself focusing on, as she says, “life and limb” partly because of the regulatory and financial climate in health care in the 1990s. The era of financial instability coincided with an increase in state and federal health regulations, meaning workers became responsible for more paperwork, and government agencies regulate health care work more intensely (AHA 2006). Failure to document tasks in the patient’s chart or fill out other paperwork could mean penalties in state inspections, mistakes in care, or a manager not believing a nurse did her job (L. Anderson 2012; Gialanella 2016). The increase in paperwork meant that nurses must devote more time to documentation and have less time available for direct patient care.

The American Hospital Association (AHA) (2006) has documented the drastic increase in regulations since the mid-1990s. These regulations mean facilities must spend more money, time, and labor planning for, implementing, and training staff on new procedures. Depending on the type of unit, the AHA estimates that for a single hour of direct patient care39, the patient’s care team must complete between 30 and 60 minutes of documentation. For nurses, the paperwork responsibilities mean more time documenting and less time with patients face-to-face. Nurses spend between nine-teen and twenty-seven percent of their shifts on documentation alone, depending on the

39 Direct patient care refers to tasks that involve face-to-face time with patients and/or body work, as opposed to tasks such as planning care, coordinating with other workers involved in a patient’s care (e.g., specialists, therapists, and social workers), and documentation.
type of unit (Hendrich et al. 2008; Yee et al. 2012). Meanwhile, they spend a total of just over twenty-two percent of their shift on direct patient care and assessment (Hendrich et al. 2008). At best, this means equal time is spent face-to-face, as is spent recording their work. The increase in paperwork and persistence of new regulations is a drive towards the quantification of care, and, supposedly, efficiency. But this is a particular type of accounting that documents easily chartable tasks.

A chart is an essential document. It records a patient’s history, is a means of communication between different members of a patient’s care team, and outlines a patient’s care plan and instructions. Charting ensures tasks such as giving medications are completed, and only completed once, and legally documents health care workers’ labors. Charts document the services a patient receives, recording the work done on patients (Diamond 1995; Ward 2012). Nurses use them to document what tasks they performed on the patient, if they encountered problems, and what they did to fix the problems.

Charts are rationalizing documents. They do not include nurses’ assumptions, intuitions, or feelings. In his ethnography of nursing home work, Diamond explains that charts exclude as much as they include. Gender, sexuality, and emotion disappear from

---

40 Nurses spend the rest of their shifts performing myriad activities: unit-related functions, such as transporting patients, preparing equipment, counting narcotics, and using the fax or copy machine, account for 2.8% of the shift; wasted time accounts for 6.6% of the shift. The rest of their time is spent on other forms of nursing practice including medication administration (13.4%) and care coordination, or communicating with other departments and members of the patient’s care team (16%). Interestingly, in Hendrich et al study, non-clinical activities related to patient care are specifically not included in the nursing practice category. The non-clinical activity category includes personal time, patient/family care, and administration/teaching, counting for 12.6% of nurses’ shifts. As a result, it is impossible to discern how much time nurses in their study spend on non-clinical care work.
charts. As the cardiologist, oncologist, and gynecologist add their specialties to the chart, the patient’s body is deconstructed and made legible to medicine, to paraphrase Boyer (2015). “In documents,” Diamond (1995, 121–122) argues, “[people] become patients, identified by their pathologies... The process involved the ongoing creation of phenomena the organization could service.” As Duffy (2010, 88; citing Diamond 1995) explains, while a chart only says that a patient received a bath, it does not explain how the nurse’s assistant or nurse “also listened to the [patient] talk about her loneliness.” Caring for the body in the bath and caring for the emotional needs in the conversation are both part of delivering medical services. Charts often miss the dual nature of nursing work, prioritizing the clinical tasks. While charts cannot capture everything a nurse does for and with a patient, they are a vital document for measuring nurses’ work, as the common refrain, “If it’s not charted, it didn’t happen,” indicates.

For example, both Sophie and David complain about the time spent charting during their workday and how documentation shapes their work experiences. Sophie feels overwhelmed by the increasing amount of documentation required of her:

Every year it gets more, you know, things we never had to document [previously] and make sure you doing it every hour. And even like basic stuff, like hourly rounding, you didn’t think that you had to, to document that you did that. They were kind of expected that you did it, but now you have to document so that they can actually believe that you did it.

For Sophie, she now has to prove she has completed normal tasks that constitute her job through the chart. The chart becomes proof that care happened.

David’s facility was transitioning to electronic charting when I interviewed him. Having to enter information directly into a computer, rather than use a paper chart, was causing him a lot of stress and changing the way he did his job. Previously, David would
enter information on a paper chart, but now, he has a computer workstation on wheels that moves with him from room to room. He explains how charting now shapes his interactions with patients and the care he provides:

I’ve really enjoyed my job until recently, when the computers came. It’s been very challenging, and I’m supposed to be one of the computer guys! ...I enjoy doing that kind of stuff, so the administration thought I would be a good computer guy. But it turned out to be really rough, and I’m not as good at it. Paper charting is awesome, because I like talking to people. I don’t like charting necessarily. And I found out I could do a minimum amount of charting and maximum amount of patient care. So now it’s reversed. But maybe I’ll get faster at it. ...The system is very cumbersome. We’ll try to make the best of it. I really like the people I work with and the patient population...I felt energized working here, until the computers came. Loved it! I never really felt like “I can’t make it!” but now I do! Now that stress is intense. Very, very intense stress because you have to give your medication somewhat on time but you can’t because of the [new charting] machines. Like I had 4 diabetic patients on insulin. In the past I would be in the med room, and I would draw up my insulins, and go out and give them. Simple. Took like five minutes. But now, you have to load everything in the machine, and then it didn’t load. What was his blood sugar? Oh I didn’t write it down. You have to do it again. Finally a half hour later, you get the insulin, and you have to go in to the patient’s room with another nurse to witness you give the insulin. They give their name and password into the computer after you enter all the information. Plus you have to drag the nurse out from their other room and you are waiting for them. There’s not enough staff to do this! Last night, with 8 patients and the new computer, I was so stressed. I had to use every single stress relieving mental strategy I knew just to main a sense of calm.

Simply put, charting took a much more prominent role in his day. The new system is less flexible, and while charting took considerable time before, he had figured out a way to make paper charting work for his work style. David could complete his tasks and take time over the course of the shift to keep up with charting. The new system interrupts the flow of patient care. Furthermore, the inflexibility of the system and its new requirements, such as a second nurse witnessing the medication administration, stretch the staffing resources on the floor. David continued, explaining that, with the computer charting system, he has to stay “really really focused” and
cannot ask patients personal questions or chat with them, something that significantly changes the care experience.

There is an important relationship between what is documented and what comes to be seen as essential. For example, toileting a patient is on the chart, but the chart does not account for the time it takes to make sure that happens safely and according to a patient’s needs, or exactly when the patient needs it to happen (Diamond 1995, 87). Similarly, no box exists for “eye contact” between the patient and nurse, even though good eye contact is key to establishing a trusting relationship and performing a proper assessment. This is why ER nurse Hannah says that “really actually physically looking at the person” is part of good nursing practice. All of this is not to say that what is on a chart is unfairly deemed essential. Passing medications is essential work, but spending a few extra minutes talking with a patient’s family is equally important. With less staff, less money, and more regulations, nurses have found themselves forced to do, as Regina says, only the most essential. Often, this means chartable tasks. Because of overwork, understaffing, and a particular method of measurement that emphasizes clinical tasks, the seemingly unquantifiable tasks simply do not happen, either on the chart or sometimes in practice. If only charted work “happens” as the saying goes, what is left out of the official record and of daily practice? What work is ignored or made superfluous?

In short, a trend has emerged: financially troubled hospitals cut staffing and underinvest in their nursing department, leaving more work for fewer staff who are undervalued. With more work, nurses are unable to do everything and must focus on only the essentials. With government regulations requiring patient care to be
documented, and only certain tasks and procedures appearing on the document, a new
criteria for “essential” emerges. What work is deemed essential becomes filtered
through a method of measuring (primarily clinical parts of) a nurse’s performance.

Measurements help to establish norms but do not always reflect the actual work
being done (Joseph 2014, 141). A budget, chart, or regulation can shape what is
considered essential and what is extra. In other words, processes of abstraction
influence which tasks become valued as legitimate work. They foster a binary and
hierarchy of work that allows for a rationalization of labor, both in what counts as
essential work and how many nurses a facility staffs per shift. For Regina and her co-
workers, this meant making decisions according to a binary and hierarchy of their work
in which the clinical was privileged over the caring work. What she also explains is that
patient care suffered. Nurses at her hospital were unable to complete their jobs.

A POLITICS OF MEASURE

Social reproduction is key to understanding the separation between care and
clinical work, as well as the ways in which modes of measurement obscure or prioritize
different work, relationships, and places. Social reproduction refers to biological
reproduction, as well as the tasks, institutions and social relations involved in the
reproduction of everyday life. Health work, such as that which nurses do, is social
reproductive work. Nurses nurture and repair people through the life course, in times
momentous and ordinary. They play an essential role in community health and public
health education. Also, they are the backbone of the health industry as the largest
segment of the health care workforce (S. Gordon, Buchanan, and Bretherton 2008).
Social reproduction includes much of the most undervalued and precarious work. It is “women’s work” or natural and thus non-work (Fortunati 1995). For example, in the patient’s chart explained above, emotional labor is largely absent. If a chart documents the work done on a patient, then non-work is not documented. Both worker and patient are, through the chart, reduced to only specific tasks deemed to be work. Such modes of counting nursing work obscure much of the labor that constitutes nurses’ whole jobs.

Feminists have long struggled to expand the limits of what counts as work. The Wages for Housework and basic income campaigns both represent challenges to the ways in which tasks, jobs, and contributions to society are valued. Both campaigns come from a politics of social reproduction. The Wages for Housework campaign of the 1970s demanded that historically unwaged, non-work be recognized as work that produces value and is essential to the workings of life and capitalism (Federici 2012; Fortunati 1995; Weeks 2011). The basic income is an unconditional, universal, and continuous income of sufficient amount, regardless of work past, present, or future (Weeks 2011, 138). This demand recognizes the myriad contributions individuals and collectives make to society, often in non-waged work contexts. The basic income “invites the expansion of our needs and desires” to demand more time, money, and freedom (2011, 146). It is a demand that expands the notion of what tasks, work, and social relations garner value. Both of these campaigns foreground a politics of social reproduction. These campaigns aim to acknowledge and even compensate people for the variety of contributions they make to society that are not waged labor.
These campaigns offer insights into the care and clinical division in nursing, even though it has been commodified work for over a century. Feminist demands for recognition and valuation of social reproduction dovetail with Regina’s frustration over not being able to do her job. Social reproduction’s historical positioning permeates the ways nursing is commodified. Nurses struggle to have the more feminized tasks (i.e., care work) recognized as work that is essential and valuable.

Geoff Mann aims to understand the function and contents of quantifications. He argues that the “organic and conjunctural relations of quantity (how much) and quality (meaning)” are essential to understanding the functions and content of what is quantified (2007, 21). In other words, quantities are more than numbers; they include all of the social relations within which work and struggle happen. A quantity, such as a wage rate, a budget, or a type of documentation, is not an “empty indicator” of struggle, “but a simmering pot of the material and symbolic stuff that makes up lived time and space” (2007, 23). Quantities both produce and reflect social difference and social relations. Measure, the practice that produces quantities, is the “node or knot that constitutes the space in which value is politicized, and the politics of measure constitutes” both the spaces of struggle and the struggle to produce those spaces (2007, 52). Struggles over the value of work represent what Mann calls a politics of measure, or an understanding of measurements as a politically full and dynamic “unity of quality and quantity” (2007, 27). A politics of measure is an analytical tool for viewing how “domains commonly considered purely quantitative and economic are shot through with cultural political weight” or the qualitative (Huber 2009, 472). It describes the struggle, relationships, and politics that are part and parcel of determining value. In
other words, a politics of measure politicizes the ways in which value and quantity are determined and describes measurement itself as an arena of political struggle.

While Mann does not explicitly address social reproduction, his discussion of a politics of measure addresses questions that are also matters of social reproduction, about “how we live” (K. Mitchell, Marston, and Katz 2003, 416). Mann’s concept of politics of measure and feminist political economic theories on social reproduction can complement each other well. Feminist political economy makes explicit the importance of realms and relations of life that have often been made to seem non-essential (Bakker and Silvey 2008a; Vosko 2000). Mann’s politics of measure provides language for analyzing the ways in which the valuation of different types of work and non-work happens, as well as the political stakes of such evaluations. As Strauss and Meehan (2015, 3) explain, “…many approaches to conceptualizing the interrelationship of ‘the economy’, ‘society’, and ‘capitalism’ still fail to take into account the relationship between paid labor and unpaid work, or to understand value in ways that don’t rely on monetization and traditional definitions of productive activity.” Bringing together theories of social reproduction and a politics of measure enables such an analysis.

Mann’s politics of measure helps in understanding how and why charts and budgets shape and invisibilize nursing work. Making social reproduction explicit in a politics of measure reveals the historical continuities of the devaluation of particular types of work. Feminist scholar Miranda Joseph’s (2014) recent work on debt takes the analysis a step further. She presents a politics of the possible and offers a method for a feminist politics of measure. Joseph’s politics of the possible echo those of other scholars (Gibson-Graham 2006a; Gibson-Graham 2006b; Hall, Massey, and Rustin 2015;
Harvey 2000; Mohanty 2003), but it is her specific focus on modes of abstraction and accounting I find useful here. While she does not use the language of social reproduction, her call to appropriate modes of accounting is also, I argue, one that is inherently oriented towards an accounting for social reproduction.

In her book Debt to Society, Joseph (2014) approaches accounting broadly: from the profession of accounting, to a diversity of modes of accounting, to the role of accountability in society. Similar to Mann, Joseph is uninterested in a simplistic opposition or binary of quantity and quality, with abstract and quantitative being analogous, as are particular and qualitative. Quality refers to meaning, thick description, and the contents of quantities, and the particular adds more specifics and nuance to qualitative analyses. Quantity is achieved through processes of abstraction that count and measure qualities and particularities.

Rather than calling for a wholesale refusal of quantification and abstraction, Joseph “[explores] the extent to which their very potencies – the productivity of accounting, accountability, and abstraction in constituting subjects and social formations – are subject to engagement, transformation, and appropriation” (2014, xix–xx). As “numbers have an unmistakable power” in the governance and everyday life in liberal democratic societies (Rose 1991, 673), then how can that power be seized for different ends? Joseph argues for “a strategy of critical abstraction through which invisible social processes can be perceived beyond the visible empirical phenomena that are the instantiations of those processes” (2014, xx). In other words, she demands critical modes of abstraction that make visible and valuable social processes and relations that are often hidden and undervalued in dominant methods of abstraction.
She asks: “to whom are we accountable and in what terms?” (2014, 130). Such an approach requires a definition of the political that focuses on understanding the current conditions with an eye for intervention – to assess the conditions to inform a strategy of resistance and transformation. It also creates an opening to mess with the accounting project, produce new data, analyze new conditions, and create new forms of quantification, relationships, care, and accountability. Following Joseph, I ask, how can nursing appropriate methods of accounting so as to actually account for social reproduction?

Commodifying or quantifying care raises a lot of anxieties for people, because paying for care might worsen and depersonalize the care and the caring relationship (for critiques see Green and Lawson 2011; J. Nelson 1999). Yet as Joseph’s call explains, the methods of accounting are important, and alternatives to current modes of abstracting care exist. In nursing, outright resistance to recent methods for accounting have undermined nurses’ ability to fully do their jobs (Weinberg 2006). Management often has opted not to prioritize work that ‘can’t be counted’. However, I argue that the abstraction of care need not be impersonal. In fact, abstraction is a process constituted by and through the particular. Abstractions reflect particular experiences, in a dialectic relationship with the particular (Joseph 2014).

While appropriating modes of accounting may not entirely capture qualities, a feminist politics of measure critically engages with the ways such work qualities are counted. A feminist politics of measure means considering the ways in which systems of measure create norms to aspire to and thus, to consider what aspirational norms even are. When nurses have more time to complete all of their tasks, mortality rates, injuries,
and rates of mistakes decrease (S. Gordon, Buchanan, and Bretherton 2008). When nurses can do their whole jobs, patients and nurses do better. Thus, the ways that quality is quantified matter deeply. The question is how measurement happens. How can ways of counting better reflect and support the actual work being done? In the final section, I employ a feminist politics of measure to reconsider the abstraction of care.

CHANGING MODES OF ACCOUNTING FOR CARE

If measurement is an arena of political struggle, then openings and alternatives to current modes of accounting exist. In this last section, I use a feminist politics of measure to analyze two modes of accounting for care in an austere health care environment. First, I examine recent changes to Medicare reimbursements from the federal government to consider the limits of modes of accounting that devalue care. Second, I examine an alternative driven by nurses: the regulation of staffing levels.

Medicare’s One Percent

In the past decade, Medicare has made changes to the way it reimburses hospitals for services rendered. Starting in 2013 as part of the Affordable Care Act, the federal government began withholding one percent of Medicare reimbursement money as part of a Value-Based Purchasing program (VBP) (Meyer 2012; Mullin 2014). Hospitals can earn the one percent as a “bonus” or lose it according to their scores on a combination of surveys on clinical practices, outcomes, efficiency, and patient satisfaction. For example, hospitals can “lose” the one percent in cases of hospital-acquired infections, injuries and falls, bedsores, and mistakes (QualityNet 2016).
performing well on surveys, they can earn the one percent. These changes build upon 2008 restrictions on reimbursements after re-admittance or hospital-acquired conditions (Brooks 2007). The VBP program is a different mode of accounting for care. The Centers for Medicare and Medicaid Services (CMS), which administers Medicare, has determined that, rather than directly pay for services, hospitals will receive reimbursements that are, in a small part, determined by the quality of care they provide.

Medicare’s one percent is important for a few reasons. Hospitals overall are financially unstable, with the vast majority struggling to break even (Henry 2015b; Levine 2010; Salit, Fass, and Nowak 2002). Even busy and at-capacity hospitals compete to attract insured patients. Sandra, a certified registered nurse anesthetist, was frustrated that the drive for more patients made for a more demanding and stressful workplace. She explained that, “The more patients you have, the more revenue that’s coming in...everything’s just busier...Not that [the administrators] are trying – it’s not like they’re trying to become, you know – Of course they want a business to do well, but they also need to stay in the black to stay open.” Sandra stops short of saying administrators are trying to get rich, but she make a connection between the austere financial environment and the ability to provide services. Current budgets do not ensure the conditions of providing good care; facilities struggle to simply stay open. The VBP program puts the uneven geography of health services in the spotlight.

Withholding any Medicare reimbursements, in a move similar to the education sector’s
No Child Left Behind program,\footnote{No Child Left Behind is the George W Bush-era education reform that emphasized standardized testing scores. Schools that did not show improvement on tests were threatened with a decrease in funding, while schools that improved year-to-year received more funding. In other words, schools that were often under-funded to begin with, were forced to do more with less. Education critique Diane Ravich describes it as a program of “measuring and punishing” (see Inskeep 2010 for more information).} will more greatly affect hospitals serving poorer patient populations, as these facilities are the most financially precarious (Henry 2015b).

The VBP program also has implications for health care workers. Low staffing levels have been a key way administrators have tried to save money over the past few decades (for example, see Weinberg 2003). Nikita, an emergency room nurse in the Bronx, puts it succinctly:

[The administration] always says ‘we’re trying to hire more nurses, we’re trying to get staffing numbers up.’ But for it to actually come into fruition is another story. I think a lot of it is financial. It’s tough. A lot of money issues in hospitals. They don’t want to hire too many people. They assume nurses can do anything. But I really think it’s financial when it comes to the administration, which is sad.

Nurses, however, cannot do everything. Hannah, Nikita’s co-worker, explained the limits she works within when I asked her why she thought her unit was understaffed.

Money. Definitely. (Laughs). Because whenever you are scratching your head, it comes down to money. I know there’s a national lack of nurses, but I think if you have the appropriate salary, they will come. I think it’s a money issue. Money and literal space, which again comes down to money. And we’re very short with computers. We have to fight for a computer. It’s ridiculous. You’re so busy, you have so many people [to care for], and you can’t get a computer to document what you’ve done? Let alone a chair so you can sit while you’re at the computer! It sounds so silly but those things make it more challenging.

Wages are important. As Krista, a nurse in Brooklyn, said, “you have to work! What you have to do for that hour, you don’t get paid enough!” Yet, wages are not the
only way nurses are undervalued, as Hannah explains above. Hannah and her coworkers do not have enough computers to complete essential documentation, and space in the ER is cramped. Nikita also complained about space: “there’s a lot of resources we don’t have, and lots of unsafe things... stretchers upon stretchers always in the way.” A broader investment into nursing staff and the tasks they must complete, for example space and computers to do the essential documentation, is equally as important as wages. For example, overall working conditions, rather than simply or even primarily wages, has been a long cited factor in the chronic nurse shortage in the US (J. Spetz and Given 2003; Tregarthen 1987). Hannah and Nikita draw a clear connection between the investment in nurses on many fronts and the ability to do their jobs – or, put differently, their ability to care for patients. With hospitals already struggling to stay open and already cutting staff in order to do so, demanding more of workers while threatening to cut funding even more is a contradiction. It demands facilities do, to paraphrase Regina, even more with even less.

**An Alternative Abstraction of Care**

Alternative modes of abstracting nursing work exist, though. Regina, the nurse manager in Yonkers, explains how the VBP program and leadership changes are impacting her hospital.

**R:** The midline nursing leadership like me, the directors, the clinical nurse managers, we kind of all banded together. And over the last couple of years – now that you get scored for how your patients rate you on surveys, now that the government has started to not pay for things that shouldn’t happen, like hospital acquired infections or a bed sore – what we were talking about was if you want good patient satisfaction scores and if you really want a good quality product, then you have to put something into it. If you’re the biggest car-maker in the
world, and you start cutting corners on whose doing the work, what kind of parts you’re using? You’re gonna see a decline in the quality of what you do. We had seen that decline...Then we got a new CEO; we got a new VP of nursing. They have started to slowly change...the number of people we have taking care of the patients.

CH: Why do you think the new administration is agreeing to hire more staff?

R: They want quality. In this climate, if you don’t produce quality, you are not going to be a hospital. The CEO of this hospital is very forward thinking. I like him. He’s an accountant, so his knowledge of money is very good, let’s put it that way. But he also realizes that the product we sell is what? We sell patient care. We sell making patients happy and their families content. We sell that if your mom is here you can leave the hospital tonight and go home and sleep and know that when you come here in the morning that she’ll be well taken care of. And if you don’t have people to do that then you can’t do it! And I think they realize that you need people to take care of patients. You can’t cut corners like you can in other businesses.

Regina is speaking from a context that has made her work reducible to scores on a survey, in which she understands herself as part of the selling of care. Yet, what I find important and provocative about her explanation of recent changes at her hospital is the way she focuses on investment on the caregivers as key to improving the hospital overall. She explained to me that the nursing department is not only investing in hiring more nurses, but focusing on treating each other with respect and compassion. This approach begins within the staff and extends to patients.

Hospitals are nursing institutions (S. Gordon, Buchanan, and Bretherton 2008). You are admitted because you need nursing care. Nurses and lower-level nursing staff perform the bulk of the care and medical work. And yet, as I have outlined above, dominant modes of accounting for care, from the budget and chart to federal insurance regulations, have worked to undermine the very service hospitals exist to provide. Recent modes of abstracting nursing work have support the logics that lead to cutting staff.
This represents the contradiction of social reproduction: necessary to life yet elastic, able to be stretched so thin. The work, spaces, and social relations of reproduction make life possible. Social reproduction is, as Katz (2001b) explains, a necessity. Partly because of its necessity, social reproductive spaces, workers, and institutions are expected to pick up the slack of a disappearing welfare state (Hossler 2012; Katz 2001a; Meehan and Strauss 2015). Social reproduction’s necessity facilitates its elasticity. Family members piece together childcare; emergency rooms become people’s primary means of accessing health care; food banks provide more food to more people. Elasticity sacrifices quality, sometimes at dangerous levels. Time, labor, and personal resources have their limits. For health, these limits are literally life and death, or at least the quality of life and death. For nurses, the limits are chronic burnout, apathy, injury to themselves and patients, and overall poor working conditions (Henry 2015a). For patients, the limits to social reproduction’s elasticity are in the quality and quantity of health care services they can access.

Nurses frequently connected the fact that hospitals are businesses with the limitations placed on their ability to provide high quality care, or, said differently, their inability to fully do their jobs. My interviewees expressed frustration about not being paid enough to do the work nurses have to do. Many said they love the job, yet do not feel the compensation is adequate for the quantity and quality of work. Nurses care for too many patients, with too little time, doing physically, emotionally, and mentally difficult work for too little pay. They are highlighting that the measurements used to regulate nursing work – paperwork, staffing levels, resources, wages – are incompatible with the actual qualities of those quantities. Inside those quantities are the seemingly
unquantifiable labors of care: the emotions, the smiles and eye contact, the time for conversations big and small, the gentle touches and gestures. The abstractions used to regulate care do not capture the daily activities of nursing work and patient care. In fact, many ways that care is abstracted, through the budget and the chart, for example, have served to systematically undermine the value of care, as I outlined earlier.

In contrast, a central part of what Regina says is changing is that her hospital is investing more money and energy in to the nursing staff. The nursing department is focusing on taking care of each other as a way to better care for patients. The hospital is overall staffing more nurses per shift, lowering the nurse-to-patient ratio. When I asked nurses either what the biggest barriers were to providing high quality care or how they felt care could be improved, every nurse told me they needed more staff.

Nurse-to-patient staffing ratios offer an alternative abstraction of care. Called “safe staffing” laws by nurse unions, these regulations set specific ratios of patients to nurses for each type of unit in a facility. California passed such legislation in 1999, and Massachusetts legislated ratios for intensive care units in 2014. Since 2007, sixteen states and the federal government have introduced safe staffing bills. Nurse unions have been the driving force behind these bills, organizing across the country to introduce them as well as making staffing levels central to their bargaining demands.

Ratios have been proven to be one necessary means of uniting care and clinical work (for a succinct review of studies examining ratios, see S. Gordon, Buchanan, and Bretherton 2008). Ratios are a quantitative way to address quality, i.e., care. Setting ratios also gives nurses control over their time and more control over the space of the workplace, in no small part because there are just more of them. Lower ratios give
nurses more time to spend on those tasks that are not on the charts as well as more
time care-fully doing the clinical work. More nurses and more assistants mean each
nurse is responsible for fewer total patients. Each nurse is responsible for fewer
patients, giving her less work overall, and, in turn, more time to spend with each patient
performing care or clinical responsibilities. Lower ratios help lower rates of injury to
patients and nurses, and improve work environments. This leads to better nurse
retention and lower rates of mistakes. As ER nurse Hannah explained, she wants
enough time to get someone a cup of water or walk them to the bathroom. In sum,
Hannah wants to do her whole job.

The abstract and particular are in a positive dialectical relationship in staffing
ratios (Joseph 2014; Ruddick 2008): as attention to individual (i.e., particular) needs of
patients and nurses intersects with universal (i.e., abstract and generalized) numerical
staffing standards to produce a new holistic standard of care that values all of the work
nurses do. Set staffing ratios are essential to creating the conditions of valuing caring
work alongside clinical expertise. The struggle to limit the number of patients per nurse
is a struggle over the quality of quantity and the quantity of quality. Safe staffing ratios
are an alternative mode of accounting for social reproduction – one in which social
reproduction takes priority – and a way of investing in nursing labor.

CONCLUSION: TOWARDS JUST ABSTRACTIONS

When I asked Joan how she thought doctors and nurses approached patient care
differently, she said, “Nurses definitely spend more time [than doctors] on the little
things: on the explanations, the details, the picking up the pieces.” These little things
include preparing a patient for surgery, explaining medications to an elderly person or someone who speaks English as a second language, or assessing a sick child. Each task is a matter of quality and of life and death. The conditions under which nurses practice care and clinical work is instrumental to social reproduction and health of patients, communities, and workers. By bringing together care work and clinical work with a politics of measure, nurses offer new possibilities in how they can take care of all of the “little things” their patients need. New modes of accounting for social reproduction are not a panacea, but they open up possibilities for managing nursing work. Understanding the two sides of nursing as an inseparable, mutually constituted pair means refusing to render half of the job invisible or excess. Instead, such a conception of nurses’ work shows how current modes of accounting for care do not actually measure the work nurses do. In turn, critically analyzing the care-clinical binary opens up new possibilities for counting value.

Debates over modes of abstraction have broader purchase than nursing. In health, rich debates exist over numbers and quantification, for example, over obesity and the body (B. Evans and Colls 2009; Guthman 2011), or the performativity of pharmaceutical pricing (Christophers 2014). Debates over how much a medication is worth, what disease warrants testing and research, or what numbers represent healthy and unhealthy bodies and communities are, essentially, debates over social reproduction. They reflect contestations over the value of bodies, both patient and worker, and over the labor that goes into fostering good health. These are contestations over the value of good health and good jobs, over a just geography and for whom. They
are debates over how we live, what lives are good, and who deserves good health and a good life.

Measurements are representations, though, and correcting them therefore only offers partial solutions to many problems, such as fairly compensating nurses for their work, fully recognizing the range of important tasks nurses do, and ensuring patients receive sufficient amounts of the highest quality care. “Responsible action,” as Joseph (2014, 148) explains, cannot come from within the system of measurement. Safe staffing regulations are necessary, but they are also partial. Abstracting the labor of nurses or of other social reproductive workers is part a means to an end, not the means or the ends themselves. They are a means for, as Joseph argues, “[accounting] for justice, on behalf of justice” (2014, 148). Ultimately, a feminist politics of measure asks how abstractions can make visible the absolutely necessary labor and relations of social reproduction and do so for justice.
Chapter 5
Conclusion: Towards a More Just Geography of Nursing Work and Good Health

In this dissertation, I have engaged with Marxist and feminist theories on labor and social reproduction to explore different mechanisms that control, manipulate, and reproduce nursing work in the US. I have brought together feminist literature on the gendering of work, as well as on care and social reproduction, to argue for a more nuanced analysis of social reproductive labor. Through an analysis of the management of the time, spaces, and measurements of nursing work, I have shown how labor and the value given to different types of work is a site of political struggle.

In Chapters 2-4 I have analyzed three basic elements of nurses’ days: where they work, how long they work, and what tasks they must perform. These are both mundane and fundamental aspects of nursing work. They are building blocks of nurses’ working conditions. While I have analyzed each on their own, the time, space, and measurement of nursing work are inseparable, with each impacting the others. For example, the regulation of nurses’ shifts has implications for the documentation requirements and staffing levels. If nurses have fewer patients to care for, they have more time per patient. The ratio of nurses to patients impacts the ratio of time a nurse has to spend with each person. Similarly, nurses complained that eight-hour shifts were too short for
taking care of all of their tasks. Yet, instead of limiting the tasks, time expanded. In their extended working day, nurses can still have too much work for the time allotted, as I addressed in Chapter 3. The backdrop of a changing service delivery landscape complicates this even more, again raising my research questions: how can such essential work be so undervalued? How are health and health care labor commodities? What is the relationship between this commodification and devaluation? This dissertation contributes to answering these questions, demonstrating that value is contested and shaped (for different reasons and different ends) from multiple directions, scales, and positions in the hierarchy of health care services and management. The dissertation also demonstrates the ways that nursing work and health fall under the umbrella of social reproduction. This categorization has serious implications for the ways in which work and services are valued, funded, regulated, and prioritized differently by different actors and institutions, such as governments, administrators, communities, patients and workers.

This dissertation makes empirical and theoretical contributions to feminist political economy and geographical research on health and work. Empirically, this dissertation contributes to feminist research on care work and feminist political economic analyses of labor and social reproduction. It makes these contributions by focusing on skilled workers and analyzing nursing work not primarily from the question of migration. I have also contributed to feminist political economy and social reproduction theory by developing a substantial analysis of and argument for considering health as a component of social reproduction. While health care institutions, for example, are often mentioned in the list of institutions and arenas that
contribute to reproduction (Bakker and Silvey 2008a; Harvey 2014; Katz 2001b; K. Mitchell, Marston, and Katz 2004), the literature analyzing health as a part of social reproductive is a nascent one (see Connell and Walton-Roberts 2016; Henry et al. 2015; P. Jackson and Henry Forthcoming; P. Jackson and Neely 2014; Loyd 2014). This dissertation demonstrates the usefulness of understanding health as under the purview of social reproduction. The division between production and reproduction is always blurry, and one could categorize nursing’s tasks as both productive and (mostly) reproductive. Yet, as this dissertation shows, and echoing Strauss and Meehan (2015), approaching nursing labor from the perspective of social reproduction is both politically useful and best for capturing the fullness of nursing work. Centrally, my dissertation analyzes the processes of devaluation of feminized care work with an eye towards political struggle and ideal conditions for care and labor. Such an analysis, one that pairs understanding the mechanisms of devaluation and inequality with a vision for rectifying that unevenness, is an analysis that social reproduction as an analytical tool is well suited to do.

This dissertation has also contributed to feminist geographical analyses of care and work by foregrounding a specific work site: the hospital. I have shown the spatio-temporal aspects of nurses’ work by analyzing the lengthening of their working day. I have analyzed the impacts of specific rational logics of measurement on nursing work in hospitals, sites of hyper rationality. Furthermore, these analyses are situated within a broader context of the revolutionizing of the health care service landscape. By pairing the geography of hospitals with a geographical study of work done in hospitals, I have
demonstrated the relationship between the work done inside the building and the geography of such spaces.

In Chapter 2, I argued for a stronger integration of Marxist theories of investment in the built environment and feminist theories of social reproduction. Such a pairing sheds light on the relationship between capitalist investment in spaces and the work done in those spaces. Empirically, I have shown that hospital closures, the state of the nursing workforce, and the provisioning of health services are in a constitutive relationship. When one changes, it impacts the other two. When the spaces of work disappear, jobs also disappear. These restructurings are part of a shifting and redistribution of resources, and importantly, the redistribution is felt unevenly, being a reconstitution of work and service provisioning for some, and an effective withdrawal of work opportunities and health care services for others. This threatens access to health care services and the sustainability of healthy communities. This process is possible, in part, because nursing work is reproductive work. Nurses assist in biological reproduction, help with everyday care, and reproduce capitalist social relations, in particular because of their vital role as the backbone of the hybrid public-private American healthcare system.

In Chapter 3, I argued that the extension of nurses’ working day was a neoliberal tool that avoids dealing with root causes of the chronic nurse shortage and the under- or de-valuation of the workforce. In a move that may appear to be a workplace improvement, I have argued that twelve-hour shifts shift the scale of discussion over workplace rights. Rather than working less and providing better patient care, twelve-hour shifts involve working fewer but longer and harder days. The lengthening of
nurses’ working day to twelve hours obscures smaller, more mundane forms of exploitation such as the small amounts of overtime with every shift, the spillover of work into personal life, the increase in apathy towards patients. It shifts the conversation away from demanding more resources and staffing and towards working within the existing conditions.

In Chapter 4, I argued for an explicit politics of social reproduction in critical analyses of measurement. This chapter contributes to understanding both how health is social reproduction and the valuation and management of social reproduction by foregrounding social reproduction in analyses of work, value, and health. Geoff Mann (2007) and Miranda Joseph’s (2014) work on modes of abstracting or quantifying the qualitative implicitly, rather than explicitly, deal with social reproduction. Making social reproduction a more prominent focus in a politics of measure furthers discussions of measuring what we actually value, to paraphrase Joseph, pushing to the forefront of a politics of the possible that values good jobs, good health, and the conditions and relationships that make living possible. For nurses and their work, a feminist politics of measure that foregrounds social reproduction reveals the ways in which certain aspects of their jobs become invisible or deemed as excess. This in turn opens up new possibilities for better accounting for nursing care, in ways fair to both nurses and patients.

Finally, this dissertation adds texture to geographic analyses of care work. My analysis speaks back to the rich literatures on domestic workers (England and Stiell 1997; Giles, Preston, and Romero 2014; Parreñas 2001; Pratt 2008; Silvey 2004) and migrant nurses (Blouin 2005; England and Henry 2013; Pratt 2008; Raghuram 2007;
Walton-Roberts 2012; Yeates 2010). The domestic worker literature demonstrates the impacts and political work of processes of deskilling and labor market segmentation. For example, Pratt (2008) shows how through immigration restrictions and formal and informal discursive practices, Filipina migrants find themselves deskilled from nurses to nannies and subsequently trapped in a ‘lower’ segment of the labor market. My research adds nuance to domestic worker literature by adding a discussion of a higher skilled segment of care work, one that many domestic workers and lower-ranked nurses trained as before migrating to the US or Canada. For example, most of the migrant nurses I interviewed had to retrain to maintain their rank once they immigrated (see also England and Henry 2013; Pratt 2008; Walton-Roberts 2012). Understanding the general working conditions of nurses shed light on how the profession is maintained (and devalued) as a domestic workforce, in which the vast majority of nurses in the US have American citizenship (Aiken 2007). Furthermore, as Kofman and Raghuram (2006, 282) have argued, analyses of skilled feminized workers such as nurses expand research sites and foci to beyond the household to “social reproduction as organized by the state”. This broader geography reveals the commonalities and differences across both spaces of work and the care work sector more broadly, all situated in a new international division of reproductive labor. Although migration is not my focus, my dissertation adds to the project of understanding the global devaluation of reproduction, focusing not only on skilled workers, but adding a particular site, i.e., the hospital, to the geography of care work.

In sum, these chapters provide an intersectional and feminist analysis of the work that nurses do, how their working conditions are changing, and what some of the
implications of those changes are. Because nursing work is patient care, nurses’ position as interactive service workers raises new possibilities for solidarity and organizing for social justice. As McDowell (2009) explains, in interactive service work, the recipient of the service is integral to the work. Therefore, following Ruddick’s (2008) call for a dialectic of the positive\textsuperscript{42}, what possibilities for affinity between workers and patients exist? When nurses and patients are not seen as solely distinct entities, but different parties in a relationship of shared interest, what new possibilities arise for valuing nursing work and patient care?

NEW AND LINGERING QUESTIONS FOR A CHANGING LANDSCAPE OF LABOR AND HEALTH

Many changes are afoot in health care in the US and beyond, and this dynamic context makes the question of organizing for social justice and reproduction especially pertinent. While my dissertation did not deal directly with the issues the nurses below discuss, many raised these as important concerns. My analysis can offer a small starting point for understanding the changing landscape of US health care. Consider the following statements from my interviews:

My brother-in-law lives in Cairo in upstate [New York], and they closed the hospital there. They opened the emergency room as just a walk-in clinic with limited hours. It was just open until 9pm. And they had some people who were in cardiac arrest, and they just zoomed in to the ER because they thought it was still a hospital. They didn’t realize it had closed. They opened up this treatment center, but it wasn’t even a full service hospital...The closest major hospital was in Albany, which is an hour away. (Connie)

\textsuperscript{42} A dialectic of the positive is “a problematic that might enable us to think across our differences to a political ontology that embraces the posthuman, immanent, and affirmative qualities of struggle” (Ruddick 2008, 2588). Without ignoring difference, this approach to politics and relationships foregrounds shared interests and asks no more than that. The limits of the relationship sit at the limit of the shared interest.
[We discharge quickly to] a nursing home or a sub-acute rehab which a lot of the nursing homes now have because the hospitals can’t get them walking, moving, able to do things for themselves. So they go there to have that done. And now we’re seeing denials for a lot of those places. The insurance doesn’t even want to pay for that. They say send them home and have someone take them to therapy. It’s vastly changing, health care in this country. (Regina)

Katherine: In the nursing world, especially at NYU, people say there are no jobs, and then a non-nurse would ask about it. And then people would say you’d have to move away. In NYC everyone’s concentrated on staying here where it’s so over populated [with nurses]. So a shortage doesn’t get discussed... Everyone’s like ’California, isn’t there a shortage there?’ But they’re laying nurses off. The state is cutting nursing jobs.

Alyza: Why?
Katherine: Because that state is broke.
Alyza: So they can’t pay us even though they need us. Cool. I’m glad we stayed in a fucking war for so long.

We all need health insurance. We need to do away with CEOs of insurance companies!...My husband hears me all the time, because he doesn’t care for Obamacare. I say, ‘Well then it should be like the unions. They all have national health care, the unions do, and then you don’t have to worry about these CEOs. You just get [the insurance coverage]. That’s my biggest gripe. That’s what, if I could have something different...Obamacare is not perfect, but it’s a start. A start on the way to universal health care which – ‘Oh, we’ll be come a socialist nation!’ Oh, no you wont! You’ll just take care of the people who need to be taken care of. Everyone needs to be taken care of. (Margaret)

These nurses raise many issues, but what all of them call into question is how nursing work and health care services are valued both socially and economically. This dissertation has provided some answer to how nursing work is devalued, but the political question of why nursing work is subject to continuous but dynamic processes of devaluation persists. Nurses are frustrated with the hierarchy of priorities in government spending that places, as Alyza expresses, national defense over public health and meeting health needs. They question the uneven geography of services and work and the uneven investment in their labor and the other conditions that foster good health. This dissertation cannot offer answer to these emerging challenges, and I
do not pretend to do that in this conclusion. Yet, this dissertation offers a starting point to move forward from, a starting point from which to consider the changes currently happening in US health care. In this final concluding section, I offer for consideration three important changes under way: changing spaces of health services, the increasing activism and unionization of nurses, and the changing care needs that come with an aging population.

**Changing Spaces of Health**

As I discussed in Chapter 2, in the past decade, the American hospital system has been in crisis, shrinking across the country. Hospitals across the US are closing in greater numbers, consolidating services to larger, centrally-located facilities owned by large corporations. Yet, the geography of centrally-located services leaves many people without access to care. As Connie’s quote above mentions, the changing landscape of health care institutions leaves many people without close access to vital health services.

Each time I visit New York and St Louis since my initial research stints, I see more and more urgent care centers in the city. Also, just this spring, yet another major hospital, Beth Israel in Manhattan, announced it would be closing and building a new facility that is a fraction of the size after years of financial difficulty (Ramey and Evans 2016). Similarly, in the St Louis metropolitan area, the landscape is becoming increasingly uneven as two hospitals in the metro-east area around East St Louis. Touchette Hospital is downsizing and in a precarious financial position, while another has been approved to move to a new location miles away in a wealthier township (Liss 2015; Bouscaren 2016). These two changes will leave the poor, mostly racialized
residents of East St. Louis and surrounding municipalities with considerably less access to clinics and a full-service hospital.

Across the US, the trend is similar. In the Bay Area, the San Francisco Chronicle warned of a dangerous trend: community hospitals are closing or finding it increasingly challenging to stay open (Colliver 2015). Twenty percent of Oklahoma's rural hospitals are on the verge of closing because they are “financially vulnerable,” a condition made worse by the state’s refusal of the Affordable Care Act’s (ACA) Medicaid expansion funding (Muchmore 2015). In Ohio, the Cleveland Clinic has been facing its own financial difficulties; in the past five years it has begun closing some of its nine community hospitals around the greater Cleveland area (Abelson 2011; Geiselman 2015).

The spaces of health care are changing in other ways, as home care and private clinics are increasingly important care settings. Jobs for nurses in home care and lower-paid positions for home care workers are projected to grow significantly in the coming decade (CHWS 2012). As hospitals’ viability become more uncertain, some nurses I interviewed mentioned both of these spaces as increasingly popular sites for work and care for nurses as well as doctors.

The Affordable Care Act has provisions for increasing support for home care (CMS 2015; 2016) and hospital administrations continue to try to reduce the length of patient stays. The move away from institutional care is in many ways welcome. Institutions are clinical, sterile, and often impersonal. Researchers have shown people can often improve more quickly and also prefer the home to the hospital (Leff et al. 2006). Also, people who are admitted are at risk of hospital-acquired infections. Finally,
as Regina also explained, the increased reliance of the system on home care is connected to the restrictions insurance companies impose on reimbursements.

Geographers, though, know to be critical of the home (Blunt 2005; England 2010; Fannin 2003; Milligan 2009). Take for example the story a nurse in St. Louis told me. Mary was frustrated about discharging a patient who was recovering from a gunshot. The patient was now paralyzed and lived in a walk-up apartment. Medicaid, though, refused to cover a motorized wheelchair or a lift for getting up the stairs. As a result, Mary spent a considerable portion of her shift working with the social worker to coordinate care and a ride home for the patient. They also spent time begging Missouri’s Medicaid to pay for a motorized wheelchair. Home is not necessarily a haven for this patient, and, for the workers like Mary, ensuring a patient has care after being discharged is both stressful and work-intensive.

This raises important questions for social reproduction. Who is now doing the care work? Who does and doesn’t have family, friends, or resources for receiving necessary care? Who does and doesn’t have a clean and safe home to be discharged to? Whose home is accessible? When and for whom is home not safe? What is the role of the state in supporting social reproduction?

The US hospital system is not unique, and that hospitals in very different healthcare systems are closing demonstrates the importance of thinking across contexts. Hospitals are closing across rural Canada (CBC 2013; Howlett and Morrow 2014). In the past decade, over 40 obstetrics units have closed in rural Canada, making mother and baby care more inaccessible (Grant 2015). In the UK, the National Health System has been considering closing hospitals across England in order to sustain the system
(Campbell 2012; Carter 2013). In a very different context from the US, Canada, or the UK, Switzerland’s hospital system is facing a similar crisis: the hospital system is financially unstable and many hospitals are closing, only to reopen as small clinics (O’Dea 2014). The US, UK, Canada, and Switzerland all have quite different health care systems, from a mix of public and private to fully public. Taken together, however, the closures show how hospitals have been made to be unsustainable across a wide variety of contexts. The closures require critical analysis of the limits to and ways of commodifying health.

**Nurse Activism and Unionization**

Nursing has historically not been a unionized profession, either by law or by its own internal resistance to unionization. Yet, as I have mentioned throughout this dissertation, nursing is one of the few occupations with increasing rates of unionization. The profession is changing, not only by becoming a more secure job, but also because the profession is increasingly situating itself as an advocate for social justice.

Nationally, the National Nurses United (NNU) has led this initiative. The NNU, formed in 2009, is successfully unionizing across the country, in places far and wide.

---

such as Texas, Illinois, Missouri, Maine, Florida, Nevada, Pennsylvania, DC, California, Massachusetts, Michigan, Minnesota, plus Veterans Affairs hospitals around the country. The NNU currently represents 185,000 nurses, spread across the country in every state (NNU no date). The NNU is also expanding unionization beyond registered nurses. They are working to unionize technicians (also called nurses aids) in California in the Caregivers Union. As I conducted research in St Louis, the National Nurses United was organizing registered nurses at area hospitals as well as bargaining new contracts.

In New York City, the New York State Nurses Association (NYSNA) has been aggressively organizing nurses around the state. In 2012, after a decade of attempts, a slate of radical members took over NYSNA’s executive board.44 This was part of a broader sea change in NYSNA, with the organization breaking away from the American Nurses Association (ANA), transforming from a professional association with bargaining rights to being an independent trade union. NYSNA now represents approximately 37,000 registered nurses in New York State (Gaus 2009; NYSNA no date).45 That number continues to grow as NYSNA is aggressively organizing more nurses in facilities around the state.

In addition to growing their membership, the NNU and NYSNA have positioned nurses as social justice advocates. NNU runs campaigns for living minimum wage, guaranteed health care, pensions, improved public education, safe housing, a healthy environment (NNU no date). Calling on nurses to get involved, the NNU explains, “The fight for our communities is our fight. Nurses know that when healthcare, pensions, 

44 This takeover was messy and took multiple court orders to seat the newly elected radical leaders (Gaston 2012; Sheridan-Gonzalez 2013).
45 The ANA also “suspended” NYSNA for one year in 2012 for their attempts to leave and affiliate with another union (ANA 2012).
safety net programs, or education is cut for anyone, everyone is harmed. Nurses bring
goods, now we must fight to protect them — and assure a better
quality of life and a secure future for our communities, our patients, our families, and
ourselves." The NNU is framing nurses’ responsibility as much broader than direct
patient care.

Additionally, similar to the NNU, NYSNA has placed itself at the forefront of
struggles for better health care and better quality of life. They have fought to keep
hospitals from closing, such as the struggle to protect both Long Island College Hospital
and Interfaith Medical Center in Brooklyn over the past three years. With at least 28
closing in the state – 22 of which are in New York City – since 2000, NYNSA is making
connections between good health and good jobs, even if they are not always successful
in fighting hospital closures. They position themselves – as nurses – as the defenders of
the system, explaining, “New York State’s public hospitals never turn a patient away.
That’s the mission of RNs everywhere” (NYSNA no date). NYSNA is lobbying, organizing
petitions, and taking to the streets to prevent the closing and the privatization of
hospitals.46

46 They are also fighting to prevent the creeping privatization in New York’s hospital
system. Over his tenure, however, former Mayor Michael Blumberg privatized laundry,
cleaning, and dietary services in the city’s public hospitals – a move that Dan Zuberi
(2013) has shown cuts costs but threatens patient care. Outsourcing this labor to poorly
paid and overworked precarious workers has negative impacts on hospital cleanliness,
not to mention put these workers themselves at risk. Hospital-acquired infectious
diseases are more prevalent and are spreading more easily; and this threatens both
patient and worker safety. Furthermore, NYSNA has successfully organized against the
privatization of dialysis services in city hospitals, showing that for-profit dialysis
services have a mortality rate 13% higher than non-profit dialysis services (NYSNA
Defend Public Hospitals, no date).
I do not want to overemphasize or romanticize labor unions. Many nurses in New York City, St Louis, and the rest of the US are not union members. And certainly, as with any political group or large association, they have their conflicts and problems. I also do not want to imply that organized labor is the best structure for political organizing. Unions are inherently exclusionary organizations, meant to serve their members. Yet, the actions nurses are taking are impressive and stretching the boundaries of what unions can do and stand for. Indeed, the NNU is making labor experts reconsider what unions look like, how they operate, and the decline of the labor movement over the past three-plus decades (see Semuels 2014). Last year The Economist declared, “Just as the car industry was the 20th century's main battleground for fights over labor, it is increasingly clear that health workers will the at the center of the latest bitter conflict” (C.H. 2014, no page). The care industry is today’s labor battleground. Across the US nurses have gone on single and multi-day strikes over staffing levels, pensions, and workload (Crowe 2011; Associated Press 2015; Lindelof 2014; “UPMC Altoona Announces New Three-Year Pact with Nurses” 2014). They came to the defense of two nurses the CDC wrongfully blamed for the spread of Ebola in 2014 by staging one and two-day strikes in fourteen states and the District of Columbia (Resnikoff 2014). Nurses around the world are both unionizing and taking labor action, from Kenyan nurses striking for hospital supplies and increased pay (BBC 2012; J. Mitchell 2012) to Nova Scotian nurses protesting staffing levels and essential-service legislation with illegal strikes (R. Benson 2014; Taber 2014) to National Health

47 This legislation designates particular workers as “essential services”, such as emergency medical services and firefighters. Essential service workers are not allowed to strike. In recent years in Canada, it has been used to prevent strikes and other labor
Service nurses in the UK employing work-to-rule tactics for one percent wage increases (Donnelly and Swinford 2015; Merrifield 2015). In these fights, nurses have paired labor and patient rights. They are striking simultaneously for better working and caring conditions and for better health overall. Nurses are using their traditional image, as mothers, nurturers, and angels, to aggressively defend health care, social services, and good jobs.

**Changing Care Needs for an Aging Population**

Across the Global North, populations are aging, and health care systems are facing new challenges as they care for more and older patients with more chronic conditions. Put simply, people’s care needs are changing in significant ways. How the health care system and the nursing profession meet those needs is in question.

In the US, people over 65 will account for twenty percent of the US population, a seven percent increase from 2012 (Ortman, Velkoff, and Hogan 2014, 6). This means that an increasing proportion of the population will need long-term, chronic, and then palliative care. Currently, the health care system is not set up to sufficiently meet those care needs. Additionally, the aging of the nursing workforce presents further challenges for how care needs will be met and by whom. The average age of nurses working in the US is 50, and over half of nurses are over that age (ANA 2014). In the coming decade, a great portion of the nursing workforce will age into retirement, out of the workforce.
Not only are the spaces and means of provisioning care in flux, but so too is one of the main workforces that provides long-term and elder care in the US.

Home care is an increasingly popular ‘solution’ to the developing care needs of the aging population and financially unstable health care systems. For example, in Canada, the Canadian Medical Association recently called for increased investment in a wide variety of supports for seniors, including “providing sufficient long-term home care and support for unpaid caregivers” (Picard 2015). The shift away from institutional care and towards home care is not necessarily a negative. Yet, in a recent expose, the Globe and Mail referred to Ontario’s home-care system as a “byzantine...underfunded, complicated system faltering in the face of skyrocketing demand” (Grant and Church 2015). The system appears to be wholly unprepared for the changes that are underway.

As Ai-jen Poo, a leader in the movement to improve elder care in the US explains, the “elder boom” itself is not a crisis (2015, 3). The challenge, and opportunity, is how society meets the changing care needs of its population. Currently, the support network for people needing chronic and end-of-life care, a patchwork of family members, paid caregivers, and state and private institutions, is wholly insufficient. In sum, the aging of the population raises new issues and new possibilities for what workers are needed where to provide what care.
CONCLUSION

As populations age, new and increased care needs arise. As I have illustrated, the changing care needs are underway, and my dissertation research informs my analysis of what care needs emerge, what new possibilities can be created, and what questions are raised in the face of these dynamic needs. This new context raises important question for (1) how caring will happen and (2) the value of that care and the workers providing the care. How will health systems and institutions adapt to provide enough services? Who will be left without access to services? What and whom will fill in the care gaps? What is the relationship between the landscape of health services and the value of patient and workers’ lives? Furthermore, as long-term care has long been the least respected form of nursing and other health care, how will the demographic shift impact the social valuation of caring for people in the later stages of life? What implications do these changes have for the social and economic valuation of social reproduction overall? What is the role of workers and organized labor in shaping the future of good health and good jobs? What possibilities for political alliances exist across patients, workers, and communities? By foregrounding a politics of social reproduction, as I have done in this dissertation, the fullness of nursing work becomes more apparent, a crucial step in creating a more even and just geography of good health and good jobs.
References


http://link.library.utoronto.ca/eir/EIRdetail.cfm?Resources_ID=601431&T=F.


Concerned Physicians of LICH. no date. “Homepage: Help Save Our Hospital!”
http://www.lichmedicalstaff.org/.


Keep Brooklyn Hospitals Open for Care. no date. “Funeral March and Rally to Save Interfaith and LICH.”


wants-to-end-inpatient-pediatric-services/article_9eb01968-2e1a-5a44-8db5-ed8fb8e7c715.html.


Resnikoff, Ned. 2014. “Nurses Strike over Ebola Concerns, as Death Toll Ticks above 5,000 | Al Jazeera America.” Aljazeera America. November 12.


Appendix 1:
Participant Biographies

New York:

Alyza graduated from New York University’s nursing program 2 years ago, which she completed after finishing her bachelors degree on the west coast. She is working at an outpatient surgery clinic in Manhattan. She is single with no children and lives in Manhattan. While working, she is attending Columbia’s nurse practitioner program. Alyza is in her late-20s and is the daughter of South Asian immigrants to the US.

Bettina works in a women’s clinic in a hospital in Nassau County, Long Island. She is Latina, a native New Yorker born and raised in the Bronx, and a mother to one son. She is in her late 40s. Bettina has worked in hospitals across the New York metro area over her career, primarily in women’s health and Labor and Delivery, including facilities in the Bronx, Manhattan, Queens, and Nassau County.

Carol is a lactation consultant at a hospital in Nassau County. She is white, in her 60s, middle-class, and originally from Queens. After working at American Airlines for three years and then having her first child, she became a nurse, 30 years ago. She has worked in maternity nearly her entire career, having started in the specialty because of convenience – a job opened at a hospital near her home. When she realized she had a knack for helping new mothers breastfeed, she returned to school for her lactation certification and has worked as a consultant ever since.

Connie is a recently retired nurse in her late 60s. She worked as a nurse for 45 years. She is white, middle-class, and originally from Queens. She wanted to become a nurse after seeing a family friend become a nurse and live as a young, single woman in the 1960s; she was also hooked on medical shows. She has worked in nearly every specialty in the hospital. She worked the first 15 years in Queens then went with her husband, a doctor, to work in Florida. She returned to New York and finished her career working as an OR and recovery room nurse in Nassau County.

Donna has worked as a labor and delivery nurse her entire career. She currently works at a women’s clinic at a Nassau County hospital. A mother of four children, she always knew she wanted to be a mom, and nursing was a job that offered her flexibility and stability as a parent. She left the workforce for 8 years after having her forth child. She is white and originally from New York.
Hannah works at an emergency room at a hospital in the Bronx with Nikita. After finishing her BSN at a college in upstate New York, she searched for a job for about 6 months before finally finding this one. She graduated when the job market for new nurses was tight, and she was lucky to have a friend with a connection in the hospital. Hannah is in her mid-20s, white, and grew up in Westchester County, just north of New York City.

Joan is an emergency room nurse at a hospital in Nassau County, Long Island. She is white, in her late 20s, and has been a nurse for 11 years. She grew up in Queens and now lives in Nassau County. She has no children and is not married, but has a partner who is a police officer. She previously worked as an oncology nurse before landing this job, which is in her desired specialty. She decided she wanted to be a nurse after being in the hospital at age 4; the nurses dressed her up and she handed out Valentines’ Day candy. She is currently enrolled in a program offered by her hospital for registered nurses who have an associate’s degree to complete their Bachelors of Science in Nursing at a local college.

Janie is an operating room nurse at a hospital in Nassau County, Long Island. She is in her mid-20s and graduated from SUNY Binghamton’s BSN program 3 years ago. Finding a job was a challenge, but she had a connection at her hospital who helped her get a job in the specialty she wanted. She is white, single with no children, and from Nassau County.

Jocelyn works in the mother-baby clinic at a hospital in Nassau County, Long Island. She had always wanted to be a nurse, but her mother discouraged her from the job, saying it was a really hard job. Jocelyn agrees with her mother – it’s a really hard job! – but she left accounting at the age of 30 to retrain as a nurse. She is 40 years old, Latina, a native New Yorker, and mother of 5 children. She has previously worked in public hospitals in the city and non-profit hospitals in Queens and Nassau Counties. She chose this job because it’s close to her home, and, as an out-patient clinic, the hours suit her busy life the best.

Katherine is in the last semester of her nursing degree at NYU, a 2 year-program for people who already have a bachelor’s degree. She hopes to work in a hospital for a few years and then return to school to become a nurse practitioner. Katherine is white, single with no children, and in her mid-20s. Originally from California, she plans to stay in New York after finishing her program.

Krista is a medical surgical nurse working in Brooklyn. She is in her early 30s, has 2 children, and she describes herself as coming from a family of nurses. Krista is African American, and born, raised, and continuing to live in Brooklyn. A year ago, she left nursing full time to open a bakery in Brooklyn. She still works part-time as a nurse to supplement her income and keep herself fresh as a nurse.
Kyle is the nurse manager of an intensive care unit (ICU) at a hospital in Westchester County. He is white and in his late 30s. Nursing is his second career. After selling vacuums in Florida for years, he retrained as a nurse over a decade ago and returned to New York, his home, to work. In the late 2000s, he was a staff member of the New York State Nurses’ Association. He lost his job when the union changed from being a professional association with bargaining rights to a full-fledged trade union. Kyle then returned to floor nursing, eventually making his way into the nurse manager position.

Lucia is an emergency room nurse at a hospital in Nassau County, Long Island. She is in her late 20s and is originally from Peru. She is currently enrolled in a program offered by her hospital for registered nurses who have an associate’s degree to complete their Bachelors of Science in Nursing at a local college.

Margaret is a recently retired nurse in her 60s. She graduated from her nursing program in Queens in 1966. She has worked in many specialties over her career, at hospitals in New York City and in Nassau County. Her preferred specialty was medical-surgical nursing. Margaret now works as an emergency medical technician (EMT) in Floral Park, Nassau County, a community sitting on the border of Long Island and New York City. She is white, middle-class, and a mother.

Nikita is an emergency room nurse at a non-profit hospital in the Bronx that serves a diverse lower-to-middle class population. He graduated from nursing school 3 years ago, and found his job 6 months after finishing his degree. He is single, in his mid-20s, and born and raised in the Bronx. Nikita’s parents immigrated to the US from the Balkans.

Pauline is in her late 60s. She retired in her early 60s, but that didn’t stick – she returned to work two weeks later. She returned to work to follow a good friend and former colleague, who had become the manager of a women’s clinic at a different hospital. She has two children, is white, and is a native New Yorker.

Raj is a nurse who emigrated from India approximately 5 years ago. She brought her children over to join her husband, who had come ahead of them. She was originally trained as a registered nurse in India, but her credentials did not transfer, a common issue that many migrant nurses face. Raj works at a hospital in Westchester County and is enrolled in their nurse certification program. After completing their nursing assistant program, she now works there as a CNA.

Regina is a nurse manager at a step-down unit at a hospital in Westchester County, just north of the city. She is white, in her 50s, and is a native New Yorker. After working in IT then leaving the workforce when she had her 2 children, she decided to retrain as a nurse in the 1980s. She trained at her hospital, first as a CNA then eventually completing the RN program. Regina has worked at the same hospital for her entire career of nearly 30 years.
Roseanna is a registered nurse and midwife at a women’s clinic in a hospital in Nassau County, Long Island. She has been a nurse for 20 years and a midwife for 17.

Sandra is a certified registered nurse anesthetist at a hospital in Nassau County, Long Island. After working as an operating room nurse for a few years in multiple hospitals in Manhattan, she returned for her CRNA degree. Upon finishing that program, she worked at Beth Israel in Manhattan, but moved to a hospital in Nassau County a few years ago to work closer to home. The shorter commute makes more sense for her family. She is 38, from a white middle-class family, and her husband co-owns a DJ company. They live, with their five children (ages 18 months to 8 years) in the Rockaways, a peninsula in the south part of Queens.

Victoria is a white, middle-class nurse in her 60s, originally from Queens. She is white, middle-class, and a mother of 4 children. She graduated from a now-closed nursing program in Queens in the 1960s, run by the same hospital group that owned many of the hospitals that closed in the 2008 financial crisis. For most of her early nursing career, she worked as a medical-surgical nurse at a hospital in Rockaway, Queens. In the 1990s she and a friend started a staffing agency that placed nurses in hospitals in Brooklyn, Manhattan, and Queens. She retired in 2007 when she sold the staffing agency.

**St Louis:**

Aye became a licensed practical nurse in 2009 and is currently enrolled in a part-time BSN program. His mom is a nurse and he’s always been interested in the medical field. He worked in long-term care as a CNA and now works in an acute rehabilitation unit. Originally from Nigeria, he plans to move to Dallas with his wife and two sons when he finishes nursing school.

David came to nursing after trying a few other career options. After realizing that real estate wasn’t for him, and that he was not going to make enough to support his family teaching at a Jewish school, he trained in the CNA program at a large hospital in St Louis City. After graduating from the hospital’s BSN program a few years ago, he worked at a specialty hospital and then home care for children before his current job, a rehab unit at the same hospital where he trained. He is currently training to become a nurse practitioner so that he can have more freedom and earn a better salary. David is a father of 3 children, married, and in his late 30s.

Faith emigrated from Kenya in 1998. She is long-time friends with Grace and Sophie, who helped her get set up in St Louis and were the reason she chose to move there. She worked for 2 years in South Africa and then in Israel for a period before coming the US. She has one child and is married, though her husband lives in Nairobi most of the year.
Grace is originally from Kenya, having come to the US to continue her nursing education in 1993. She earned a nursing certificate in Nairobi, and came to the US to complete her BSN. She chose St Louis because she had friends here from Kenya. She’s married and has one son. Her husband splits his time between Nairobi and St Louis, and they hope to move back to Nairobi in the near future.

Hope emigrated from Nigeria, coming to the US as a political asylum seeker in 1998. She’d earned her BS in biology in Nigeria, originally planning to become a pharmacist. By the time she was settled in the US, her biology credits were too old to count, so she had to retake many courses, and decided to train as a nurse instead. She currently works at two different rehabilitation institutes in St Louis, one in the city and one in the county, caring for brain and spinal cord injury patients. She is married, in her 40s, and a mother of 5 children, ranging from 2 to 17 years old.

Iskra came to the US as a refugee when the USSR broke up in the early 1990s. She and her daughter arrived in Omaha, Nebraska from Moldova. Though she had a BA in English literature, she also received a certificate in military nursing in the Soviet Union. When she came to the US, she decided nursing would be a stable job, so she enrolled in the RN program at Creighton University in Omaha. She has worked in many different units over her career, is currently working in a rehab unit.

Joy is originally from the Philippines, where she graduated nursing school in 1994 and worked in neonatal ICU and medical surgical unit, as well as in a school. Joy watched as her sisters became nurses, and she knew it would open up travel possibilities for her, so she followed their lead (her sisters are in Saudi Arabia and California). She immigrated to the US in 2002 with her husband, who is also an RN. They came to the US through a recruiter who placed them in St Louis. She works with her husband in the same rehab facility. She is a mother in her 40s.

Jennifer is a new nurse, completing orientation at her first job, early 20s, originally from rural Illinois. Came to St Louis for treatment of an eating disorder and wants to eventually get into that type of nursing. Is currently exhausted in orientation as she learns time management and how the unit works. Wanted to be a musician until a “life-changing event” where she was taken care of by nurses and wanted to be a nurse.

Joe retired from nursing in 2011. She’s originally from Chicago, and came down to southern Illinois in 1969 to get away from home. She wanted to go to college, and as she explains, at that time, her options were to either “be a nurse or a teacher.” Teaching wasn’t for her, but it turned out she really liked nursing. She spent most of her career working with long-term acute patients with respiratory issues. She spent the last decade of her career working as the weekend supervisor at a rehabilitation institute, from which she retired after a knee injury.
Katie is a new nurse in her late 20s. Graduated in the past year and found a job fairly quickly. She recently finished her orientation at her first job and works in the lockdown unit of a skilled nursing/acute rehab unit. She is white, single with no children, and from the St Louis area.

Linda is originally from the Philippines, where she trained as a nurse. Her two sisters are also nurses, and she followed them to the US. She and one of her sisters were placed in the same hospital in St Louis when they immigrated. She currently works at a rehabilitation institute in St Louis.

Mary is a nurse manager of a rehab unit at a hospital in St Louis. She has a long career having worked in many different facilities in hospitals and long-term care facilities in the Midwest and on the east coast. She is white, married, and a mother of 2 children.

Ruby came to Iowa from Nigeria for school in 1998. She trained in Iowa before moving to Missouri to get married and start her family. She trained as a phlebotomist to see if she like the medical field and decided it was a fit for her. She currently works as the weekend night shift supervisor for 3 units at a hospital in St Louis County. Ruby is also finishing prerequisites for medical school.

Ruth trained as a nurse in the Philippines. She followed her sister, who is also a nurse, to the US. Her credentials eventually transferred, but she worked as an assistant for a few months when she first arrived in Chicago. Eventually, she and her sister moved down to St Louis, where she currently works at a sub-acute care facility at a major hospital in the city. She is married, in her early 40s, and a mother of three small children.

Sharon retired from nursing 2 years ago after suffering an aneurism, from which she’s made a nearly full recovery. She is in her early 60s and is single with no children.

Sophie came to the US in 1997. When she first arrived, she stayed with Grace for the first while, In fact, Grace was the reason she came to St Louis; they knew each other from Nairobi. She completed her BSN a few years after coming to the US and has been working in St Louis ever since. She is a de facto single mother, as her husband has returned to Nairobi to live and work there (he didn’t like living in the States).
Appendix 2: Interview Guide for Nurses

Education History
- When and where did you attend nursing school?
- What was the degree program?
- Have you returned to school?
- Why did you decide to become a nurse?

Employment History
- Please describe your employment history.
- What specialties did you work in?
- Where did you work – facility and geography?
- Did you have any difficulties finding jobs when you wanted/needed them? Or when you looked for a change or promotion?

On Shifts
- What shift structure do you work? Have you work in other shift structures?
- What are the pros and cons of this structure for you? What changes would you make?
- What flexibility do you have in your scheduling? How flexible is your unit/workplace?

On Staffing
- What are staffing ratios like on your unit? Is it sufficient?
- What about at other work places?
- What changes would improve workloads on your unit? What are the shortcomings and needs?
- What works well?

On Quality of Care
- What do you think of when you think of “quality of care”? How would you define “quality of care”?
- What would you say is the state of the quality of care in the facility where you work?
- In facilities where you used to work?
- How have you noticed changes to quality of care over your career?

On the Nursing Shortage
- When did you begin to notice the nursing shortage? (Multiple times/phases?)
- How did it affect your daily work?
- What kind of talk did you hear from managers or facility administrators?
- What was the talk like around your co-workers (i.e., the floor nurses)?
• Did the shortage – and its impacts – influence your job decisions? (i.e., changes, promotions, facility changes)

**On Unions**
• Are you a member of a union? (If so, which one?)
• Is the union active in your workplace? Are you active in the Union?
• What do you know about or hear about nurse unions in New York?

**On Working with Migrant Nurses**
• Have you worked with many nurses who trained abroad? (migrant nurses)
• Where did you work with them?
• What was it like to work with migrant nurses?
  - work dynamics; comparative experience and knowledge; issues; Benefits?

**On Hospital Closures**
• Have any of the places where you worked closed?
• Any facilities in your neighborhood closed in past decade or two?
• Why do you think so many hospitals are closing?
• What are you hearing in the nursing and HC industry about why places are closing?

**Plans for the Future**
• What are your work plans for the future? (intend to stay in specialty? Current job? In the US? Intend to return to school?)

**Changes to the Profession**
• What do you think is the biggest change or challenge facing nursing? Health care in the US?
• What changes in nursing and health care have you noticed over your career?

**Questions Specifically for Migrant Nurses**

**Migration**
• When did you start to think about working abroad? Why? Where did you want to work?
• What kind of contact did you have with any recruitment agencies?
• What benefits and drawbacks did you see in working in the US?

**Immigration process**
• *If worked with a recruiter:*
  Please describe your immigration process from start to finish. Describe your relationship with the recruitment agency and what assistance they did (or did not) provide you.
• *If migrated without a recruiter:*
  Please describe your immigration process from start to finish.
- Why did you immigrate without the assistance of a recruitment agency? Did you consider the possibility?

**Settlement process**
- *If worked with a recruiter:*
  - Please describe your first few months after arriving in the US and how you found getting settled into work and life.
  - What support services did you receive from the recruitment agency during this time?
- *If migrated without a recruiter:*
  - Please describe your first few months after arriving in the US and how you found getting settled into work and life.
  - What support networks or individuals did you have to help you get settled?

**Relationships back home**
- Do you have friends and colleagues that have migrated to the US before or after you? Explain.
- Would you recommend working in the US to colleagues and friends back home? Please explain.

**The Foreign-Trained Nurse Community**
- In an estimate, how many nurses do you work with that were trained abroad?
- What kinds of support networks are you part of for nurses who were trained abroad?
- What is the relationship like between nurses who were educated abroad and those who went to school in the US?
Copyright Acknowledgements
