Making Gray Gold: A Twenty-Year Retrospective

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In keeping with the theme of this session, I am reflecting on the meaning(s) and implications of *place*, in connection with a critical ethnography of nursing home care that was published twenty years ago this year: *Making Gray Gold* (1992) by Timothy Diamond. This book has been important and influential, both in its voice and style—a first-person, narrative voice that reflected debates, then vigorous, about representation in ethnographic writing—and in its substantive focus on direct caregivers in nursing homes, who had been largely invisible, even in the ethnographic study of nursing home life prior to the publication of Diamond's book. Also important is the analytic strategy that underlies *Gray Gold,* that of *institutional ethnography* as elaborated in the work of Dorothy Smith and her many colleagues and followers in the U.S. and Canada (DeVault, 2006; Smith, 2005). I will argue that Diamond's book, which I have taught in various courses for more than a decade, was prescient in placing such workers, nurses' aides (or certified nursing assistants, CNAs, below), at the center of attention in long-term care. More, the author made a vital contribution by linking, explicitly, the routines and relationships of workers and residents, to social policy, i.e., reimbursement regimes under the Medicaid and Medicare systems. In making this connection, Diamond integrates neo-Marxian interest in the labor process, with investigation of the sentimental order of caregiving and of everyday life in total institutions (Goffman, 1961).

***The Impact of* Making Gray Gold**

Despite claims surrounding the scientific status of sociology in the positivist tradition, metaphor has always been a fundamental basis of theoretical insight (Nisbet, 1976). Diamond, alluding to an article a financial journal, "Gray Gold," about the profit potential in an aging society, takes the metaphor of extraction and industrial exploitation seriously. He writes, "A sociological approach which does not assume that care for older, frail people is naturally a business might ask how it is that their current expansion comes to be defined in those terms." "What is the process for making gray gold?" (1992, 4-5).

The book's reception and distinctive contributions are reflected in the reviews that followed its publication. Conway-Turner (1994), reviewing for *Gender & Society,* notes that Diamond had entered a setting, and reflected on work tasks and relationships, that historically have been almost exclusively the province of women. She also noted (1994, 132) the bitter irony in the book that the organization of nursing homes disempowers two groups that, at first glance, appear to be antagonists—residents and caregivers: "Older white women consume their life savings and find themselves in Medicaid beds, whereas middle-aged women of color, limited by a combination of racism and sexism, and restricted in their choice of caregiving occupations." Harrington-Meyer (1994, 407) applauds a portrayal in which "readers can see how the personal needs of residents are balanced against the goals of profit-oriented owners and budget-strained state and federal administrators." And Almgren (1994, 1380) argues that *MGG*

> "…is a unique and compelling illustration of the interplay between capitalism and stratification…..Diamond describes the productive process as one where quite specific reimbursable activities and supplies are provided to (extracted from) the institutionalized elderly in closely measured quantities, documented, and then processed for payment. The process of extraction has little to do with patient care, as care is understood in its common usage, because the professionalized, industrial model of health care recognizes and values a narrow range of activities that are only peripherally tied to the actual needs of….patients. "

In constructing an argument on these terms, Diamond's book meets the threshold of truly important ethnography—not only documenting a place and social order, at one point in time, but also posing and elaborating theoretical questions and empirical mechanisms that have broad and enduring significance. In concluding the discussion, I'll identify what I see as critical, current questions that grow out of the argument in *Making Gray Gold* (MGG below), and note ways in which concerns and insights of the book are evident in contemporary research and advocacy regarding long-term care.

But the theme of the session also calls for reflection on the nature of "place" in research, and on the assumptions, interests, and rhetorical choices by which places are constructed and *re*constructed in research. These are especially salient questions for ethnography, in which description and portraiture are so interwoven with theoretical meanings and policy implications. In *MGG*, Diamond renders the particulars of everyday life, through affecting vignettes, even as he challenges and expands the definition of what kind of place a nursing home is: in part, it is a workplace—even a kind of factory floor—in which the commodification of care is regulated and monitored in ways that seek to render the workers interchangeable cogs. A profound and subtle claim in the argument, informed by critiques of bureaucracy and insights of ethnomethodology, is the extent to which quasi-medical categories for documenting "care" come to govern how staff members perceive aged residents. As Diamond writes,

> "To be sick, frail, confused, disabled, or old is not the same as to be a patient. In becoming a patient in a nursing home one enters a social organization; patient emerges in the meeting of person and institution. Day and night, as boxes got checked and records reviewed, these people were entered into the administrative language and codes of what services were rendered to them. In turn, these terms, categories and codes came to be viewed by many staff and outsiders as the ultimate reality itself, rather than a small part of it" (1992, 126).

But, alongside this industrial metaphor is a call for nursing homes actually to be places of authentic community and self-determination, despite illness and disability. In some approaches to

reform, "culture change," in nursing home care, such as the *Eden Alternative*, the physical transformation of the setting—including plants, artwork, and other cosmetic changes—is promoted as an antidote to the medical model out of which nursing homes emerged historically. Whether in fact such changes alter more fundamental bases of commodification in caregiving (reflected in occupational hierarchies and achieved through textually-mediated controls) is very much at issue.

In an insightful essay, Vesperi (1995) argues that nursing homes, which emerged largely after World War II, have often resisted critical ethnographic attention because they seem to reflect inevitable, universal processes of death and decline, and also because of the ambivalence they provoke in a society in which familial responsibility for care continues to be assumed and idealized. Still, Vesperi asserts that, "Social Security, Medicare, and Medicaid have not just enabled but actually promoted the medicalization of old age" (1995, 10). Despite this connection, Vesperi argues persuasively that, like much ethnographic research, nursing home ethnography has tended to neglect larger, systemic, economic and regulatory conditions that impinge on everyday life. This tendency continues to be true, as evidenced by a recent (Stafford, 2003) collection on current themes in nursing home ethnography.

For example, in *Living and Dying at Murray Manor* (1975), a landmark study in its own right, Gubrium is acutely aware of the discrete "places" in the nursing home he studied, and documents the parallel, segmented nature of everyday life as it is lived, respectively, by residents, "floor staff," and "top staff" (administrators). Even the most dramatic episodes of everyday life, such as deaths among residents, are filtered through the distinctive relevancies and routines of the three groups; Gubrium concludes that "Three worlds of dying and death exist in the home, adhered to separately by top staff, floor staff, and clientele. When the participants of one world deal with [those] of another, they may make trouble for each other" (1975, 197). While invaluable in showing the internal complexity of the setting, the account leaves the reader without a clear understanding of what underlies this segmentation or, for that matter, how or why residents' careers might change

over time (independent of changes in health status). Gubrium concludes that "Each world provides its participants with a way of looking and understanding daily life….And each has its own logic: its own ideals, sense of justice and fair treatment, methods of expedience, prescribed duties, rhetorical style, and proper mode of making decisions" (*ibid,* 37). In *MGG*, by contrast, Diamond traces the experience of fragmentation and alienation in nursing home life to specific features of the funding and regulation of long-term care, and to the structure of bureaucratic authority that enforces this logic despite inadequate staff training and chronic turnover. Guided by the perspective of institutional ethnography, Diamond traces these recurring problems to sources well outside the ambit of the nursing home: federal regulations and policies that govern reimbursement; status distinctions within medical professions, which discredit "hands on" care and replicate the hierarchical model of the hospital; and a gender order—cross-cut with racial/ethnic stratification—in which such care is rhetorically exalted, even as it is trivialized as "natural" to women and, thus, unskilled. All of these themes, which have since been points of departure by scholars in many related fields, are interwoven with the everyday narratives of *MGG.*

***Legacies of* Making Gray Gold.**

Time permits me to address but two of the legacies of *MGG*, one substantive and policy-oriented, the other more analytical in nature. However, in the spirit of institutional ethnography, which informs the book, one is reluctant to dichotomize the two.

Attention to the Direct Care Workforce

First, the attention among researchers and policy makers to direct care workers, such as CNAs and home health aides, so scant when *MGG* appeared, has exploded in the past decade or more. This is evident not only in dozens of journal articles, but also in websites such as "4CNAs," (with extensive information about training, certification, and comparative features of work settings), advocacy groups such as the *Direct Care Alliance,* and in reports from the *Bureau of Labor Statistics*. A current BLS profile reports that,

> "Nursing aides, orderlies, and attendants held about 1,505,300 jobs in 2010. The majority of nursing aides, orderlies, and attendants work in nursing and residential care facilities. Others are employed in hospitals, home care, and hospices…. Because of the growing elderly population, many nursing aides, orderlies, and attendants will be needed in long-term care facilities, such as nursing homes. Growth in the demand for healthcare services should lead to increased opportunities for nursing aides, orderlies, and attendants in other industries as well, such as hospitals and clinics. Demand …may be constrained, however, by the fact that many nursing homes rely on government funding, which tends to increase slower than does the cost of patient care." (BLS)

The Direct Care Alliance (DCA) has become a clearinghouse for research and advocacy regarding this segment of the workforce, for example, seeking to extend basic labor rights (such as minimum wage and overtime protection) to workers who, historically, have been defined as "mere companions" and thus exempt from such protections. Research sponsored by the DCA documents the continued depression of wages—median annual full-time salaries in the field are roughly $24,000—and rates of workplace injury that are significantly higher even than those in the construction industry.

Increasingly, the plight of direct care workers is seen as central in the larger challenge facing women workers in America's service economy. Indeed, occupational groups such as CNAs and home health aides represent the largest (both in numbers and as a proportion) and fastest growing in the service economy generally, with wide-ranging implications for the economic well-being of women and children (not to mention those for whom they care). With the eldest of the 60 million baby boomers reaching retirement age, and new consumer preferences and legal rights centering on autonomy in home and community-based care, the cadre of direct care workers will continue to grow rapidly; this is true for nursing homes, but even moreso in assisted living and home health agencies. For women without higher education, the lure of direct care work is strengthened by the humanistic desire to do meaningful work that enhances others' quality of life. Yet, the fortunes of what will be millions of workers are stymied by a combination of poor wages (constrained by low reimbursement rates set by government) and benefits, and a training regime that, as Diamond showed, emphasizes instrumental aspects of care, to the detriment of socio-emotional and communicative skills that are required, especially, for the growing numbers of clients with cognitive impairment.

A promising trend, albeit with much variation across states, is the revision of curricula for certifying nursing assistants, over the past decade or so. Reports from those who have recently been certified indicate a far more broad and rigorous training process than was described in *MGG*. Some states require up to 40 hours of class-time, along with twice as many clinical hours. Attention is paid to residents' rights and ethical dilemmas; the *continuum of care* and characteristic challenges for elders in facing residential relocation; and behavioral changes and care strategies for those with dementias. As the discussion above makes clear, without more wide-ranging reforms (in compensation and working relations with others in the field of long term care), enhanced training will have only limited impact. However, as part of a broader strategy of occupational mobility, this is a necessary—if not sufficient—trend, and one which can only enhance work satisfaction and, in turn, help in slowing what have been staff turnover rates that range from 40 to 90 percent annually (for a recent report, integrating attention to education and training, see Wellin, 2008).

Along with efforts at *professionalizing* direct care staff, through more rigorous training and credentialing standards, there are exciting instances of collective action that have complemented and strengthened those efforts. According to the website for the San Francisco In-Home Supportive Services Public Authority (http://www.sfihsspa.org/):

> In San Francisco, the Public Authority and others have fought hard to improve workers' wages and benefits. As a result of advocacy efforts by the IHSS Task Force, SEIU-UHW, Consumers in Action for Personal Assistance (CIAPA) and the Public Authority, IHSS Independent Providers (IPs) received a significant wage increase of 58 cents above minimum wage on January 1, 1996.
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> At the beginning of 1997, the Public Authority and other parties dedicated themselves to the "Living Wage Campaign," initiated by Local 250. The campaign asked Mayor Willie Brown to budget $8.00 per hour plus benefits for IPs. PECC and the IHSS Task Force began a postcard campaign and 2,000 postcards were sent to the Mayor in support of a living wage. CIAPA organized a Living Wage rally in May, and the Senior Action Network included the Living Wage as an issue in their June rally. In July everyone's hard work paid off when the Board of Supervisors approved an IP wage of $7.00 per hour, to be effective August 1, 1998, and agreed to fund the medical plan for IPs, which started in March 1999. In late 1999, the County agreed to fund a dental plan, which started in January 2000. The IP wage was increased on a semi-annual basis, reaching $11.54 plus fringe benefits in 2008.

The Emergence of Institutional Ethnography

In grappling with the problematic of linking the local and systemic dynamics of life and care in nursing homes, Tim Diamond was guided by the perspective of institutional ethnography (IE). This approach, which grew out of work by Dorothy Smith (2005) and colleagues, has flourished

since, as evidenced by the vital division, devoted to IE, in the SSSP, and in a large and coherent literature by scholars and activists in Canada and the U.S.

Drawing on Marxian insistence on historical materialism, as well as on ethnomethodology, IE recognizes the dominance, in contemporary forms of hegemony ("ruling relations") of texts in mediating and governing far flung systems of administrative control. This stance, which transcends topical and empirical boundaries that have come to define contemporary academic sociology, is nonetheless grounded in the ethnographic analysis of daily work *practices* by which the actions in a particular setting are reconciled with and accountable to plans and goals imposed from without. Marjorie DeVault, in an introduction to a collection of IE studies in the journal *Social Problems,* writes that "Ruling relations is not a heuristic device and does not simply point to 'structure' or 'power,' but instead refers to an expansive, historically specific apparatus of management and control that arose with the development of corporate capitalism and supports its operation" (2006, 295).

Other visible examples of the relevance and need for such a stance include teachers laboring under the testing regimes of *No Child Left Behind,* and medical clinicians under prospective payment systems as part of "managed care." In both cases, one sees tensions regarding occupational autonomy, even as the overarching rhetorics purport to uphold (and rationalize) professional goals. IE took root as part of a commitment to construct a sociology *for women*, and the groups understudy have often been traditionally women's occupations (e.g., teaching, nursing, social work) though not necessarily so.

In the years since the publication of *MGG,* institutional ethnography has advanced through an agenda that integrates description and conceptual development aimed at *mapping* the nature and consequences of textually-mediated policies and practices; these emanate not only from governmental and corporate entities, but in the non-profit sector as well. Indeed, IE provides a grounded, empirical method for advancing the analysis of *institutional isomorphism* as defined by DiMaggio and Powell (1991), which so energized organizational studies in roughly the same period.

In conclusion, the explicit application and integration of IE research, across multiple settings of the healthcare system, broadly-defined (spanning national, policy and organizational domains), promises to galvanize insights, not only into paid caregiving for the aged and disabled, but also its myriad interconnections with family, gender, and social inequality more broadly.

(***To conclude:*** Bring in the didactic advances, as in the book by Campbell and Gregor, and sharpen the sense of what the focus is/should be of IE research on institutional care in the future.)

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