Time, space and touch at work: Body work and labour process (re)organisation

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Abstract:

With 'efficiency savings' the watchword for health and social care services, reorganisation and labour rationalisation are the order of the day. This article examines the difficulties involved in (re)organising work which takes bodies as its object, or material of production. It shows that working on bodies ('body work') systematically delimits possibilities for labour process rationalisation which, in turn, constrains reorganisation of the health and social care sector. It does this in three main ways. First: rigidity in the ratio of workers to bodies-worked-upon limits the potential to increase capital-labour ratios or cut labour. Second: the requirement for co-presence and temporal unpredictability in demand for body work diminish the spatial and temporal malleability of the labour process. Third: the nature of bodies as a material of production – complex, unitary and responsive – makes it difficult to standardize, reorganise or rationalise work. A wide-ranging analysis of body work in health and social care, as well as other sectors, flesh out these three constraints and show that attempts to overcome them and reorganise the sector in pursuit of cost savings or 'efficiency', generate problems for workers and the patients, whose bodies they work upon.

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Introduction

The present 'austerity' period is witnessing the emergence of new political mantra: the realisation of 'efficiency savings' in health and social care without degradation of frontline services. This mantra shows naiveté about the work involved in delivering such services. Specifically, since health and social care services require workers to work on, with and sometimes inside the bodies of others, bodies are both the object of labour and the material of production. As this article will show, human bodies are a peculiarly intractable material of production. This intractability constrains the (re)organisation of work, especially labour rationalisation. Consequently, realising 'efficiency savings' is comparatively difficult and unlikely to occur without degradation in the treatment accorded to both workers and the bodies they work upon.

Increasingly, the sociology of health and illness has paid attention to embodiment (Williams 1996; Corbin 2003). There have also been excellent studies of the working lives and labour process experiences of health and social care providers, and of the consequences of structural (re)organisation for work in the sector (c.f. Doherty 2009; Armstrong and Armstrong 2010). These two trends have, however, not been well integrated.[1] Sociological analysis of the labour process tends not to focus on patients' or workers' bodies, nor the requirement for bodily manipulation (Wolkowitz 2006). Conversely, sociological analysis of the sick or medical body has paid little heed to the structural organisation and reorganisation of paid work on the body. This article suggests that conceptualizing health and social care work as 'body work' (Twigg 2000; Wolkowitz 2002; Twigg 2006; Wolkowitz 2006; Gimlin 2007) enables us to bridge that gap. In so doing it also provides a lens through which to compare work in health and social care with work in other sectors.

Over 10 percent of UK jobs involve 'body work': the touch, manipulation or physical constraint of bodies (see Table 1, below). These jobs are in expanding sectors: personal

services and security, as well as health and social care. The workforce involved in 'body work' is therefore likely to increase over the foreseeable future. Consequently understanding the social organization of body work is of growing importance to our ability to make sense of not only the health sector, but wider labour process conditions.

Conceptualizing work as 'body work' highlights an overlooked aspect of work: that bodies form the objects or materials of production for a range of jobs. Understanding the ways that working on bodies systematically delimits possibilities for the (re)organisation or rationalisation of the labour process – the ways in which these limits may be circumnavigated as well as why we may want them to be reinforced – suggests a novel and useful agenda for labour process analysis. It also provides a way of understanding why labour process (re)organisation in health and social care is difficult and contentious, and, why it rarely disappears from the socio-political agenda.

[Table 1 here]

Organisation and Reorganisation of the Labour Process

Notwithstanding professional or compassionate commitment to patients, work and employment in health and social care settings is played out on the same territory as other work in capitalism. This territory is marked by persistent, albeit not always predictable, conflict and constraint (Thompson and Smith 2010) and shaped by the imperative on capital to continually increase productivity and, to this end, engage in ongoing reorganisation and rationalisation of the labour process (Marx [1867] 1967). When organisations are in the public sector this imperative is somewhat altered, but increasingly the public sector is also subject to pseudo-market mechanisms, incorporating targets, audits and rewards for cost-cutting (Nettleton, Burrows et al. 2008). Moreover, all workers, in public and not-for-profit as well as private organisations, sell their labour-power on the market, making it available only for a limited time (for instance 9 to 5). Profit, or efficiency, therefore depends on the output of these workers within this time period. This provides managers with the incentive to substitute labour with capital (often in the form of technology), extract the maximum effort and decrease the 'porosity of the working day' by minimizing gaps or non-working time between tasks (Green 2001).

Whereas the above imperatives are general and abstract, any particular labour process, be it banking or nursing, involves specific tasks and specific constraints on the possibilities for (re)organisation. This article examines a space between these two poles. Three constraints on labour process organisation and reorganisation are identified. These are not general to all work, yet they span occupational divides as they are produced when work takes the bodies of others as its object. They are:

1. Rigidity in the ratio of workers to bodies-worked-upon limits the potential to increase capital-labour ratios or cut labour.

2. The requirement for co-presence and temporal unpredictability in demand for body work diminish the spatial and temporal malleability of the labour process.

3. The nature of bodies as a material of production – complex, unitary and responsive – makes it difficult to standardize, reorganise or rationalise work.

The main body of the article expands on these three constraints, exploring ways in which each might be overcome, in whole or in part. The paper begins, however, by proposing a working definition of body work, and introducing the concept of 'body labour'.

Defining 'Body Work'/'Body Labour'

Setting aside (for the moment) differences between paid and unpaid work, if body work is work 'on the bodies of others' what exactly is included? Possible responses include work on conscious bodies, work on live bodies, work on intact bodies[2], work on body parts and work on bodily excretions. These responses are nested: work on conscious bodies necessarily encompasses all that follows – work on live, intact bodies, body parts and usually some excretions – but the reverse is not true; bodily excretions can be examined without encountering any live, intact bodies, or even body parts. In her overview of body work, Wolkowitz (2002) is ambiguous about how wide a conceptual net to cast. Her empirical examples involve direct and sustained contact with live, and usually conscious, bodies (nurses, care-workers, beauticians, sex-workers). She suggests, however, that body work might also encompass 'occupations that, even if they do not involve direct touching, deal with body fluids and wastes, [for example] hospital ward cleaners' (2002). Notably, this

includes those whose central purpose is the manipulation of body parts or emissions (for example, workers in a sperm bank or stem-cell scientists) *and* workers who encounter bodily emissions as debris out of place (hospital ward cleaners, but also any cleaner encountering a dirty toilet, human hairs, vomit or simply domestic dust). Such an expansive definition nicely highlights the centrality of others' physical bodies and their excretions to numerous jobs. Nonetheless the treatment of bodies as a material object like any other, physical, malleable and ultimately divisible, obviates that which makes bodies a theoretically interesting object of labour and a fruitful subject for labour process analysis: that bodies are unitary, communicative *and* mindful. A clearly delineated conceptual boundary nonetheless remains elusive because, in practice, bodies slip between consciousness and unconsciousness and work on live bodies may involve prone, unconscious, immobile or inarticulate bodies or bodies going between life and death. The definition adopted here is therefore pragmatic, rooted in a specific analytic goal – developing labour process analysis of body work.[3] It is: *body work involves the manipulation or touch of another's intact body*.

Body work has been used to describe *paid* work on the body of another (Twigg 2000; Wolkowitz 2002; Twigg 2006; Wolkowitz 2006; Gimlin 2007). In this article, however, I follow Kang (2010), and by 'body work' refer to *all work on the body of another*, reserving 'body labour' for *body work that is sold for a wage or commodified*. This conceptually parallels the dichotomy made by Hochschild (1983) between 'emotional work' and 'emotional labour', and therefore establishes a framework for analysing the interrelationship between emotional work/labour and body work/labour. The body work/labour distinction also recognises the difference between the work itself (the tasks) and the commodified form of these tasks. Whereas the tasks may be the same (for instance massaging a back), when these tasks are performed in commodified relations the end is not principally intrinsic or embodied but exterior and disembodied: profit or output targets rather than a relaxed back (although there are exceptions/qualifications). The following sections examine the social organisation of paid body work, or 'body labour'. The focus is health and social care, but examples from other body work sectors extend and situate the analysis, while contrasts with non-body work provide context.

1. The ratio of bodies to labour to capital

Body work is labour intensive. A single worker can only in exceptional circumstances work on multiple bodies concurrently: bodies are simply too large, complex and contrary. A nurse bandaging one patient cannot simultaneously take blood from another. A manicurist filing one client's fingernails cannot polish another's toenails. Notwithstanding worker dexterity, these scenarios are improbable. Accordingly, during the time that they work on any one body, the relationship between worker and body is minimally one-to-one. Where several workers work on a single body, for instance a surgical team clustered round a patient in an operating theatre, the relationship is many-to-one. Scale increases do not therefore directly produce efficiency gains; an increase in the number of bodies worked on requires a proportionate increase in labour. To cut costs, or increase profits, either the body must receive less attention (discussed below) or a division of labour introduced, with parts of the labour process assigned to lower skilled, or at least lower paid, workers. The latter has occurred over and again in health services (c.f. Armstrong and Armstrong 2010) as, for example, nurses are assigned tasks that were previously doctors' prerogative (Doherty 2009) and health care assistants take on nurses' tasks (Bach, Kessler et al. 2010). It is also found in other fields. For example, larger hairdressing salons employ a high ratio of trainees to stylists. Paid less than half the wage of a stylist, trainees wash and blow-dry clients' hair, enabling (higher paid and higher skilled) hairstylists to 'see' more clients (Cohen 2005).

As simple tasks get sloughed off to lower paid workers the number of workers attending to any one body increases. Although bodies remain unitary, this fractures institutional interactions with *the body* into multiple interactions, often each with a different body part at a different time. This undermines efforts to treat the body/person holistically; this is not the 'continuity of care' sought by patients, nor is it 'holistic nursing'. It also runs counter to the 'personalisation' that commercial sellers of body work foster (Toerien and Kitzinger 2007). Reorganisation involving labour substitution may therefore be a sign of patient/client relative disempowerment. Additionally, as each worker's embodied engagement with a patient's/client's body is reduced their reliance on notes from co-workers or oral communication with the body-worked-upon increases. In this way an unintended by-product of labour substitution in body labour is increased reliance on workers' abilities to coax out, and offer, cogent verbal and written explanations of embodied states. Yet labour substitution simultaneously undermines workers' ability to build the relationships with patients/clients

that would smooth these interactions.

Reducing the ratio of workers to bodies without labour substitution and without decreasing the attention paid to any one body may be possible where body labour is applied discontinuously; with gaps, or times when bodies are present but not being worked on. Such gaps occur, for example, while a patient waits with a thermometer under her tongue or a hairdressing client sits under the dryer while her perm 'takes'; patients/clients are in the workplace, but temporarily not being worked upon. Some gaps are brief; however others are sufficient for workers to move to work on another body. This facilitates either one-to-many or many-to-many relationships. A single worker or group of workers is able to work on multiple co-present bodies if not simultaneously then at least serially. Unfortunately, relying on labour process gaps to improve efficiency requires that workers can predict their periodicity and length. Bodies and their temporality are, however, frustratingly unpredictable (discussed further below).

Not all workers who do body labour spend all of their time doing it. Table 2 estimates the order of selected occupations on the basis of the proportion of total labour time spent engaged in body labour. At the top are jobs involving almost constant touch. A masseur spends the vast majority of income-producing time physically engaged with a client's body; similarly a sex worker or manicurist. Turning to medical occupations there is clearly a difference between a dentist and a General Practitioner. Whilst a dentist physically engages with every patient (Nettleton 1992), a General Practitioner's interactions with some patients will be entirely discursive. Similarly, whereas home-care workers are often called upon to perform general household tasks, including cleaning or even cooking (see England et al., this volume), care-workers in residential homes spend more of the working day dealing with the bodily needs of residents, due to clearly delineated work roles and dedicated cooking and cleaning staff (Diamond 1992).

[Table 2 here]

At the foot of Table 2 are occupations involving relatively infrequent touch or bodily manipulation. For example an airport security guard sometimes, but infrequently, restrains or 'pats down' bodies. Similarly a psychiatrist may occasionally conduct physical

examinations, but spends significantly more time talking to patients, writing up notes or discussing cases with colleagues. Of course the amount of body labour performed varies between psychiatric specialties, just as it does between security guards located in different environments.

In jobs where body labour is a smaller part of total labour (such as those at the foot of Table 2) or where the objects of body labour are present but do not require constant attention, it may become possible to lower the ratio of workers to bodies, thereby easing labour process reorganisation. It is not necessary to have one security guard for each body entering a nightclub or one care worker for every residential home occupant. The unpredictability of bodies means, however, that reductions in the worker-body ratio increase the likelihood that there are sometimes too few body workers. For example, if a nightclub fight breaks out requiring the restraint of several people, the need for body labour will suddenly spike. Similarly, several care-home residents may require toileting or to be taken to dinner simultaneously. Thus, critical in the organisation of body labour is *determining the balance between sporadically inactive labour and sporadically unattended bodies*. In some cases (for example when someone is having a heart attack or a fire has broken out), making bodies wait is harmful, but in other cases (a medical check-up or a manicure) delay produces little more than patient/client frustration. This suggests that an important dimension in determining how easily body labour can be reorganized is the ability or not of the body-worked-upon to wait – or its relative neediness. Where bodies are needier, and where there are social arguments for addressing that need, sufficient labour must be employed to cover peaks. This means that during 'slack periods' labour is 'baggy', at work but not working. For instance it is socially acceptable that sometimes fire-fighters have little to do or that during (perhaps rare) quiet times hospital casualty ward staff will be unoccupied because their presence during rush times is essential.

Of course the 'neediness' of bodies is not purely physical. It is also social, political and economic. As already suggested, where services are publically managed neediness is concretised as public policy. This prioritizes particular bodies. For example the UK government has introduced strict 'waiting time targets' for cancer patients but not for other seriously ill patients, thus implicitly prioritising the former. De-prioritisation of need and the normalisation of some bodies' discomfort is exposed by Diamond (1992), who details the

habitual inattention care-home residents suffer.

> Given the staff-resident ratio, it was deemed most efficient to have diapers put on many of the residents, so that their bodily cleaning could be attended to after the fact. By the time we reached some residents to change diapers, it might have been several hours after they had first called us. Residents had to learn to sit or lie in bed after an accident waiting for clean to be restored. (Diamond 1992)

Lacking socio-economic power, residents are unable to characterise their bodily needs as important. Instead, in the context of labour shortages, residents are forced to 'learn' to cope with a situation most adults would find intolerable, effectively recalibrating bodily need.

The structural relationship between worker and body also affects the calculation of need. For instance, self-employed body workers, such as hairstylists, complementary and alternative medicine (CAM) practitioners and sports therapists, depend on repeat custom and as such have a structural incentive to be available when clients 'need' to see them, even at their own inconvenience. In contrast, waged workers are structurally independent from clients and less willing to accommodate (or legitimate) client need (Cohen 2010).

2. Temporal and spatial malleability

Co-presence is tangential to much service work, a by-product of the need to communicate, transfer goods or display a corporate aesthetic in, respectively, business meetings, retail transactions and the cultural industry. Co-presence is, however, essential when the object of work is the physical manipulation of the body of a customer, client, or patient. Workers and bodies must inhabit the same time-spaces. This means that centralisation or wholesale off-shoring of body labour is infeasible, notwithstanding pressures to cut costs by employing cheaper or fewer workers.[4] Regions have nonetheless emerged as both body work destinations (Argentina for plastic surgery; Eastern Europe for dentistry (Connell 2006); the Gulf Coast for care-homes) and as centres for body work training (whether Filipino nurses (Romina Guevarra 2006) or Cuban doctors (Feinsilver 2010)).

In non-body work service industries the need for co-presence has decreased with the expansion in remote or virtual interactions mediated by information and communication

technologies (ICT). Similarly attempts are being made to substitute co-present body labour for tele-presence. For instance, 'telemedicine' (Dyb and Halford 2009), which involves virtual links between patient and clinician or between multiple clinicians. Telemedicine enables cost-cutting, for example by centralising primary healthcare advice or reducing demand for home-visits and out-of-hours doctors (Lattimer, George et al. 1998). It may be democratising, as expensive specialist medical expertise, such as surgeons, can be dispersed without dispersing specialists, although evidence for this remains scant. More pertinently, telemedicine barely reduces demand for geographically proximate body labour. Rather, advice-giving is separated off or body labour performed by cheaper workers with fewer or less specialist skills (the generalist or nurse practitioner, acting on the specialist's remote advice[5]). Hence, telemedicine barely diminishes the demand for body labour. The success of this strategy may instead be the distillation of body labour in the health sector into 'manual work' in juxtaposition with 'mental' advice or direction. This is consequential for both patients and workers. Geographically remote surgeons may be more prone to objectifying patients (van Wynsberghe and Gastmans 2008). While, if it becomes denuded of decision-making capacity, the status of body work will further erode, intensifying the 'stigma' attached to close physical proximity with bodies (Isaksen 2002). This will only exacerbate current employment trends in body labour – which relies heavily on ultra-exploitable migrant female labour (McDowell 2009; Kang 2010). Meanwhile extension of the mental/manual divide may increase the obstacles faced by patients who want control over their own physical care but whose embodied interactions are principally with workers lacking agency.

'Telecare' (Hibbert, Mair et al. 2003; López and Domènech 2008) has achieved more reduction in the demand for body labour than telemedicine. Telecare often requires the patient (or body-worked-on) to self-monitor. Service users may operate an alarm themselves, sending information to a central location; alternatively the process may be entirely mechanized, for example involving devices that automatically record blood pressure and electronically trigger alarms. In both instances the requirement for a carer (paid or unpaid) to physically monitor the body is reduced. Nonetheless, once alerted a worker is dispatched. Thus telecare does not eliminate the need for body labour but may make it possible to rationalise and allocate this from a centralised hub – with monitoring used to

determine which bodies are (most) at need. Accordingly it somewhat concentrates work without spatially centralising bodies-worked-upon. It also remains dependent upon an adequate bank of staff able to travel to bodies when required, something made difficult by the unpredictability of bodily need.

The intersection of the requirement for co-presence with the unpredictability of bodies' social and physical demands makes spatio-temporal organisation of body labour particularly tricky. As Twigg (2006) notes it is hard to schedule work on the body: 'care tasks cannot be accumulated and dealt with efficiently in one go: you cannot save up going to the toilet for a week and then do it just once. The body has its own timings.' This makes bodies a contrary material of production. Moreover the biological unpredictability of bodies is exacerbated by consciousness and autonomous mobility (in contrast unconscious or immobile bodies are less contrary and more easily 'trained', with a corpse the most manipulable of bodies). Accordingly, those who work on bodies often find it difficult to delimit working times and are disproportionately required to work outside of the 'normal' working week. For example, as Table 1 shows, workers who do body labour are about 1.75 times as likely as other workers to work Saturdays and over twice as likely to work Sundays.

A closer examination of weekend working hints at several distinct patterns for the temporality of body labour. The first encompasses workers engaged in bodily adornment: hairdressers, beauticians, tattooists and, to a lesser extent, personal trainers. These workers must 'enchant' (Korczynski 2005) and temporally accommodate their 'customers'. As such, almost all workers performing body labour for adornment work Saturdays. Since the 'need' for adornment is unlikely to arise with extreme unexpectedness or urgency most of these workers do manage one weekend day, Sunday, without work. In contrast, workers responsible for the health or control of bodies – nurses, emergency room doctors, paramedics and care assistants, as well as prison warders and security staff – are almost as likely to work on Sundays as Saturdays. For instance, over half of the workers classified as 'healthcare and related personal services' work on each of Saturday (57 percent) and Sunday (53 percent). The figures for 'protective service occupations' are similar (62 and 59 percent). Three types of body worker are, however, under substantially less pressure to extend their working time into the weekend. The first is undertakers. Working on dead bodies, undertakers are able to exercise some schedule and workplace control. The second is child-

care providers. This is an interesting case in which workers' body labour is a direct (paid) substitute for unpaid (usually familial) body work. As such, the temporal need for the former depends on the employment or other commitments of the latter. Consequently, child-care workers' hours closely coincide with the 'normal' working week. The third group with little pressure to extend their working hours comprises workers providing 'non-urgent' medical care, including for example, salaried primary care physicians, district nurses, dentists and therapists. Non-urgent medical care occupies a quite specific position with regard to the temporality of social need, on the one hand 'non-urgent' and so not provided around the clock. On the other hand it is accorded sufficient social importance that patients are (usually) able to secure leave from employment or education and schedule appointments during 'normal' working hours, thereby allowing this group of body workers to enjoy relatively regular working hours.[6]

If the temporal contrariness of bodies produces pressure to extend hours, it also makes it difficult to distribute work evenly across the working day. A constant work pace requires bodies be ready at the place and time that workers finish work on a previous body**.** Without bodies to work, on time hangs baggily. Thus one of the features of much body work is moments, even hours, of baggy time, followed by periods of intensive work. When rewards to labour are based on time at work (for example hourly pay) baggy time is costly for employers. Thus there is an incentive to reorganise body work in order to overcome this and decrease the 'porosity of the working day'. In some respects this drive is no different to that found more generally (Green 2001). However, as discussed below, the elimination of baggy time may have additional consequences and be especially tricky when bodies are the material of production being reorganised.

One way that a continuous stream of work can be achieved and baggy time eliminated is through the spatial concentration of 'needy' bodies. Residential care-homes are exemplary here: bodies are proximate and the productive use of gaps in bodily need is possible. Thus Lopez (2007) describes care-workers leaving residents alone on the toilet (despite formal rules prohibiting this), in order to use the brief temporal in-betweens to attend to other residents. Care-home residents are, however, not only clustered but also lack mobility and are, as suggested above, relatively powerless. Their powerlessness is additionally important to the temporal management of body labour. Thus hard-pressed residential care-workers

systematically ignore residents' requests to sleep late in the morning, in order to manage the intense work demands involved in getting all residents up and to breakfast on time (Diamond 1992). In a similar vein, self-employed mobile hairstylists may seek out elderly clients, who are immobile and dependent, precisely in order to gain control of their schedules and the spatial and temporal organization and ordering of work (Cohen 2010). Thus, as the dependence or powerlessness of the body-worked-upon increases temporal control shifts to the worker and, when the worker is an employee, the employing organisation.

Where it is not possible to reorganise the working day or spatially concentrate bodes-worked-upon self-employment, especially own-account work or 'self-employment without employees', is common. Since the hours of work of the self-employed worker are not valued on the market there is no requirement to recoup a specific hourly return. Consequently although 'baggy time' may slow down the earnings of own-account-workers, therefore requiring additional hours to achieve a given return (or 'self-exploitation), it does not make labour costs uneconomic; as it would if body labour were performed by hourly paid waged employees. Accordingly, there has been relatively little concentration of private capital in body work sectors and, as Table 1 shows, a proliferation of self-employment in body labour occupations in the UK outside the two large nationalised sectors (health and protection). The dominant role played by large scale capital in the US health sector, for instance in HMOs, initially contradicts this. Yet even in the US sites of body labour have undergone relatively little concentration. For instance a study of US private physicians, found that 47 percent practiced solo or with one other physician, with a further 35 percent based in practices of 3-9 physicians (Casalino, Devers et al. 2003). Generally HMOs have exerted control over body labour via contracting rather than direct employment relationships. Partial explanation for this may be found in the difficulty of consistently utilising labour.

3. Standardisation and reorganisation

Bodies' temporal unpredictability is indicative of the difference between body time and the abstract clock-time of capitalism (Adam 1993). Bodies are not unique in adhering to a temporality at odds with capitalist production. Indeed related arguments have been made about other organic materials, perhaps most persuasively by Susan Mann (1990) in an

examination of the (relatively) slow entry of capital into agricultural production. In agriculture, however, capital investment has increasingly standardised production times and inputs, minimizing the impact of organic phenomena, from seasonality to insect predators. This section examines the extent to which such standardisation and rationalisation of bodies has been able to remake bodies as predictable materials of production, including refitting body time to capitalist time.

Standardisation is desired because it enables the predictable allocation of resources. This facilitates a division of labour whereby parts of the process (and eventually perhaps the whole process) are performed by cheaper (unskilled) labour or are mechanised, increasing efficiency and profitability. Standardisation alone may not however improve efficiency. A case in point is the standardisation of appointment times common to upscale hair salons. These, for example, specify that a restyle must occupy an hour-long appointment. This is sufficient time to accomplish most new styles at a measured pace, thereby indicating the 'quality' of the service, while allowing time for stylists to suggest extra treatments and products (possibly earning commission). Since however the complexity of a restyle and the thickness, texture and condition of hair vary there is actually little standard about these timings. This means that should, clients have thin hair or request easy restyles workers resort to 'drying' or 'styling' hair that is already thoroughly dry and styled simply to fill time (Cohen 2005). This is a form of 'standardising up' – setting standard timings at maximums. It is notable that standardising up, which appears a paradoxical way to rationalise labour use, since it reduces labour efficiency, occurs primarily where 'service' premiums are sought. Thus it indicates the relative power of the body-worked-upon in this sector and the related requirement to represent body labour in terms of both quality and value.

Caesarean birth provides a contrasting instance of bodily standardisation, which demonstrates the intersection of temporal standardisation with definite structures of employment and compensation. The World Health Organisation estimates that caesareans are medically 'appropriate' in between 5 and 15 percent of births (Althabe and Belizán 2006) yet all OECD countries except the Netherlands have rates exceeding this maximum (MacDorman, Menacker et al. 2008). Rates in Latin America are especially high, however a study of Latin American eight countries (Villar, Valladares et al. 2006) found that 'the proportion of caesarean delivery was always higher in private hospitals.' For example, in

Brazil, caesarean rates in private clinics were as high as 90%, with, 'higher caesarean delivery rates mostly due to an increase in elective caesarean delivery.' The times and personnel involved in performing caesareans also differ between private and public hospitals. For instance, one comparative study showed that deliveries in a public clinic were performed by the doctor on duty, whereas in a private clinic 96 percent of deliveries were performed by the doctor who had performed prenatal care. At the public clinic deliveries occurred on all seven days of the week at relatively similar rates; at the private clinic only 10% of deliveries occurred on Saturdays and 5% on Sundays. At the public clinic deliveries were equally likely over the four quarters of the day; at the private clinic only 10.4 percent of deliveries occurred during the night (0:00 to 5:59) with the greatest number (36%) in the shift immediately prior to this (18:00 to 23:59) (de Almeida, Bettiol et al. 2008).[7] These figures describe a gradual standardisation of body time within (especially) private medicine. In this case a medical intervention, elective caesarean, is used to overcome the temporal unpredictability of childbirth despite costs to the bodies being standardised: increased risk to the health of mother and foetus. Generally caesareans are compensated at the same rate as natural birth, but are quicker and can be planned. Thus, 'doctors save much time and fit in many more activities by scheduling caesareans' (McCallum 2005).[8] Employment relations and the wider structures of social healthcare also influence incentives for, and the form taken by, standardisation. For example, private prenatal healthcare in Brazil uses a 'single named obstetrician model'. Care is personalised and doctors have an interest in producing and retaining a 'clientele'. Because a single doctor is given sole responsibility for each patient's obstetric work, care must be fit within this doctor's working (and waking) hours. This is only realisable by exerting temporal control over patients' bodies (Murray and Elston 2005).[9]

A recent Royal College of Physicians (RCP) report (2010) revealed another medical intervention aimed at the standardisation of bodies: the fitting of artificial feeding tubes. The report caused quite a stir in the UK media. Most reports concentrated on anecdotal evidence of residential care-homes making it a condition of admittance that residents be fitted with feeding tubes, 'because staff shortages mean there is not enough time for conventional feeding' (Lister 2010). Artificial feeding tubes enable feeding to occur efficiently and whenever required. Feeding tubes also circumvent two otherwise time-consuming and

unpredictable body labour activities: the intensive palliative support necessary to overcome temporary swallowing difficulties and ongoing mealtime support. Since the mealtime body labour may be required by several residents simultaneously, it is especially difficult for workers to manage. The fitting of feeding tubes is thus a 'rational' solution; a way of physically and temporally standardizing and managing bodies. As US studies have found, it is one that is also most common where there are staff shortages and care-homes are run on a for-profit basis (c.f. Mitchell, Teno et al. 2003; Lopez, Amella et al. 2010). When the RCP report hit the headlines, it was, however, greeted with outrage, with articles appearing across the print and broadcast media highlighting that, 'the technique [artificial feeding] risks infections and also deprives patients of the pleasure of taste, and social interaction that come with normal eating' (Lister 2010). As this discussion, from *The Times* newspaper, indicates, bodies are not and cannot be treated as a material of production, like any other. Feeding is understood as more than a simple biological requirement to be managed 'efficiently'. The example therefore demonstrates both the ongoing attempts to mechanically standardize bodies and the ongoing resistance to this.

Body work sectors outside of health and social care have also seen attempts to mechanise and standardise interactions with bodies. For example, scanning machines at building entrances automate bodily searches, which would otherwise require a security guard performing a 'pat down'. Coin-operated massage chairs, common in airport lounges, obviate the need for a masseur, while, mechanical seat and pillow 'massagers' are increasingly popular retail items. Yet, unlike a trained masseur mechanical massagers cannot easily adapt to different bodies. Safety requires settings appropriate for the frailest of bodies, meaning bodies cannot be vigorously pummelled. Similarly, since automated body technologies are designed for the 'average body', they inevitably fit some bodies poorly, as evidenced by a customer review for a 'shiatsu massager' available at British retailer Argos.com:

> *I am quite tall and would have preferred it if the massage could have gone a little bit higher, it stopped between my shoulder blades and I wanted it to keep going all the way to the back of my neck.*

While most reviews are positive, these above highlights the difficulties involved in producing a standardised mechanical device suitable for all bodies. An ill-fitting massager may be

uncomfortable, but in other bodily interactions, for example a dental extraction, misfit could be bloody. Unsurprisingly wholesale standardisation and mechanisation has made few inroads into body labour.

More often standardisation is piecemeal, barely apparent and subject to little resistance. Yet across body work sectors and in manifold ways bodies are prepared and made predictable in preparation for being worked upon. This frequently disempowers and, as Wolkowitz notes, is designed to constrain the body-worked-upon.

> Even when the worked-on-body is not physically weakened through disability, old age or the humiliation of double incontinence, it is frequently anaesthetised, supine or naked, or rendered immobile by gown or facial mud pack, making it difficult for the patient, customer or client to just get up and leave. (Wolkowitz 2006)

The above examples of standardisation describe in various guises the enforced transformation of the body-worked-upon in order to produce a more predictable and malleable material of production. Collectively these might be typified as *standardisation by transformation*. A second set of practices also involve standardisation, but not transformation. Collectively they may be characterised as *standardisation by selection*. Standardisation by selection can also take various forms, but because it does not require remaking the body, it has faced considerably less resistance than standardisation by transformation. The first selection point is body type. It is notable that a lot of body labour is delimited by the age, sex or other physical or social attribute, of the bodies-worked-upon (old bodies; babies' bodies; female bodies), which in turn diminishes both the physical and social variability of the work. For instance, some branches of medicine are defined by the age of the body-worked-upon (geriatrics, paediatrics) whereas other specialties involve only female bodies (obstetrics and gynaecology). Similarly, prison guards tend to work with only male or only female bodies; most sex workers work primarily with men; many hair salons specialise in men's or women's or afro-Caribbean hair; while child-care and care-home workers work with young and old bodies respectively. A second form of standardisation by selection involves focusing on a single body part, whether hair, eyes, nose, feet or spine. Finally, most body workers carry out specific and limited procedures on those body parts with which they are concerned. For example, an optometrist and an ophthalmologist will

approach and engage with the eye differently. Equally a manicurist and podiatrist may both specialise on feet but have different foci.

The result of standardisation by selection is that the live body is effectively divided into parts and functions rather than being treated as an organic and social entity. As such it exacerbates tendencies towards dividing the body that emerge from the use of a division of labour to cheapen labour (discussed in section 1, above). That bodies-worked-upon (patients or clients), recognise the medical and social limitations of this is seen in recurring pleas for 'joined up' health services, which are effectively calls for the recombination of the body-worked-upon. There seems, however, little evidence that these will be heeded, partly because standardisation by selection increases the speed with which bodies can be assessed and managed by limiting the number of, and variation in, the bodily functions of concern. It also facilitates the relatively cheap production of specialist workers and, increasingly, stand-alone centres with extensive knowledge in one body type, part, process or aesthetic, but little knowledge or interest in others. Perhaps unsurprisingly, many of the inroads made by private companies into the UK's National Health Service depend upon this form of standardisation; contracting to perform a single common operation (such as cataract surgery) at high volume.

Standardisation by selection appears less brutal than standardisation by transformation; however neither recognises the body as holistic nor less mindful. This highlights a final tension: when body work takes the form of body labour – paid work on the body of another – there is inexorable pressure to standardise and reorganise the labour process. While some standardisation by selection is perhaps inevitable, standardisation is inherently dehumanising, because human beings are not standard, not temporally and not physically. Yet whether (and how) resistance to standardisation from the body-worked-upon, in the form of patient, user or client groups, may intersect with and potentially reinforce resistance to labour standardisation and deskilling on the part of body workers, remains to be seen.

Discussion

Body labour does not involve a single set of practices, nor a single set of workers or bodies-worked-upon. Despite the diversity of forms taken by body labour there are, however,

important commonalities. Amongst these is a set of labour process constraints that occur when work takes the human body as its object. These constraints arise out of the intersection between the dynamics of capitalist employment relations and the properties of the body-worked-upon. Bodies are complex, labour intensive materials to work with. They are indivisible and located. They do not keep to industrial time and are frustratingly contrary. They are also varied, physically and socially. Lastly, they can respond in multiple ways: physically (hitting out, clenching teeth, walking away, following or not following instructions), verbally (complaining or with geniality) and, most uniquely, collectively (in social or political movements, or through the state). As such, bodies-worked-upon can demand more or different body labour be applied and direct or resist body labour.

Different bodies are differently able to make demands for, or resist, body labour. Their ability to do this depends on their physical power or frailty, nakedness or exposure (Twigg 2000). The power to demand or resist body labour also depends upon the structural relationship between body worker and body-worked-upon. This relationship may (A) be mediated by various other actors. For example, care work is funded by the state, coordinated by a private organisation/employer, carried out by an employee, negotiated with a relative, and performed on a body. Alternatively the relationship may (B) involve the body-worked-upon and body worker only. For example there is a direct and unmediated relationship between the self-employed masseur and her client; as there is between the disabled employer of a home-care-worker. In both scenarios B the body worker is directly financially dependent upon the body-worked-upon, albeit employed within different formal structures (self-employed and employee). In scenario A the body worker's income is entirely independent of the body-worked-upon; yet both may be structurally disempowered vis-à-vis a private employer, the state or other actors. These scenarios highlight variation in the distribution of power, dependence and interdependence between body-worked-upon and body worker. Finally, the power of body-worked-upon vis-à-vis body worker depends on the relative socio-economic position of each. While, in the close confines of body labour gendered, racialised and sexualised power structures can become tangible (c.f. Wolkowitz 2006; Kang 2010).

For sociologists of work and the labour process examination of body labour serves a reminder that the concrete tasks that workers do matter. Partly because these set limits on capital's capacity to transform the labour process at will. Body labour is not necessarily

better, nor worse, than other work. It is, however, perhaps uniquely difficult to rationalise, not least because transformations of the labour process directly impact the body-worked-upon. In this context struggles between the capital and workers over labour process (re)organisation cannot but include other actors: firstly the body-worked-upon, but also the state, whether as regulator or employer of last resort. In this context struggles over labour-use, the reorganisation of the day, or the standardisation of the body are not predictable, and their resolution will depend upon a series of intersecting struggles, over issues as diverse as resource allocation, regulatory frameworks, working conditions and the bodily violability and will mostly likely involve the collective organisation of both body workers and bodies-worked-upon (in patient or user groups).

The organisational 'constraints' discussed herein, may or may not be problematic when body work is performed in extra-economic social relations, subject to different rationalities and temporal logics. For instance, when body work is carried out by a friend or a family member, gaps between tasks may not signify 'inefficient time use', but rather facilitate conversation, TV-watching or other activities of the life-world. Governments readily understand and exploit this (albeit perhaps implicitly) and increasingly provide social welfare in the form of direct payments to family members to provide care (Simonazzi 2009) thereby circumventing problems associated with commodified, especially waged, body labour.[10] It might be the case that this will in turn extend pressures to standardise and reorganise body work to extra-work spaces and social relations, concomitantly extending the systematic transformation and fragmentation of the body-worked-upon.

Tables

Table 1: Body labour, schedule and employment status. Labour Force Survey, Spring 2005

	Schedule			*Employment Status*		*Total*
	Mean weekly hours	*% Work Saturday*	*% Work Sunday*	*% Self-emplyd No emps*	*% Self-emplyd W, emps*	
Not body labour	**32.8**	**25.6**	**15.5**	**9.9**	**2.9**	***25,171,130***
Body labour*	**30.0**	**44.8**	**36.4**	**9.0**	**3.2**	***2,932,679***
Health professionals	40.6	29.0	19.2	9.3	23.4	223,994
Health associate professionals	29.9	47.5	44.8	2.2	0.4	613,011
Healthcare and related personal services	28.1	56.9	52.9	1.8	0.1	898,364
Childcare and related personal services	25.8	5.4	2.9	20.2	1.1	330,882
Therapists	25.7	12.0	6.1	30.1	2.8	139,739
Sports and fitness occupations	22.5	39.1	25.0	30.5	0.7	85,759
Hairdressers & beauty salon managers	32.1	81.2	3.8	27.4	52.6	30,919
Hairdressers and related occupations	26.4	66.6	6.1	37.8	6.6	189,914
Undertakers and mortuary assistants	30.5	21.2	18.8	8.6	1.8	16,173
Protective service officers	39.8	32.4	31.2	0.0	0.7	68,498
Protective service occupations	35.8	62.1	58.8	0.2	0.0	335,426

*'Body labour' occupations were selected at 3-digit level. Therefore where workers within these 2-digit occupational groups were judged as not directly involved in body labour (for example radiologists) they were coded as 'not body labour' and excluded from tallies for the occupational group (list of body labour by 3-digit occupation available on request from author). Reliance on standard occupational codes excludes some work, including work occurring on the interstices of legality such as sex work. Workers performing body labour in a second job are also omitted. A fuller version of this table was first produced by the author for a presentation to the ESRC seminar series on *Body Work* (see www.go.warwick.ac.uk/bodywork).

Table 2: Body labour as estimated proportion of total labour

100%	**Labour/capital reorganisation more difficult**
	Hairdresser, Masseur, Manicurist, Sex worker Dentist, Tattooist, Chiropractor Surgeon, Nurse, Orderly Paramedic, Residential care worker, Physiotherapist Home-care worker, Childcare worker, Nightclub bouncer General Practitioner, Yoga instructor, Psychiatrist, Airport security worker, Prison warden, Fire fighter Police officer, Football coach
0%	**Labour/capital reorganisation easier**

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Endnotes

[1] Nettleton, Burrows et al. Nettleton, S., R. Burrows, et al. (2008). "Regulating medical bodies? The consequences of the 'modernisation' of the NHS and the disembodiment of clinical knowledge." Sociology of Health & Illness **30**(3): 333-348.
are an exception.

[2] Intact body is contrasted here with the separated body (or separable body parts and excretions), not the 'disabled' or 'damaged' body.

[3] Where the focus is body work as 'dirty work' Twigg, J. (2000). "Carework as a form of bodywork." Ageing and Society **20**(4): 389-411.
, Isaksen, L. W. (2002). "Masculine dignity and the dirty body." NORA - Nordic Journal of Feminist and Gender Research **10**(3): 137 - 146.
, Twigg, J. (2006). The body in health and social care. Basingstoke, Palgrave.
, McDowell, L. (2009). Working Bodies: Interactive service employment and workplace identities. Chichester, Wiley-Blackwell.
a broader definition (including work on bodily emissions), may be preferable, as this nicely links the 'dirtiness' of work on bodies, especially messy bodies to demeaning and distasteful cleaning work.

[4] Centralisation may have benefits beyond cost-cutting. For instance centralisation of infrequent surgical procedures facilitates skill acquisition and resource concentration, potentially improving patient outcomes. Changes in labour allocation do not however simply reflect 'technical' advantages (such as surgical effectiveness). They also reflect economic or other social logics; logics which determine the parameters by which 'technical advantage' is calculated.

[5] Telesurgery, where a distant surgeon is sole surgeon, may become more common as robotics advance. This however requires massive development and dissemination of technology and, critically, improved telecommunications reliability.

[6] The political, and economic, strength and professional organisation of primary physicians and other non-urgent care providers may have contributed to the construction of this model of social need.

[7] A US study similarly found that caesarean rates were highest where women had private insurance Stafford, R. S. (1990). "Cesarean section use and source of payment: an analysis of California hospital discharge abstracts." Am J Public Health **80**(3): 313-315.
. Therefore these patterns of medical intervention into labour are not confined to Latin America.

[8] There is relatively little evidence of women choosing caesareans for non-medical reasons despite widespread media hyperbole about being 'too posh to push' McCallum, C. (2005). "Explaining caesarean section in Salvador da Bahia, Brazil." Sociology of Health & Illness **27**(2): 215-242.
, Weaver, J. J., H. Statham, et al. (2007). "Are There "Unnecessary" Cesarean Sections? Perceptions of Women and Obstetricians About Cesarean Sections for Nonclinical Indications." Birth **34**(1): 32-41.

[9] A UK move to make a single midwife responsible for a woman throughout her pregnancy was quickly found to have "such dire implications for the predictability of midwives' working hours ...that it made recruitment and retention of midwives increasingly difficult" Wolkowitz, C. (2006). Bodies at Work. London, Sage.
. This exemplifies the problems of individualised body work.

[10] Recent Conservative Party (UK) proposals for a 'Big Society', where non-waged (voluntary) labour is used to provide social and, potentially, health care can similarly be read as an attempt to circumvent inflexibilities in the absolute quantity of labour required to deliver these services.

References:

Adam, B. (1993). "Within and beyond the time economy of employment relations: conceptual issues pertinent to research on time and work." Social Science Information **32**(2): 163-184.

Althabe, F. and J. M. Belizán (2006). "Caesarean section: the paradox." The Lancet **368**(9546): 1472-1473.

Armstrong, P. and H. Armstrong (2010). "Contradictions at work: Struggles for control in Canadian health care." Socialist Register **46**: 145-167.

Bach, S., I. Kessler, et al. (2010). "Nursing a Grievance? The Role of Healthcare Assistants in a Modernized National Health Service." Gender, Work & Organization **9999**(9999).

Casalino, L. P., K. J. Devers, et al. (2003). "Benefits of and Barriers to Large Medical Group Practice in the United States." Arch Intern Med **163**(16): 1958-1964.

Cohen, R. L. (2005). Styling labor: Work relations and the labor process in hairstyling. Sociology. Los Angeles, UCLA. **PhD**.

Cohen, R. L. (2010). "Rethinking 'mobile work': boundaries of space, time and social relation in the working lives of mobile hairstylists." Work, Employment and Society **24**(1): 65-84.

Cohen, R. L. (2010). "When it pays to be friendly: employment relationships and emotional labour in hairstyling." Sociological Review **58**(2): 197-218.

Connell, J. (2006). "Medical tourism: Sea, sun, sand and... surgery." Tourism Management **27**: 1093-1100.

Corbin, J. M. (2003). "The Body in Health and Illness." Qual Health Res **13**(2): 256-267.

de Almeida, S., H. Bettiol, et al. (2008). "Significant differences in cesarean section rates between a private and a public hospital in Brazil." Cadernos de Saúde Pública **24**(12): 2909-2918.

Diamond, T. (1992). Making Gray Gold: Narratives of nursing home care. Chicago, University of Chicago Press.

Doherty, C. (2009). "A qualitative study of health service reform on nurses' working lives: Learning from the UK National Health Service (NHS)." International Journal of Nursing Studies **46**(8): 1134-1142.

Dyb, K. and S. Halford (2009). "Placing Globalizing Technologies: Telemedicine and the Making of Difference." Sociology **43**(2): 232-249.

Feinsilver, J. (2010). "Cuban health politics at home and abroad." Socialist Register **46**: 216-

239.

Gimlin, D. (2007). "What Is 'Body Work'? A Review of the Literature." Sociology Compass **1**(1): 353-370.

Green, F. (2001). "It's Been A Hard Day's Night: The Concentration and Intensification of Work in Late Twentieth‐Century Britain." British Journal of Industrial Relations **39**(1): 53-80.

Hibbert, D., F. S. Mair, et al. (2003). "Lessons from the implementation of a home telecare service." J Telemed Telecare **9**(suppl_1): 55-56.

Hochschild, A. R. (1983). The managed heart: Commercialization of human feeling. Berkeley, University of California Press.

Isaksen, L. W. (2002). "Masculine dignity and the dirty body." NORA - Nordic Journal of Feminist and Gender Research **10**(3): 137 - 146.

Kang, M. (2010). The Managed Hand: Race, Gender, and the Body in Beauty Service Work. Berkeley, University of California Press.

Korczynski, M. (2005). "The point of selling: Capitalism, consumption and contradictions." Organization **12**(1): 69-88.

Lattimer, V., S. George, et al. (1998). "Safety and effectiveness of nurse telephone consultation in out of hours primary care: randomised controlled trial " BMJ **317**: 1054-1059.

Lister, S. (2010). Care home patients given feeding tubes 'to save on staffing'. The Times. London, News International.

López, D. and M. Domènech (2008). "Embodying autonomy in a Home Telecare Service." Sociological Review **56**(s2): 181-195.

Lopez, R. P., E. J. Amella, et al. (2010). "The Influence of Nursing Home Culture on the Use of Feeding Tubes." Arch Intern Med **170**(1): 83-88.

Lopez, S. H. (2007). "Efficiency and the fix revisited: Informal relations and mock routinization in a nonprofit nursing home " Qualitative Sociology **30**(3): 225-247.

MacDorman, M. F., F. Menacker, et al. (2008). "Cesarean Birth in the United States: Epidemiology, Trends, and Outcomes." Clinics in Perinatology **35**(2): 293-307.

Mann, S. (1990). Agrarian Capitalism in Theory and Practice. Chapel Hill, University of North Carolina Press.

Marx, K. ([1867] 1967). Capital. New York, New World.

McCallum, C. (2005). "Explaining caesarean section in Salvador da Bahia, Brazil." Sociology of Health & Illness **27**(2): 215-242.

McDowell, L. (2009). Working Bodies: Interactive service employment and workplace identities. Chichester, Wiley-Blackwell.

Mitchell, S. L., J. M. Teno, et al. (2003). "Clinical and Organizational Factors Associated With Feeding Tube Use Among Nursing Home Residents With Advanced Cognitive Impairment." JAMA **290**(1): 73-80.

Murray, S. F. and M. A. Elston (2005). "The promotion of private health insurance and its implications for the social organisation of healthcare: a case study of private sector obstetric practice in Chile." Sociology of Health & Illness **27**(6): 701-721.

Nettleton, S. (1992). Power, Pain and Dentistry. Buckingham, Open University Press.

Nettleton, S., R. Burrows, et al. (2008). "Regulating medical bodies? The consequences of the 'modernisation' of the NHS and the disembodiment of clinical knowledge." Sociology of Health & Illness **30**(3): 333-348.

Romina Guevarra, A. (2006). "Managing Vulnerabilities' and Empowering' Migrant Filipina Workers: The Philippines' Overseas Employment Program." Social Identities **12**: 523-541.

Royal College of Physicians (2010). Oral feeding difficulties and dilemmas: A guide to practical care, particularly towards the end of life. London**:** 112.

Simonazzi, A. (2009). "Care regimes and national employment models." Camb. J. Econ. **33**(2): 211-232.

Stafford, R. S. (1990). "Cesarean section use and source of payment: an analysis of California hospital discharge abstracts." Am J Public Health **80**(3): 313-315.

Thompson, P. and C. Smith, Eds. (2010). Working Life: Renewing Labour Process Analysis. Critical Perspectives on Work and Employment. London, Palgrave.

Toerien, M. and C. Kitzinger (2007). "Emotional Labour in Action: Navigating Multiple Involvements in the Beauty Salon." Sociology **41**(4): 645-662.

Twigg, J. (2000). Bathing: The body and community care. London, Routledge.

Twigg, J. (2000). "Carework as a form of bodywork." Ageing and Society **20**(4): 389-411.

Twigg, J. (2006). The body in health and social care. Basingstoke, Palgrave.

van Wynsberghe, A. and C. Gastmans (2008). "Telesurgery: an ethical appraisal." Journal of Medical Ethics **34:**: e22.

Villar, J., E. Valladares, et al. (2006). "Caesarean delivery rates and pregnancy outcomes: the 2005 WHO global survey on maternal and perinatal health in Latin America." The Lancet **367**(9525): 1819-1829.

Weaver, J. J., H. Statham, et al. (2007). "Are There "Unnecessary" Cesarean Sections? Perceptions of Women and Obstetricians About Cesarean Sections for Nonclinical

Indications." Birth **34**(1): 32-41.

Williams, S. J. (1996). "The Vicissitudes of Embodiment Across the Chronic Illness Trajectory." Body Society **2**(2): 23-47.

Wolkowitz, C. (2002). "The social relations of body work." Work, Employment and Society **16**(3): 497-510.

Wolkowitz, C. (2006). Bodies at Work. London, Sage.