Intimate Labors

Cultures, Technologies, and the Politics of Care

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From Objects to Affect

Ariel Ducey

IN THE LITERATURE on caring labor, technology has arguably been viewed as nonessential to caring relations or a barrier to them—when technology is considered at all. There is certainly evidence from health care settings to support such a perspective: Nursing home patients, for example, can often be found summarily parked in front of televisions, "nursebots" threaten to substitute for human interaction, and bureaucratic forms and information systems recognize only those activities amenable to the calculation of productivity and profit.[1] All of these undermine caring labor, especially when it is understood as a "face-to-face service that develops the human capabilities of the recipient."[2]

Yet a conception of caring labor that does not make face-to-face or human interactions so central would hew more closely to what frontline health care providers do and the more varied part technology plays in their work. Caring labor, more broadly conceived, enhances capacities to affect and be affected—arguably for those who provide care as well as those who receive it. Some recent radical political theorists have therefore opted to call it "affective labor"—meaning laboring practices that produce "first and foremost a 'social relationship,'" according to Michael Hardt, or "produce collective subjectivities, produce sociality, and ultimately produce society itself," in Maurizio Lazzarato's words.[3] This conceptualization suggests the wide array of situations and settings in which affective labor takes place. It also rightly brings to the foreground that sociality is actively produced and that those who produce it do labor of the most necessary kind.

Michael Hardt and Antonio Negri, however, have further argued that affective labor is one face of "immaterial" labor—which generates the cultural,

informational, and symbolic aspects of commodities. The process of affective labor may be corporeal, they acknowledge, but its products are "intangible, a feeling of ease, well-being, satisfaction, excitement, or passion."[4] In so doing, they have written technology out of the story of caring (and affective) labor. By depicting caring labor as unique because of its nontechnological or immaterial character and acknowledging only its corporeal elements, they not only create a partial image of the process of caring labor—one that offers little resistance to the gendered notion of caring labor as primarily emotional and innate—but also disguise material shifts in the nature of contemporary sociality and strategies for governing bodies, subjects, and populations.[5]

This chapter draws on concepts of objectualization and affective technologies to suggest how technology might be theorized in relation to caring labor in a way that is felicitous to what caring laborers do and the political and economic forces that shape their work. While these concepts involve different notions of technology, they share in making it integral to human relations and the laboring practices that enhance capacities to affect and be affected. Their relevance is especially apparent in the world of health care work, in this case in the New York City hospitals and health care facilities where, beginning in the mid-1990s, "restructuring" policies premised on neoliberal principles of an expanded role for markets and profit making drove health care politics and policy. Theories of objectualization and affective technologies both attempt to reimagine changes arguably linked to the rise of neoliberalism, changes often characterized as entailing increased individualization and the retraction of traditional social forms and structures, such as the state, that previously anchored identity and social order. Certainly in New York City's health care sector, as politicians attempted to withdraw the state from its role in subsidizing and regulating health care, one of the few new programs they were willing to support was hundreds of millions of dollars to train health care workers for the jobs of the market-based future—and thereby shift responsibility for any deterioration in working conditions and patient care that accompanied the market onto individual workers.[6] Yet the concepts of objectualization and affective technologies draw attention to how technology—literal objects on the one hand and new techniques and practices of governing on the other—destabilizes a simple story of growing alienation and exploitation in health care under neoliberalism and caring labor in restructured health care institutions.

Karin Knorr Cetina has conjectured that the corollary of individualization and the withdrawal of older, traditional social and institutional forms has been

the heightened importance of relationships with objects, "an increasing orientation towards objects as sources of the self, of relationship intimacy, of shared subjectivity, and of social integration." Therefore, we have not seen a "loss of texture for society" but "what the texture consists of may need rethinking." "Postsocial" society, Knorr Cetina argues, is not asocial or nonsocial but characterized by new kinds of relations that have not previously been considered social.[7] This is most apparent in the case of the knowledge objects of expert and scientific cultures, for instance in the biologist Barbara McClintock's relationship to maize, and plants more generally, which was marked by desire, bondedness, and moral in addition to epistemological dimensions. The nature of McClintock's attention to her plants enabled her to see (in the visual and imaginative senses) the possibility of the exchange of genetic information between chromosomes well in advance of colleagues using techniques regarded as more technologically sophisticated.[8] Knorr Cetina argues such relationships with objects are characterized by a wanting or lack. Knowledge objects indicate both what is missing in our understanding of them and what we should be wanting to know about them—unlike objects that are tools, which raise no questions, or are commodities, from which we can be alienated. Knowledge objects are continually unfolding in conjunction with our own subjectivity and epistemic powers. Moreover, these relationships are neither solely cognitive nor necessarily the source of positive emotional ties; they can be imbued with ambivalence and distance, as well as elements of power and domination.

The implications of this argument for cultures, relations, and institutions of caring are several.[9] Knorr Cetina draws attention to the possibility that the type of things or beings in a relationship does not determine the quality of the relationship—that is, whether that relationship can be intimate or, more specifically, caring. Care can be extended to things, just as people can be treated like tools or commodities. Although objects are not usually considered the focus of concern in institutions and relationships that provide care, the objects that figure in such institutions can arguably become the source of intimate and caring relationships in their own right or the basis of unfolding awareness and what Bruno Latour would call increasingly articulate bodies.

My own fieldwork in health care settings presented examples of the centrality of objects to the daily lives of health care workers, including their sense of themselves and their ability to provide caring labor—even for nursing assistants, who are usually viewed as providing the most hands-on and least technological aspects of care, whose jobs would seem the least tied to a world

of things. For instance, everyday tools and devices took on some of the dimensions of knowledge objects when they became problematic, when they ceased to be simply "ready-to-hand" and transparent.[10] On one unit I observed, a "step-down" unit between acute and long-term care, both showers on the floor were unusable—one was broken, and the other had no hot water. The nursing assistants were required to offer showers to their patients every other day, but the patient charts left space only for the nursing assistants to record whether a shower had been given or "offered but refused." Unsurprisingly, there was no space for the nursing assistants to write "shower not working" or "cold shower refused," and the unit supervisor told all the staff in a meeting that she did not want this information documented anywhere. Yet it was the nursing assistants who would face questions and blame if patients were not showering regularly. So, one resourceful nursing assistant in the meeting related, in detail, a procedure that a maintenance staff person had explained to her for coaxing hot water out of the shower, which required knowing what time of day there was most likely to be hot water and fiddling with the water nozzle in a particular way. Nursing assistants and nurses were often likewise absorbed in getting wheelchairs, feeding tubes, scales, and blood glucose meters to work right. These objects sometimes required more time and attention than what might typically be imagined as caring activities, such as conversations with patients. And while some of this attention was that of frustration at routine malfunctions, it could also be the source of experimentation and innovation, eliciting skills and accomplishments that made their work richer and more interesting. Such frontline health care providers were continually adjusting, and adjusting themselves to, the objects and equipment around them.

Knorr Cetina also suggests objects may become an "embedding environment for the self," that is, they constitute contexts and settings for belonging,[11] which is arguably why missing or malfunctioning objects had an impact on the sense of self and security of health care workers who needed them. I watched one nursing assistant tell a patient who had been vomiting that the unit was out of toothpaste. She made do and gave the patient a lemon-scented glycerin toilette and a bowl of water instead but felt personally at fault for not being able to provide toothpaste. The nursing assistants at another facility were similarly chagrined that they had to tell diabetic patients the hospital had stopped carrying sugar-free ice cream. One male nursing assistant pointed out to me, while helping a patient shave in the shower, that the hospital razor blades were useless because they were purchased at ten for ninety-nine cents.

One nurse, sitting at the nurses' station doing paperwork, said with some irritation to those around her, "How can we work without scissors?" Even though outcomes for patients do not seem to hinge on these objects, they are nonetheless important to health care workers because they are the things that can make patients feel better when so much else is going wrong; they can have a disproportionate effect on how patients perceive the care they receive. And frontline staff, like nursing assistants, are most likely to bear the emotional consequences of patient dissatisfaction. These gaps in a world shaped by objects, or holes in the workers' embedding environments, support Knorr Cetina's thesis about the significance of object environments to belonging and identity. These staff are made to feel through objects—in this case incomplete and inadequate—that their work and their needs are not very important.

The perspective I am moving toward therefore foregrounds objects and technologies, such that they are the structure on which sociality, and the caring labor that produces it, hangs. As a heuristic device, we could conceive of relationships—even those with and between people—as entering into and negotiating a framework of objects and technologies, rather than objects and technologies being incorporated into a network of personal relations. The dynamic is more accurately one of ongoing and mutual construction between objects and subjectivities, but the heuristic puts objects on the same plane as interpersonal relations and matters of individual motives and decisions. Objects are intertwined with caring relations—they are not just intermediaries in them. Objects may be artificial, or constructed, but their evolution, effects, and meaning are not entirely given at the beginning.

Furthermore, the technological infrastructure on which care hangs includes not only specific objects and devices, but—in a more Foucauldian vein—mechanisms, techniques, and technologies of power. The latter create and/or foster the objective conditions for not only enhancing affective capacities but also channeling such capacities into behaviors and expressions that support existing structures of power and domination. In the case of caregiving in formal health care settings, such techniques and practices include, for instance, public and private policies on wages and immigration that influence who will be more likely to find him- or herself performing caring labor (namely women and the poor) and on what terms. Such policies create obdurate realities—a network of practices, advice, bureaucratic procedures—and even condition how those people will feel about the caring labor they are doing.

This observation alone is not new. Existing institutional structures and

and relations are actualized. Ideas and ideologies inform this process as well. What appears to be new, however, is the attempt to subject the capacity to affect and be affected to ruling relations, via technologies aimed at an affective level. As Brian Massumi argues, the "affective modulation of the population" is "now an official, central function of an increasingly time-sensitive government," seen, for example, in the color-coded terror alert system created after 9/11—which was intended to create a perpetual level of readiness to the threat of terrorist attack and therefore has never dipped below yellow, or "elevated."[12] According to Massumi, there are two levels "at play" in any event: that of intensity, a state of suspense, of potential disruption; and that of semantics and semiotics, of language, narrative, and expectations. These two levels resonate with one another; their vibrations are sometimes dissonant and other times harmonious. Affect is "their point of emergence" and "their vanishing point," where the vibrations between the levels either emerge as something actual or fade into the virtual. Affect therefore shadows every event. It is the source of the unexpected, of the unmotivated, of surprise. The level of noncognitive intensity is autonomous from what emerges in consciousness, but it is nonetheless the realm of potential from which any cognitive realizations will be drawn. Cognition—the realm of language and decision-making—reduces intensity, converting suspense into expectation.[13] To intervene in affect, as does the terror alert system, is therefore to attempt to control or modulate how intensity becomes expectation, action, and decision.

The training industry for health care workers that emerged in New York City in the 1990s could also be construed as a means of affective modulation, especially (but not only) in the ubiquitous talk of the market in, and the incorporation of workers' bodies into, "soft skills" training seminars. As I have examined more closely elsewhere,[14] in New York City during the 1990s, private hospitals and 1199/SEIU United Health Care Workers East, the union representing frontline workers in those hospitals, leveraged billions of dollars from state and federal officials to prepare for presumably radical changes underway in the health care sector. The newly elected Republican governor and mayor favored policies that shifted patients from Medicaid (the state's single largest budget expenditure) into managed care plans and forced hospitals to behave as if they were in a market by, for instance, bidding competitively for payment rates from private insurers. Such changes threatened the sizeable proportion of hospitals' revenue that either came from or was guaranteed by the state, and hospital leaders used this environment to argue that wage increases

in the corporate sector the only way to save themselves. Dennis Rivera, then president of 1199, opted to partner with the leaders of the private hospitals to fight the new policies. The partnership was not without contradictions for the union and its members, and its chief result was a health workforce training industry to which the state claimed it had contributed $1.3 billion by 2005.[15]

The most common training programs were for "multiskilling" (that is, training nursing assistants to take on some of the tasks of nurses), individualized upgrading, and "soft skills" training—the single largest category of spending and my focus here. Tens of thousands of New York City hospital workers were sent to training seminars in areas such as customer service, communication skills, team building and teamwork, cultural diversity, conflict resolution, and leadership training.[16] In 2001 and 2002, I observed such courses in three settings—a communication skills program at a private hospital, a "retreat" on teamwork and customer service for employees of a public hospital, and in-services at one of the city's largest (and recently unionized) home health care agencies. In those courses, an infrastructure of techniques and practices to mold and redirect the affective capacities of the allied health workforce took shape.

By affective capacities, I do not mean emotions and feelings, which these courses sometimes addressed. For instance, the courses directed frontline health care workers to take responsibility for managing the emotions of others and subordinate their own feelings to the larger cause of getting along. The longest section in the communication skills course was on anger management, during which the instructor advised participants not to "stuff" their anger but to express it—only with "respect and calm." In this sense, such courses very much recall the training for flight attendants documented by Arlie Hochschild thirty years ago. In the in-services for home care workers, participants were told to imagine their patients as family members, or themselves as patients in the future, just as airline managers told flight attendants to think of the cabin as their living room. They also resembled the training Hochschild observed in their demand that workers align their emotions, bodies, and behavior to the goal of profit making.[17] Instructors I observed asked health care workers to compare their hospitals to Microsoft, McDonald's, Disneyland, and Singapore Airlines, and themselves to Donald Trump and Bill Gates. Patients became "customers" or "clients" and clinical services "product lines." Private consultants, some new to the world of training altogether and others possessing proprietary training packages they had long offered to private businesses, created presentations tailored for what they saw as the "un-

Perhaps unsurprisingly, much of this soft skills training conveyed that the responsibility for ensuring high-quality care lies with those on the shop floor. The problems course participants raised—shortages of staff and supplies, too much paperwork, and too little time with patients—had all been exacerbated or created by restructuring reforms, which were largely means of lowering costs by shifting as much work as possible onto the least-paid workers. When instructors considered these conditions at all, they were framed as problems the workers themselves could change—if they demonstrated qualities of responsibility and self-management. As the communication skills instructor succinctly put it, "the most fertile area for greater control lies within the self." A lack of supplies and staffing were part of the cold, hard realities of a market-driven health care sector for which the workers needed to prepare themselves. What were in workers' control, on the other hand, were their attitudes and willingness to work together as a team, both of which could potentially improve the hospital's image and "customer" satisfaction. The communication skills instructor took such logic an additional step and argued that improved customer satisfaction might, in turn, create more business for the hospital and therefore the revenue necessary for supplies and greater staffing levels.

Yet sometimes participants' skepticism of such messages forced the instructors to shift gears. In the communication skills class, participants questioned the instructor's command to "give themselves enough time" to get their work done. They felt the main problem was not their time-management skills but continual understaffing. When the instructor of the retreat asked participants to write an advertisement for their hospital and read them aloud to each other, one nursing assistant had to stop reading hers after the line "anyone is welcome—good credit, bad credit" because the laughter was so loud. The ad cleverly imitated a type of advertising directed only at poor communities, in which businesses offer guaranteed loans to even those with bad credit for outrageously high interest rates. (Or consider ads for renting furniture on credit, which are never seen in affluent neighborhoods.) The participants' laughter suggested that if they saw the hospital as a business, it was as one that serves and suckers the poor at the same time. The nursing assistant's "ad" pointed out that the hospital could not in fact shape its "clientele"; the public hospital could not deny someone care on the basis of his or her ability to pay. The camaraderie in the room this advertisement produced came at the expense of the hospital and course instructor's message.

In light of such resistance, to the extent the course instructors could chan-

employer or a market-based health care system, they had to do so at a level that was not explicit and not even predictable. If they were to be effective—from the perspective of control—it could not be simply or primarily at the level of ideology. Whether or not planned, it seemed to me that those who taught and developed these courses hoped participants would not think about them too much. The courses were not meant, in the end, to be taken literally or consciously evaluated and assessed. Emotions and feelings are affectivity made conscious or actualized, and in these course instructors sought to move beneath consciousness.

For example, the training courses focused not on the working conditions and stresses workers faced but on the future changes to their work that would be caused by the presumably inevitable introduction of market mechanisms into health care. The "market" was held up in a pure, idealized form as something always in the future, something for which health care workers must always be prepared. As Massumi says of the "threat" signaled by the terror alert system, it "bore precious little content," and the "alerts presented no form, ideological or ideational." The threat was neither specified nor named—no one was told (if it was even known) the source, nature, and location of the threat. Threat exists only in the future, yet "its future looming casts a present shadow, and that shadow is *fear*."[18] The market, too, cast a shadow of fear in the training seminars and became a placeholder for almost any change to the nature of health care imaginable. Given this lack of content or form, the market was something for which these workers could never, in the end, prepare. Rather than working through reason or emotional appeal, therefore, the courses functioned by habituating workers through fear to expect—and accept—anything at all imposed in the name of the market.

The courses were at points even indifferent to their manifest (conscious, measurable, observable) effects, including the specific emotions they evoked. At the retreat, the instructor had the participants play Pictionary, in order, she said, to unite team members with a common goal—"to win." During the game, however, the overwhelming emotion in the room was that of stress and tension. None of the participants had played Pictionary before, and some were clearly intimidated by it. Not only was there a sense of competition with other teams, but there was tension even within teams because various members caught on to the game more quickly than others. The emotions evoked hardly seemed conducive to improved workplace relations. The exercise created an environment in which emotions were set loose with no means of containing

or directing them. I asked the instructor later about the logic behind having the group play Pictionary. She said,

> I thought Pictionary is a very interactive game, and also part of psychology is you ask people to draw their feelings, and how they express themselves is how they're feeling, so it also brings them to a lower level where they're not thinking, they're not analyzing data, they're just doing it spontaneously, and we want some spontaneity.

Though partially a rationalization of the exercise, her comment did seem to pinpoint how the game worked. The exercise could not be called effective in terms of conventional outcomes because it was, as Massumi says of the terror alert system, an attempt to "capture spontaneity" and habituate participants to the techniques of affect modulation.[19] The instructor spoke of drawing out the participants' feelings, but she was not, in fact, much interested in their specific feelings—only in triggering action. As one pharmaceutical marketer told medical anthropologist Emily Martin about the purpose of prescribing combinations of multiple drugs—"cocktails"—to those with manic depression, it is not necessarily to achieve a state of equilibrium but "a sort of mania or hyper-alertness."[20] Playing Pictionary was not so much a game in emotional management as in emotional provocation, tapping into a realm of virtual energy and hoping it would, in its openness, be amenable to managerial and ideological control.

Agnosticism or ambivalence is intolerable in a biopolitical regime based not on discipline and control but on the possibility of increasing capacities of a population—to be productive, to be "healthy" rather than not sick, to make live rather than merely let live.[21] Under such a regime, alienation or disengagement is more troubling than hostility or resistance—the latter are, at least, active positions. Much of the training I observed seemed targeted to produce any kind of engagement, and thereby risk resistance, for the chance to appropriate that energy and channel it into greater productivity and commitment to paid labor. Such training, now part of the "texture" of sociality, is a piece of an infrastructure for the explicit and continual modulation of moods and capacities that remake sociality.

The same type of modulation was evident in the handling of the bodies of course participants. At the end of the long training day, the retreat instructor led an exercise in which she asked three participants to leave the room with her for a few minutes. When they came back, she had them stand in a line

in front of the class, with their arms around each other, and asked a fourth participant—who had remained in the room—to join them at the end of line. She then asked the four people in the line to close their eyes and silently count down from one hundred. When they opened their eyes, the instructor asked the fourth participant, on the end of the line, to raise her free arm. The instructor pressed down on her arm and observed that it was stiff and firm. She then asked the group to again close their eyes and count down from one hundred. This time, when she pressed down on the fourth participant's raised arm, the instructor commented that it was loose and free. She asked the fourth participant how she was feeling. "Kind of sad," she replied. A fleeting look on the instructor's face showed this was not the answer she hoped for, but she proceeded undeterred. The instructor revealed that she had told the group of three to think of something bad the first time and something happy or pleasant the second time. So, the fourth participant's arm was more loose and free the second time supposedly because she had picked up on the bodily energies of those physically connected to her.

Thus, the lesson was, apparently, about how emotions and moods are physically embodied and can be directly transmitted through touch (though the instructor did not elaborate much on the purpose of the exercise). My impression, as with the Pictionary exercise, was that the instructor hoped to bypass conscious reasoning and articulated emotions (which, after all, could be the source of much trouble for the instructors and hospital management) and gain access to and channel a sort of collective energy more directly. The focus on the bodies and energies of the workforce is significant; the trainer recognized that workers' dissatisfaction with their work is embodied, so that a more direct route to adjust their attitude toward their work might be through their bodies or through the precognitive level that conditions which emotions or attitudes can be expressed.

As Bruno Latour has pointed out, bodies are "interfaces" that become more and more distinct as they learn to be affected by more and more elements of the world. And it is through "artificial setups"—what I have been calling objects, technologies, techniques, and practices—that bodies become more sensitive to differences of the world, more articulate. These setups are not merely vehicles through which subjects become more aware of an exterior world—they are extensions of bodies and parts of the world that allow for more, and open-ended, propositions about the world, for becoming more sensible to differences.[22] While Pictionary may be a crude setup, it suggests that

the instructor recognized that, to be effective in her assignment, she needed to capture something other than workers' hearts and minds, which it turns out are not easy to manipulate, especially under conditions of overwork and exploitation. How can people be motivated to care—about their jobs, their patients, their employers—when all objective indicators suggest there is little care for them? Affective interventions, techniques, and technologies are the contemporary mode of governance in a society that is anchored by injustice and inequality that is, arguably, increasingly apparent and difficult to rationalize. The training programs described here aimed to intervene in affect, which shadows but is independent of consciously modified emotions or feelings. As Patricia Clough has put it, "even when appealing to the human subject," affective technologies "aim to affect the subject's subindividual bodily capacities, that is, capacities to be moved, to shift focus, to attend, to take interest, to slow down, to speed up, and to mutate."[23] Or, as Massumi has argued about the U.S. color-coded terror alert system, it was meant to trigger readiness at a "presubjective" level.

These dynamics—objects becoming embedding environments of the self, governmentality that is focused on affective modulation—are not limited to settings of institutionalized health care and can elicit reactions and emotions other than care.[24] Yet the way in which objectualization and affective modulation intersect with institutions and relations of caregiving is particularly important because care produces society itself. When the processes of objectualization and affective modulation change caregiving, it raises concerns about whether the "care" produced is genuine or meaningful and therefore capable of producing "society itself." In my view, however, this concern also leads to a knot of motives and perceptions that is impossible to untie: What do health care providers really feel? What drives them to do their work? We might focus instead on the seeming reality that acceptable and effective care has long been provided by people with a range of motivations. Gabrielle Meagher has argued that the basis of good care in situations of paid caring labor need not be feelings of affection, like those we typically expect in familial and unpaid caring relationships (though, of course, those relationships, too, are more complex than is often acknowledged).[25]

The "technology" of affective modulation in the soft skills training I observed is troubling because it seeks to align care with bureaucratic and commercial ends, but it does not predictably produce superficial care compatible with profit making. The shift toward techniques of affective modulation is an

acknowledgment of the complexity of social life and therefore governing, or the impossibility of a correlation between "official speech or image production and the form and content of response." Affective techniques address "bodies from the dispositional angle of their affectivity, instead of addressing subjects from the positional angle of their ideations."[26] Such an angle, however, entails risks. In some moments, soft skills training courses triggered a form of collective solidarity and heightened awareness of the unjust demands made of frontline health care workers.

Objectualization, similarly, could create new solidarities or even a greater range of caring interactions—including those with objects. Health care workers are sometimes inspired by the objects around them to invest more in their jobs, to learn more, and to challenge themselves. The objects and technologies become reasons for doing the work and doing it well. Relations with objects are integral to helping patients. It is perhaps not surprising that computer designers are experimenting with machines and interfaces that encourage greater emotional reflexivity. They recognize that emotions are an emergent property of bodies and interactions, so the technologies—which might have applications in health care—are designed not to narrow or control emotions but to enhance their richness and complexity.[27] In this way, we might imagine technologies or techniques that create more fertile conditions for the emergence of care, which multiply—rather than classify and reduce—the motives and emotions compatible with caring relations.

According to Latour, the normative position of those who study science (and caring or intimate labor!) might be "the more mediations the better."[28] The more artificial setups, the more chances there are to become more articulate, more sensible to differences, and more capable of affecting and being affected. This implies a different conception of the possible relationship between care and technology than that of interference or incompatibility, whether the setups are objects like nursebots or soft skills training. Still, technologies, objects, and techniques may block the capacity to affect and be affected, especially for certain bodies and subjects, which a complete normative position must recognize as well. So too it might not always be desirable to be "open" to affecting and being affected.[29] In particular, the demand that workers remain ever ready for, and open to, the effects of the market can lock them into a disposition of fear, while those who stand to profit from these workers' labor in turn frame them as fearsome because they are underprepared and threaten the survival of health care institutions. Fear, Sarah Ahmed points out, "works

to restrict some bodies through the movement or expansion of others."[30] Endless preparation for, and fear of, the market forecloses imagination and preparation for other sorts of futures, and in the world of health care imagined alternatives are urgently needed. Yet it is not technology that stands in the way of the actualization of care—technology will likely rather prove to be an essential ally in that process.

Notes

1. The example of televisions is from my experience in health care settings. On nursebots, see Folbre, 2006; on patient charts and how activities such as talking to patients are excluded from them, see Diamond, 1992. Some examples in this chapter have also appeared in my previously published work. See Ducey, 2009, especially chapter 5, "More than a Job"; Ducey, Gautney, and Wetzel, 2003.
2. England, Budig, and Folbre, 2002: 455, 459.
3. Hardt, 1999; Lazzarato, 1996: 138.
4. Hardt and Negri, 2000: 292–293.
5. Hardt and Negri may downplay the technological aspects of affective labor because it does not readily fit their political message—that precisely because of its immaterial character, those who do such work are less dependent on capitalists to provide the "means of production" and thereby freed from a fundamental constraint on the possibilities for the formation of alternative solidarities and economies.
6. For a discussion of the universal appeal of job training to politicians, see Lafer, 2002.
7. Knorr Cetina, 1997: 23, 27.
8. Keller, 1983.
9. Knorr Cetina, 1997: 2.
10. Objects do not have the same status all the time and may circulate among the states of knowledge object, tool, and commodity (Ibid.: 10).
11. Ibid.: 24.
12. Massumi, 2005: 32, 35.
13. Massumi, 2002: 26–27, 32–33.
14. Ducey, 2009.
15. Commission on Health Care Facilities, 2005.
16. Other major areas of spending were on computer skills training and, by the end of the 1990s, training more nurses. See Ducey, 2009: chapter 3.
17. Hochschild, 1983.
18. Massumi, 2005: 32, 35.
19. Ibid.: 33–34.
20. Martin, 2006.

21. Foucault, 2003.

22. Latour, 2004. Latour provides evocative examples of how bodies interface with artificial setups, but see also Wissinger, 2007 on the case of fashion models.

23. Clough, 2004.

24. On affective modulation in other contexts see, Clough and Halley, 2007.

25. Feelings of affection may very well arise between caregivers and those for whom they care, but "these feelings are not—or even cannot be—a necessary basis for good quality care." Meagher argues there are a number of other possible motivations to care, such as the bond of a contract, a sense of professional duty, or compassion, which enable "good enough" care (Meagher, 2006).

26. Massumi, 2005: 33, 34.

27. See, for instance, Boehner et al., 2007; Sengers et al., 2008.

28. Latour, 2004: 219.

29. Lisa Blackman raises important critical questions about how, in much recent work on affect, the "subject" is considered in a generic mode and all movement/becoming is uncritically considered desirable (Blackman, 2008).

30. Ahmed, 2004.

3 The Transmission of Care

Affective Economies and Indian Call Centers

Kalindi Vora

"THE BANGALORE BUTLER is the latest development in offshore outsourcing," announces Steve Lohr in a *New York Times* article, referring to the growth of long-distance customer service into the realm of personal assistants and primary and secondary school tutors.[1] The *Bangalore butler* is a compelling phrase, redolent with a fantasy of the luxury of British colonial India, where brown men in crisp white uniforms and turbans served meals on silver platters to smartly dressed colonials, allowing them not only to get their work done in an unmanageable Indian environment but to experience indulgence and pleasure. The image is apt because the outsourcing of personal care and assistance creates the potential for middle-class Americans to use more of their time as they please without sacrificing the feeling of having personal attention and service.

Indian workers occupy particular positions in the international division of labor as a result of the material conditions India inherited from the British colonial period, as well as from its postcolonial economic and political history. Indian workers are also figured by an economy of imagination and desire that is interlaced with these histories, part of what allows for a spark of recognition on hearing the phrase *Bangalore butler.* In the past fifteen years, as innovations in telecommunications reached a level that allowed affordable real-time interaction with service workers abroad, English-speaking middle-class college graduates in India became the appropriate source of inexpensive service labor for industries relying on English-enabled customer service. This work is cheaper for U.S. corporate entities than in-country labor both because