Downwardly Global
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A notable exception to this failure to integrate skilled immigrant women workers into regulated professions is the feminized field of nursing. This chapter draws on fieldwork conducted with a government-funded pilot project (referred to here as “Nurture”) to help foreign-trained nurses become licensed in Ontario, in order to examine a special case in which extensive reeducation was not required to reenter one’s field in Canada. While locally, the high rate of reentry for nurses has been attributed to the success of this resettlement program, I assert that its practitioners can enter into Canadian venues because of the way nursing is understood as gendered labor. After all, nursing is a feminized profession—that is, it is understood as “women’s work”—and so workplace ideologies surrounding masculinized performances of a global modern worker are not applicable. The logics imposed in these classrooms, and the pedagogies employed, are rife with racial and gendered ideologies of appropriate citizenship and appropriate womanhood in a model of care.

During classes at Nurture, a group of foreign-trained nurses and I learned how to control our affect for legibility on the job market, including how to manage conflict. The instructor, Libby, a Black Canadian nurse, had been working with the program as part of her service to the professional nursing association. Conflict, she explained, could consist of “disagreement, crisis, clash, fight, or an argument” that could manifest both internally (guilt, anger, frustration) and externally (yelling at a colleague). In handling “one’s own anger management,” the first strategy she offered was to “stop being
angry.” She suggested “breathing deeply,” “walking away,” and “not cursing” or “yelling.” Libby offered her own strategy of singing to herself in order to avoid cursing. In effect, her pedagogy focused on self-management of one’s affect, seemingly geared toward the production of a docile and deferent subject who would be legible in the professional world of the global economy.

This chapter examines classroom pedagogies that focus on affect and the regulation of emotion as necessary parts of the professionalization of nurses. Nursing is a form of intimate labor (Boris and Parreñas 2010)—work that involves intimacy and the body. Combining both emotion and physical touch, intimate labor can include familiarity, sexual contact, bathing another, or being party to intimate information about another. It is important not to conflate intimate with emotional labor, though nurses perform both. Emotional labor instead concerns the face-to-face work in which “one displays certain emotions to induce particular feelings in the client or customer” (Hochschild, cited in Boris and Parreñas 2010: 6). Emotional labor can be performed, for instance, by prostitutes who project love to make clients feel good, domestic workers who suppress frustration or anger in order for their employers to feel comfortable (Boris and Parreñas 2010), or nurses displaying empathy to make a client cooperative. While the intimate has historically been positioned within the private sphere, and labor within the public, intimate labor such as nursing or domestic work crosses these realms and forces a reconsideration of what intimate work in the public sphere looks like. What Nurture teaches is the way that the intimate dirty work of affect and affective labor is made public, so that in order to become a nurse, one’s affect—or performance of a particular kind of affect—is just as important as one’s knowledge of biomedicine.

This chapter builds on the affective turn in anthropology. McElhinny (2010) asserts that the ways scholars differentiate between concepts such as affect, feeling, and emotion speak to their intellectual genealogies; thus, I locate my work in studies of gender, emotion, and labor. The feminist study of emotion was differently attuned to questions of gender from contemporary anthropological uses of affect, and that the recent turn in anthropology owes a great deal to this legacy—a debt that goes largely unacknowledged. The recent trend has mostly neglected the body of work by feminist theorists on the study of emotion and gender, which in anthropology appeared as early as the 1980s and 1990s. Studies by feminist scholars such as Catherine Lutz and Lila Abu-Lughod (1990) and Elinor Ochs and Bambi Schieffelin (1989) challenged the idea of emotions as biologically determinate and
instead understood them to be culturally produced. As McElhinny (2010) argues, these studies also challenged the binary between reason and emotion, in which emotion was characterized as irrational in contrast with the rationality of reason; such irrationality was also associated with women, racialized groups, and the poor (311).

Here, I focus on the social work that these affects do. I argue that these classroom sites and pedagogies of affect are critical in the making of global workers. Therefore, scholars must take seriously the fact that “frustration” or “guilt” have become emotions that need to be suppressed or trained away. Similarly, power and marketability lie in one’s ability to smile in the face of humiliation, a strategy that teachers in the neoliberal state explicitly articulate in order to produce legible immigrant women workers. A number of studies on globalization and neoliberalism have investigated the production of new subjectivities in which emotion is “managed.” In these accounts, under neoliberalism a subject must cultivate herself as responsible, self-sufficient, entrepreneurial, and the idealized Western masculine self (Kingfisher 2002 and Rose 1996a, cited in McElhinny 2010), as women were encouraged to do in many of the workshops I attended. What I want to bring attention to, however, is how in contrast to this idealized, masculinized, neoliberal subject of the state, immigrant women learning to be professionals in the global market must conform to a contrasting gendered self. Thus, as this chapter demonstrates, race and gender importantly figure in the making of subjects under neoliberalism.

In this chapter I examine the notion of “care work” in a global perspective and analyze the colonization of the intimate labor that women do. The term colonization draws attention both to the assimilatory process by which a nurse must make herself into a legible worker in the Canadian context, but also to the ways that the state regulates and manages such intimate labor. The focus on intimacy and affect in the training of foreign nurses provides an excellent example of this interpellation and management. Further, these classes employ what I call “pedagogies of affect,” which reproduce racialized notions of femininity deemed appropriate for immigrant women in Western settings. By pedagogies of affect, I refer to the educational imperatives surrounding the management of affect, emotion, feeling, and ways of being. These pedagogies serve the sanitized sensorium as they concern the explicit training of the interiority as well as the exteriority of the body.

In contrast to many studies of immigrant women that address their exploitation in low-wage work, here I examine the experience of displaced
professionals. I focus on the training of particular forms of affect—especially conciliation, cooperativeness, and deference—at Nurture, which was a program designed to educate foreign-trained nurses to succeed on a national exam. Understanding the meaning and underlying logics of such classroom interactions reveals how ideas of race and gender are understood and inscribed on the bodies of immigrant women. Women, particularly those of color, are expected to perform Westernized notions of docility and deference in order to be marketable on the global stage. Despite the popular stereotype of the passive Asian woman (Guevarra 2010; Rodriguez 2010; Stiell and England 1999), in the context of training classes, nurses had to learn to suppress anger, resolve conflict, and become subservient—suggesting a fear that the immigrant woman is anything but an obedient subject. Rather than draw out some innate passivity, these classroom encounters suggest that Asian immigrant women need to mold themselves to fit this cultural notion of natural passivity to be legible workers. In these sites the neoliberal, entrepreneurial nurse-to-be must perform an alternate version of the self that counters the masculinized neoliberal subject. Pedagogies of affect render migrant nurses legible not only in the micro context of the training sessions but also in the macro context of neoliberal capitalism.

Nursing in Multicultural, Neoliberal Canada

Nurses occupy an ambivalent position in the world of care work, being both professionalized in the Canadian context and devalued as a gendered and racialized worker. Nursing provides an excellent example of the intersectional convergence of the practice of raced and gendered performance. These kinds of performances are not inconsequential, but critical to one’s ability to make a living. Several authors have examined the racialization of nursing in Canada (Bakan and Stasiulis 1997; Calliste 1993; Damasco 2012; Das Gupta 1996 and 2009; Das Gupta, Hagey, and Turritin 2007; Flynn 2009). Among the most prominent, Tania Das Gupta (2009) details how in 1990, seven Black nurses and one Filipino nurse who worked at Northwestern General Hospital in Toronto filed complaints with the Ontario Human Rights Commission claiming they had been subject to racial harassment, and some had been fired or forced to resign. After four years, they received a landmark settlement in which the hospital paid each nurse $10,000–$100,000 for mental anguish. In addition, the hospital created a position for a vice-president of Ethno-Racial Equality. Das Gupta suggests
that public cases such as this demonstrate the need for examining not only gender, sexism, and class, but also questions of race and racism within the nursing profession.

The kinds of racialized and gendered performances nurses are called upon to act out put them in the precarious position of being subject to race-based discrimination, but identifying race-based discrimination is not easy. Identifying gendered forms of racism in intimate interactions is complicated when one is responsible for a sick or dying person, a situation predicated on different forms of vulnerability. In Das Gupta’s (2009) study of race discrimination for Canadian nurses, she found it was difficult for nurses to establish harassment on the basis of race because they had little evidence beyond their own descriptions of their experiences. As I demonstrate below, in the classes run by Nurture, there was no explicit mention of race or race-based discrimination, as the pedagogy was geared toward the management of one’s own affect and the suppression of anger in the face of mistreatment. Given the important role of race and racism in hospital encounters, it is critical to examine this in light of the failures of multiculturalism and the failure to recognize explicit issues of race.

In the examples we have already seen, classes for foreign professionals do not focus on anti-racism training, but rather on making oneself into someone who will not be discriminated against. Indeed, as others have shown (Calliste 1993; Flynn 2009), throughout history Canadian immigration policies have discriminated against and created hurdles for women-of-color, migrant nurses. Agnes Calliste (1993) argues that between 1950 and 1962, immigration control created a context in which Caribbean nurses who wanted to enter as permanent settlers had to demonstrate they were of “exceptional merit,” in contrast to white nurses who were admitted on more general qualifications (85). While this is no longer the case in terms of immigration policies, the state’s legislation and management of the nursing profession has set up other significant hurdles that immigrant women of color must learn to scale.

Foreign-educated nurses are required to get accreditation according to the dictates of the College of Nurses of Ontario (CNO), the regulatory body for all nursing in the province. While not an academic institution, CNO is responsible for ensuring safe and ethical nursing practices for the public, as well as determining the criteria for becoming a nurse or practical nurse. It establishes the standards of practice, develops a framework for ongoing learning for nurses, and provides a complaint process for those in
need. In order to practice as a nurse in Ontario and to use the titles “nurse,” “registered nurse (RN),” or “registered practical nurse (RNPN),” one must have a current certificate of registration from CNO.

According to CNO, there are seven requirements to register as a nurse in Ontario: “complete an acceptable nurse or practical nursing program; provide evidence of recent safe nursing practice within the past five years; pass the national nursing examination; be fluent in English or French; be registered in the jurisdiction where the program was completed; have proof of Canadian citizenship or landed immigrant status; and be of “good character and suitable for practice.” Foreign-educated nurses must also provide evidence of any convictions of a criminal offense or any offense; previous proceedings having to do with professional misconduct; incompetence; any physical or mental condition or illness; and any suspension or denial of a nursing license. Fees for this process total approximately $800.

In an interview with Linda, the executive director of Nurture, I learned that the organization arose from the realization that there is a contradiction in the current state of nursing: while there is a shortage of nurses in Ontario, there are a large number of nurses with foreign credentials who are unable to work. Recent healthcare reforms in Ontario have had a dramatic impact on nursing, as the provincial government has struggled to slash deficits by freezing or cutting nursing jobs—work that continues in the context of a severe nursing shortage. According to Judith Shamian, president of the Canadian Nurses Association, “Many nurses work part-time because they find it so exhausting when they get into the workplace . . . we are currently short of around 22,000 nurses. We compensate for that by having a lot of nurses doing a lot of overtime, which leads to other concerns” (cited by Winston 2011: para. 4). Citing a recent study of fatigue levels among nurses conducted by the Canadian Nurses Association, she says, “Nurses end up being far sicker than the rest of the population, so that absentee days in comparison with the general public are much higher. That’s what happens when you keep working very long shifts and come to a point of exhaustion” (Winston 2011: para. 5). In 2008, Statistics Canada conducted a study of nurses’ working conditions and found links between “medication error and both work organization and workplace environment, including working overtime, role overload, perceived staff shortages, or inadequate resources, poor working relations with physicians, lack of support from co-workers and low job security” (Winston 2011: para. 6). Thus, rather than improve working conditions for all nurses, including addressing race-based
discrimination, the government sees foreign nurses as a partial solution to the shortage.

In 2001, the provincial government, through the Ministry of Training Colleges and Universities, announced that it would provide funding to launch Nurture as a pilot program. Nurture was organized specifically to assist with the national nursing exam, which had been a major barrier for foreign-educated nurses. Linda suggested that many immigrant women fail the exam because they are “not aware of the legal and ethical framework of nursing,” or what she also termed the “psychosocial” aspects of the profession, which is what they attempt to teach in the space of their classrooms.

What the nurses are preparing for is the Canadian Registered Nurse Examination (CRNE) and the Canadian Practical Nurse Registration Examination (CPNRE). The CRNE includes approximately 200 multiple-choice questions and takes four hours, while the CPNRE consists of 180–200 multiple-choice questions and also takes four hours. The exams are designed to test the basic competency expected of a beginning nurse in Canada. The passing score is 59–68 percent. While all applicants to Nurture must be fluent English speakers, the curriculum includes three levels of language instruction: “Intermediate Assessing, Reporting, and Explaining”; “High Intermediate Telephone, Documentation, and Intercultural Communication”; and “Advanced Communication Strategies for Working/Workplace-Ready IENS.”

Nurture has worked in tandem with a number of settlement services in addition to local hospitals and palliative care centers. The program has been wildly successful and is now in its twelfth year. By the end of 2003, over two hundred nurses had signed up for the program and successfully passed the exam. Before its implementation, foreign-trained nurses had a passing rate of 33 percent; graduates from Nurture now have a 65–80 percent passing rate. According to CNO, the pass rate for RNS trained in Ontario in 2011 was 75 percent, while only 37 percent of those trained outside of Ontario succeeded; for RPNs, the pass rate for those trained in Ontario was 82 percent, but only 52 percent for those trained outside the province. Since 2001, Nurture has expanded beyond Toronto and served over a thousand foreign-educated nurses.

Participants in the Nurture program must take two mandatory courses: Competency Skills Assessment and Introduction to Nursing in Ontario. In addition, each participant spends 200 hours of practicum in a hospital setting. Students also receive mentoring and guidance in applying for
government funding (in the form of loans to immigrants and bursaries) to pay for their Nurture program. Once they pass the nursing exam, participants are assisted in their search for work. At the time of my research, no other profession had this kind of mentorship and guidance for immigrant practitioners.

Entry into Nurture is highly competitive. To qualify, potential candidates must have a letter from the College of Nurses saying they are eligible to write the exam, they must be permanent residents in Canada, they need intermediate English skills, and they must voluntarily agree to join the program and to commit their time and money. In terms of costs, participants pay $700 for the two mandatory courses, or $4,000 for the complete package. In addition, participants must pay for books, transportation, and childcare, as well as specialized items such as lab coats. More than 50 percent of participants held bachelor’s degrees; 90 percent of the participants were female, aged thirty to forty-five; more than 50 percent had a minimum of ten years of experience; and more than 70 percent spoke more than one language. Participants largely originate from Asian countries including the Philippines, China, India, and Pakistan, followed by Eastern Europe, the former Yugoslavia, Russia, and Latin America. Half were unemployed and the rest were working at survival jobs as cashiers or service workers. The maximum income for those participating was $20,000, and participants were largely from two-parent families with two children.

While in both global and Canadian national contexts foreign-trained nurses are very successful at finding work, foreign-trained immigrants from professions that are considered masculinized are much less successful, even within the field of medicine. Consider Basheera, a woman in her thirties who was trained as a doctor in Karachi, Pakistan. Basheera had migrated to Toronto alone, and was living in a government housing project in Scarborough, to the east of the city; at the time of our meeting she had been in Toronto for six months. I met her during fieldwork with a women’s nonprofit center in the context of a job-search workshop. She had been learning the intricacies of what it means to have a firm handshake, but had grown increasingly frustrated with the process. Basheera never worked as a doctor again, eventually giving up the retraining and re-accreditation process. At the time of our last interview, she was working as a cashier at a food court in a local mall. Among those employed in 2006, 62 percent of Canadian-born professionals were working in the regulated professions, in contrast to the
24 percent of foreign-educated immigrant professionals who did (Zietsma 2006: 15).

The context that sets the scene for Nurture’s practices is the idea that nursing itself is understood as a feminized profession. Several authors have examined in great detail the history of nursing and how it has come to be considered “women’s work” (D’Antonio 1993; Flynn 2009; Gordon 2002, 2009; Sexton 1982). D’Antonio (1993) has written that since the responsibility for caring for the sick has historically rested on women, this laid the domestic roots of the practice of modern nursing. Building on the perceived idea that women were innately loving and caring, nursing became unquestionably something they could do. However, in the first half of the nineteenth century that “duty” became the actual profession of nursing, transforming with ideas of “expert knowledge, correct social order, viable occupational options, and the centrality of therapeutic alliances in the caring process” (34). Gordon (2002) has suggested that while nursing is the largest female profession in the United States, it was the first secular profession for respectable women and a feminist achievement; thus, nurses played a key role in developing the American hospital system in which nursing is devalued.

If nursing has historically been understood as women’s work, it is perplexing that the education at Nurture focuses on the training of affect and feeling, a realm that has also been naturalized as the domain of women. Yet the existence of these trainings seems to denaturalize the presumed link between women, affect, and emotion. This contradiction also exists in the context of training around race and what kinds of bodily and affective performances are demanded of nonwhite women. It is important to understand that gendered and racialized performances of deference or docility are not endemic to Asian culture (I use Asian here because the bulk of Nurture’s nurses-to-be are from Asian countries), but rather are part of a pedagogical training strategy that produces Otherness for immigrant women.

Nurture’s orientation session for new students imparts much of the information I detailed above concerning “women’s work,” which gets complicated in the context of the multicultural state. At the one I attended, Linda, the executive director, assured participants they would receive excellent mentoring, but that they would need to learn the standards in Ontario and they would need to “assimilate.” Linda’s use of the word “assimilate” in the context of Nurture was seamless, but to my ethnographic ear it was painful. In the context of multicultural Toronto, a city that prides itself on
“equality based on a model of difference,” assimilation was central to much of the rhetoric I had heard in government training classes; if we are to take the success of Nurture’s graduates seriously, assimilation seems to be the order of the day. Here, the emphasis is on affect as a governing and governable quality, or what I see as the colonization of the intimate labors of immigrant women. Linda assured the women that tutoring in how to assimilate would be available.

Another aspect of orientation that day was Linda’s discussion of professional partnerships, in which immigrant women would have time to shadow other professional nurses. “The standards are different in Canada than in other countries; there are things that are difficult to quantify,” Linda assumed. Job shadowing usually happened in the space of a hospital, in order for potential nurses to understand the protocol. If the classroom space is any indicator, what they are to learn in terms of protocol is how to suitably display the affect of a Canadian nurse. To end the orientation, Linda left the participants with five tips: be punctual, do not bring friends, be confidential, go early and stay later, and do not speak a language other than English because it is considered rude.

Teaching Gendered and Raced Affect

This disjuncture between training at the Center versus training at, for instance, Nurture demonstrates that on the global market, there is no singular gendered and racialized performance one must carry out to gain access to legibility. That is, acting like the masculinized white subject endemic to neoliberalism—through actions that include firm handshakes, strong eye contact, and the use of first names when referring to each other and superiors—only works in certain situations. In other chapters I consider the ways immigrant women trying to gain entry into masculinized labor (e.g., as a doctor, engineer, or lawyer) must learn to reproduce these very actions. Here, however, the focus is different and these nurses must act according to what is culturally appropriate for their gender at the time. For instance, in the 1940s Black women had a difficult time entering the field of nursing because nursing was defined around the Victorian ideal of “true womanhood,” and that ideal excluded Black women (Flynn 2009). This concern about Black women in nursing and how it would affect the profession carried on into the 1960s and was only overturned by Black women’s performances of femininity (Flynn 2009), to the point where today, Nurture’s
classes concerning the appropriate and correct affective and bodily performance for a nurse can be taught by Black nurses, and thus are central to the training in the field. The experiences of today’s woman-of-color nurse contrasts with those of Black women in the 1940s. Then, “a true woman” was a white woman; in an irony of racial hierarchy, the nurse today is still a “true woman,” but because that requires docility and subservience, Asian women can now perform this work as well. In both cases, the whiteness of multiculturalism is unspoken.

Prevailing constructs of gender and women are still ideologically linked with ideas of proper behavior that transcend the space of nursing. Women are imagined to be half of a heterosexual pairing, ideally responsible for domestic labor, including cooking and childcare. Thus, when women seek help in finding work outside the home they face a kind of perverse sociality that guides women away from professional fields and back toward their imagined place. In contexts such as these, an individual’s identity as a “foreign immigrant woman” eclipses her professional qualifications and thus becomes a defining factor in her professional life. Notions of “appropriate modern womanhood” are intimately connected to the body and its regulation, the meaning of which has transformed historically but is still deeply wedded to racial and cultural ideals of hygiene and dress associated with an imagined West. Sherene Razack (1998) has suggested that images of the oppressed third-world woman, “the passive downtrodden Indian woman,” and the veiled Muslim woman are “recurring and familiar images in Canadian public discourse” (100). The highly skilled third-world woman fails to have a subjective niche in the public consciousness, and so a skilled professional woman must mold herself to fit the culturally available tropes in order to become legible. She still carries the markers of difference, of Otherness, in which she is understood contextually as a “third-world woman,” and she must perform that difference through Westernized notions of docility and deference.

The popular stereotypes of Asian women and docility circulate globally and set expectations for these women as workers—and thus have disabling effects. These portrayals of docile Asian women occur in television, film, and newspaper accounts and include representations as diverse as Madame Butterfly, The World of Suzie Wong, the women of The Joy Luck Club, and news accounts of South Asian Muslim women in need of rescue from their husbands—or representations, as Gayatri Spivak (1988) argues, that “white men are saving brown women from brown men” (297). These images of Asian women circulate globally and seem to insist on an inherent docility.
and deference to men and their elders, all of which works together to make the women seemingly ideal on the global care market.

Despite the assumption that immigrant women, particularly Asians, possess these qualities, these classes, and by extension the government, realize that these characteristics, behaviors, and affects actually must be taught. There are both ontological and methodological dimensions to how these pedagogies of affect are racialized, so that it is not just a matter of to whom docility and deference are taught, but how they are. In this context, the emphasis is on the governing of affect and the colonization of the intimate labors of immigrant women. In other words, there are racialized mechanisms through which pedagogies of affect train the entrepreneurial nurse-to-be to perform an alternative version of the self, in order to be legible and to counter the masculinized neoliberal subject of Western states.

Two representative sessions of Nurture’s classes revealed to me how immigrant nurses are produced. The first class, “Nursing in Ontario,” was located in a large office building in downtown Toronto. The classroom had the familiar institutional lighting and furniture of any government office. According to the course catalog, this class “provides the graduate nurse with an overview of nursing in Ontario in preparation for registration in Ontario or a return to active nursing for RNs who have been out of nursing practice for some time. [It addresses] issues such as trends in health care, the nursing educational process in Ontario, the role of the multidiscipline health care team, legislation and professionalism.”

The twenty-two participants were mostly Asian women from the Philippines, China, India, and Pakistan. In addition there were seven Eastern European women, and one man. Libby, the middle-aged Black Canadian nurse I introduced earlier, taught the course. A few minutes into the class I noticed that I was sitting behind a woman from Pakistan who, during an earlier visit I had made to Nurture, refused to let me interview her unless I could find her a job. The topic for the day was “Disagreeing with Your Team,” specifically in reference to medical directives, which are orders from doctors or other nurses. As Libby described, “Medical directives must be written in advance; the time frame varies, but they are always written. The order is written or oral and is taken within a specific time frame, and most importantly you must always listen to the doctor.” Libby carefully outlined the division of labor between doctors and nurses, repeatedly asserting that doctors are more knowledgeable and must be deferred to in all circumstances. “However,” she said, “if you are going to disagree with your team
you must believe (1) that the plan of care is inappropriate, and (2) that the client has not given informed consent.” If a nurse is to follow through with her disagreement, “she must follow the chain of command,” which moves as follows:

Disagreement with MD → talk with MD → situation is unresolved → supervisor (RN) → supervisor supports your concern → talk to MD → MD refuses → MD supervisor.

This chain of command demonstrates just how heavily policed nurses are in contrast to registered nurses and doctors, who effectively are left to their own devices. Libby reiterated several times that it was highly unusual to disagree with a doctor, who had much more training than a registered nurse did. “The doctor is typically in charge, and knows what is called for.”

After the break, the topic for the rest of the class was “Restraint and Resuscitation,” referring to the literal use of restraints on patients. Restraints, Libby suggested, provide an ethical dilemma for nurses because they literally control other people’s bodies and restrict their movement. “Compared to your home countries,” Libby said, “you must get used to restraining less.” Her implicit assumption was that archaic practices of restraint were dominant in Asian countries. I, myself, was shocked to learn that in addition to physical restraints, there are both chemical restraints (tranquilizers and sedatives) and environmental restraints (seclusion and being locked in one’s room). Throughout the lesson Libby differentiated between the participants’ presumed “home” and the experience in Canada; home was described as a site of barbarism, while Canada was described as progressive.

The crux of the restraint lesson plan seemed to be the question of permission. “The nurse’s responsibilities are to assess the client’s behavior, consider alternatives, collaborate with the health team, and, most importantly, get consent.” Libby emphasized, “Restraint is a treatment—you must get the doctor’s permission and details of administering, and you must defer to his judgment.” Not only were nurses expected to defer to the judgment of the doctor, but also to the family: “It is the family’s decision whether or not to restrain; you must respect that.” Indeed, many students expressed surprise that they would have to get a family’s permission to use restraints, which they did not have to do in their home countries. Libby answered this by expressing that restraining a patient can lead to increased injury, skin breakdown, confusion, incontinence, constipation, loss of appetite, and bone loss, so they were to take this very seriously.
During the second class with the same participants the theme was “Conflict Resolution” and what Libby called “techniques to manage yourself.” The first technique, deep breathing, was emphasized as a productive strategy to clear one’s thoughts, which could later be followed by leaving the situation or distracting oneself by going for a walk, shopping, or taking a hot bath. Thus, in this government class to prepare nurses for taking the national nursing exam, part of the lesson was to suppress one’s emotions. Alongside the previous lesson on deferring to doctors and registered nurses instead of disagreeing with them, this begins to paint a picture of the ideal nurse-worker.

Implicit in these “techniques to manage yourself” is the training of patience, as part of the affective training for flexible nurses. Libby’s instructions centered on controlling one’s temper in the face of mistreatment, to breathe deeply instead of yelling, to go for a walk or shop to take a hot bath. Nurses were taught to do anything other than face mistreatment directly; they had to be patient. Procupez (2012) has theorized the role of patience, suggesting, “The need for patience emerges when time no longer seems to stand still, where there is the sense of something else coming. Thus, far from an attitude of conformation or passivity, patience here involves the collective acceptance to work toward an objective in the long term despite the uncertainty entailed in the processes of negotiation with other sectors. In this sense, patience effectively entails a disposition of openness toward the unknown” (173). For the nurses, patience signifies two things. First it contains a temporal orientation that departs from what Procupez (2012) describes in her study of urban squatters. Instead of containing an inherent orientation toward the future (If I am patient now, there will be a payoff later), nurses are seemingly trapped in time, for they must always be patient while working. Second, patience is a learned practice that must be trained and cultivated, something to work toward.

Libby continued her lesson by insisting that the nurses think before they talk to other colleagues, because it is unprofessional to “gossip.” “First,” she illustrated, “stop being angry, be aware of your body language and tone of voice—you don’t want to seem aggressive. You need to develop an approach or compromise; for instance, say you need a minute, then come back.” Libby continued, “If you have trouble controlling your anger, you may want to consider counseling in the form of anger management. If others notice your anger is a problem, you may be sent to anger-management training. You’re not being penalized; it’s about patient care.” Libby’s instructions
demonstrate several things. First, a nurse must always work to suppress her emotions. Second, if she is unsuccessful, she may be sent to anger management, which, despite Libby’s denial of it, is no doubt a penalty. Third, and importantly, her lesson demonstrates that women are the ones who need to work at conflict resolution. The doctor in Libby’s lessons was always a “he,” a masculinized hegemonic force that needed to be managed and dealt with, but also deferred to as the authority in the room.

These techniques also assume that rage is a part of the job, and that these women will be expected to control it at the hands of doctors, patients, and other nurses who will mistreat them. Thus, being treated badly seems to be intrinsic to the profession. One is expected to become violently angry at some point, and Nurture offers instruction concerning how to act when that happens. What this counterintuitively suggests is that women are understood to not be “naturally docile,” but rather to need to cultivate a certain affect in order to be successful as a professional nurse in Canada. In Libby’s lesson, the two major barriers to conflict resolution are low self-esteem and a lack of experience with resolving disputes, which “must be achieved without violence.” Her statement comes with an implicit idea that perhaps in “their home countries” these women are violent, savage, and in her words “lack experience with conflict resolution,” yet at the same time have low self-esteem. These kinds of instructions and assumptions again suggest that these women must be disciplined for the market. Finally, Libby illustrated two models of conflict resolution: negotiation or compromise—in which both parties reach “an agreed concession by converging ideas and opinions”—and a mutual-gains model in which “each side profits from mutual work performed toward a common goal.” The class ended with us all doing a behavior survey, and with Libby telling us that “through our lives we move between assertive, aggressive, and passive,” and thus that these are not static but rather dynamic states of being. “You are in control of how you act.” Class dismissed.

Learning Affect

I later had the opportunity to speak with Habiba about her experience with Nurture. She was a foreign-trained nurse who had migrated to Toronto six years before our interview. In Pakistan she had worked as a nurse for sixteen years; when I met her, she was working at a Coffee Time donut shop, which is a local chain. When I asked her about the classes, she happily expressed to
me that they were “very helpful” and gave her information she would not have thought of otherwise. Habiba had already completed her practicum, so when I asked her about the differences between nursing in Pakistan and nursing in Canada, she said the biggest difference was the clients’ attitudes toward nurses. “They’re so hostile here, and they don’t think we know anything.” She said that clients regularly yelled at her in the hospital or told her to “get out and get the doctor.” Here, Habiba does not suggest that her lack of authority is linked with race, but it is likely a factor. Part of pedagogies of affect consists of preparing workers for interactions in which they experience racism. In the face of it, they cannot yell or fight back, but must remain docile and deferent. Thus success in the context of Nurture, and indeed in the field of nursing, consists of managing one’s own emotions.

Though I have been very critical of these teachings concerning affect so far, it is important to consider the fact that Nurture is very successful. Remember that the success rate for their students is between 65 and 80 percent, compared to 33 percent before the program was implemented. Considering this, it would seem that these trainings do work on some level. Consider Habiba’s assertion that the biggest difference in nursing in Canada is that the patients are openly hostile toward her. It would seem in this context that a nurse would need to know how to control her feelings to keep her job. If this is the case, it seems to say more about the nature of feminized labor and racism, in which racialized women are paid to do the kind of care work not done by anyone else, than about classroom instruction.

In addition to nursing, other forms of gendered labor also reveal a racialized performance of servility necessary for the global market. For instance, Mirchandani (2012) examines the experiences of Indian call-center workers who must perform what she calls “authenticity work” to refashion themselves into what Western clients expect of them. In these exchanges between call-center workers and clients, Indian workers must demonstrate contrasting qualities ranging from servility to assertiveness, performing a kind of affective labor for legibility. Her study demonstrates that “the exchange of labor and capital occurs in the context of national histories and power inequities that make negotiation of authenticity a central part of transnational service work” (1). Mirchandani rightly demonstrates that a performance of authenticity is central to doing one’s job, when the workers themselves (and their sensorial and affective markers) signal their ability to do certain kinds of work.
In certain contexts, such as working as a doctor, being a masculinized, neoliberal entrepreneur gains one access to employment and social inclusion. However, in others, different kinds of gendered and racialized performances are called for in order to be read not only as appropriate citizen-workers but as gendered immigrant women workers. Tara Goldstein (1995) for example, has written on the need to rethink English as a Second Language curriculum for immigrant workers in Canada, which often assume it is necessary to learn English above all other languages in order to function in the workplace. In her ethnographic research, Goldstein demonstrates that in one factory workspace in Toronto, immigrant women had to learn Portuguese because the bulk of immigrants in this particular community were from Portugal and thus set the lingua franca of the factory. As Goldstein suggests, it is not always a singular form of language or even performance that makes someone legible. In the case of nursing, docility, deference, and reserve are all affects that make a foreign woman recognizable as a nurse.

Pedagogies of affect provide an entry into understanding the changing nature of gender and race in neoliberal societies. Neoliberalism has been cast as a macroeconomic series and set of practices and discourses that have had dramatic impact on the functioning of society. Scholars have been attentive to the ways such practices translate into ideologies of the local and everyday life. What I am signaling here is the way that gender and labor, including the intimate performances of what it means to be particular kinds of workers, have been transformed through processes of neoliberalism. In contrast to representations of an ideal masculine, neoliberal subject of the state, what I found was a distinct gendered performance that Asian women workers are expected to act out on the global stage. The required affects were understood as needing to be taught and learned; they were not seen as qualities intrinsic to Asian women, but as a set of strategies they must absorb to be legible as workers. These nurses are taught how to be neoliberal, entrepreneurial workers who must learn to suppress their anger and frustration in their racist and sexist encounters with doctors, patients, and even sometimes their peers. It is also worth noting the assumption that the mistreatment of nurses is acceptable, and that nurses need to learn how to deal with it, instead of indicating a necessary shift in attitude and treatment on the part of the profession and larger society. This stance is in itself neoliberal, in that it becomes the nurse’s responsibility to manage her feelings when treated badly.
My fieldwork on classroom interactions and narrative accounts by professionals does not encompass the workplace contexts themselves, so I cannot speak to the ways this affective sensibility was or was not negotiated in hospitals or the ways nurses who get jobs experience their work. In the space of the classrooms I visited, the nurses were ultimately disempowered by their unemployment. However, many understood that this was a game they needed to play, focusing on their instruction rather than on activism to change an oppressive system. Agency in this context was exercised within the constraints of a system of neoliberal capitalism that kept them underemployed. These migrants, like all of us, need a paycheck at the end of the day, but they have to perform a foreign set of affects to obtain one. Affective sensibilities and attachments linger in larger-scale economic transformations, the very transformations that are responsible for situating these women as precarious workers.

Post-Fordist Affect

Questions of affect and labor transcend the space of Nurture’s classrooms and have larger implications in the post-Fordist context. Pedagogies of affect describe the process by which affective performances are mapped onto particular kinds of laboring bodies, but there are also affective sensibilities that are endemic to the post-Fordist era and that emerge in the context of conditions for belonging. “Post-Fordist” here refers to the transformations in labor and governance I outlined in detail in chapter 1, which through rhetorics of flexibility have led to the increasing precarity of workers. Berlant (2007) argues that there is a “porous domain of hyperexploitative entrepreneurial atomism that has been variously dubbed globalization, liberal sovereignty, late capitalism, post-Fordism, or neoliberalism” (280). These terms have been used to describe a collection of phenomena impacting social life at multiple scales and in multiple domains. Throughout this ethnography, I use most of these terms to focus on different areas of social life in the contemporary moment. Here I use “post-Fordist affect” to draw particular attention to the relationship between affects and labor following transformations in the way humans understand work.

According to Hardt and Negri (2004):

Unlike emotions, which are mental phenomena, affects refer equally to body and mind. In fact, affects, such as joy and sadness reveal the
present state of life in the entire organism, expressing a certain state of
the body along with a certain mode of thinking. Affective labor, then,
is labor that produces or manipulates affects such as a feeling of ease,
well-being, satisfaction, excitement, or passion... One indication
of the rising importance of affective labor, at least in the dominant
countries, is the tendency for employers to highlight education, at-
titude, character, and "prosocial" behavior as the primary skills em-
ployees need. (108)

While the rise in the service sector created the contemporary articulation
of intimate and affective labor in the post-Fordist moment (Boris and Par-
reñas 2010; Hardt and Negri 2004; Hochschild 1983), Ford and Fordism
were also deeply invested in the production of particular laboring selves.

Henry Ford believed that workers who lived well were better workers.
In 1914, he tasked the Sociological Department of the Ford Motor Com-
pany to oversee a range of social benefits for Ford employees under the
leadership of Reverend Samuel S. Marquis. Employees received monetary
incentives for living according to Ford’s values of “living right,” which in-
cluded a range of standards from sobriety to proper hygiene. Investigators
in the Sociological Department would appear at workers’ homes to look
for evidence of cleanliness and hygiene, sobriety, family values, thriftiness,
 sanitary conditions, and good morals (Palumbo-Liu 1999). Ford linked
living well to a $5-a-day plan to give monetary incentives to workers who
lived according to Ford’s values. A Ford worker made a standard wage of
$2.34 for an eight-hour day, but he could receive an additional $2.66 if Ford
determined the worker was living well. The Sociological Department was
responsible for determining if employees’ personal lives and personal hab-
its made them eligible for the full wage. In Henry Ford’s value system, liv-
ing correctly—or in a particular moral way based on hygiene, sobriety, and
family values, among others—was directly linked to one’s wage.

Ford’s Sociological Department illustrates his investment in producing
morally right workers through the control of their bodies and behavior.
These mechanisms of control extended beyond the body and included
correct affects as well as bodily dispositions. The Reverend Samuel Mar-
quis wrote, “The Impression has somehow got around that Henry Ford
is in the automobile business. It isn’t true. Mr. Ford shoots about fifteen
hundred cars out of the back door of his factory every day just to get rid
of them. They are the by-product of his real business, which is the making
This is to say that while the articulation of post-Fordist affect is particular to the contemporary moment, it does have historical precedents in which bodies, affects, and sensibilities were tied to one’s suitability and ability to perform work. These two historical moments demonstrate the ways that the management and control of affects is critical to the capitalist enterprise.

In the post-Fordist context, there is a kind of collective mourning for a promise of a better life that never materialized, of middle-class aspirations, or the promise of safety and security (Berlant 2007; Muehlebach and Shoshan 2012). Muehlebach and Shoshan (2012) write: “The variegated modes of remembering, forgetting, grieving, and longing for these past horizons show multiple shades of ambivalence. On the one hand, we find a whole range of ways—some clamorous, others all-but-untraceable—in which people across the globe mourn, or struggle to resuscitate, certain moments of the Fordist dream. At the same time, to paraphrase Freud’s (1953) comments on melancholia, it all-too-often appears as if we know what we have lost but not what we have lost in Fordism” (318). In other words, the affects produced in the wake of the post-Fordist era generate a kind of longing or melancholia for a bygone time and an attempt to recover a kind of stability or social belonging, a theme I take up further in chapter 5. Berlant (2007) describes post-Fordist affect as “a scene of constant bargaining with normalcy in the face of conditions that can barely support even the memory of the fantasy” (278). This kind of melancholia was reflected in the ways women spoke about work and unemployment.

This post-Fordist affect, a kind of nostalgia or desire for a past that included work stability, is importantly gendered and racialized. Nursing, because of its requirements of care and perhaps its physicality, has been gendered female. There is a systemic persistence in the post-Fordist era of devaluing work that women do and the feminization of particular kinds of wage labor. Saskia Sassen (1998) examines two instances of the incorporation of women into wage labor and its subsequent feminization: the recruitment of women into new manufacturing and service work generated by export-led manufacturing in several Caribbean and Asian countries; and the employment of immigrant women in highly industrialized countries, particularly in major cities that have undergone basic economic restructuring. The feminization of the job supply and the need to secure a politically adequate labor force combine to create the conditions for precarious work. Thus, in the context of nursing, there is a labor shortage in Canada and a
surplus of foreign-educated nurses, but the presumed solution to their difficulty in entering the field does not consist of reevaluating the ways foreign credentials are evaluated and counted, but in trying to change the bodily practice and affective performances of foreign workers in ways that are deeply wedded to racialized and gendered ideologies. Thus, these questions of affect are not bound to the classroom, but to larger articulations of what it means to try to live and work in the post-Fordist era with increasing job insecurity and precarity. This precarity is exacerbated for immigrant workers who find questioned not only their credentials and training, but their very bodily movements and affective displays that now mark them as fit or unfit for work.

Yet despite this alienation surrounding their bodies, affects, and suitability for work, there is still an “intense attachment” to Fordist labor (Muehlebach and Shoshan 2012), so that women seek out assistance in how to perform these appropriate affective displays for work, evidenced by the waitlists for such programs and my daily experience of volunteering at the Center. I was sometimes taken aback by the women I was meeting, some at their most desperate, their savings diminishing, their livelihoods unable to sustain them, and their children not living in a manner they had hoped. There was a moment at the Center that will forever be etched in my memory. I was in the habit of reporting to Zubeidah upon arrival at the Center. One day, shorthanded, she gave me the new job postings to affix to the bulletin board, and so I diligently tried to find a place to staple the listings between advertisements for local restaurants and movie nights. Suddenly a woman tapped on my shoulder. I turned, and was startled by how frantic she seemed. She started to speak quickly and passionately. She had lived in Canada for fifteen years and had happily worked in the healthcare industry, but recently she lost her job because she was never made full-time or permanent. As a precarious worker, she had few rights. She tried to go back home but it didn’t work out; she had returned four months before and was desperate for work. She thought I was the employment expert because of the flyer I was holding. She begged me to help her.

This mourning, and desire, for steady full-time labor is an affective sensibility that the women in this study feel as they attempt to fulfill the promise of the good life that was not only a generational promise, but a transnational one. I explore this longing further in chapter 5, but what is important for this discussion of pedagogies of affect here is the ways affective attachments fuel the everyday encounters within and outside of the classroom.
As Molé (2012) argues, “In order to understand post-Fordist affect, we must take its paradoxes seriously: worker’s near-totalizing investment in labor yet attending displacement from it” (377). Both within and outside their classroom, there was a deep investment in work despite their inability to find it. In Nurture classrooms as well as other settlement-services programs, there was a strong desire on the part of participants to gain entrance into a system that maintained their economic and social exclusion. Workers’ investments in projects that contribute to their social exclusion may seem paradoxical in theory, but in practice they make perfect sense because women must succumb to these economic projects in order to survive. One cannot simply opt out of economic life. These women were subjected to the disciplining of their bodies and affects in order to be legible as good and modern workers, which was presented to them as necessary to support themselves.

Thus, affective and bodily performance is central to the making and practice of a modern worker. Flynn (2009) notes, “As with the category woman, there is nothing inherent or essential about the category nurse. The nurse is an invention, or a social creation, ‘a role being played, not an essentialized nurturing identity being expressed.’ In the complex web of the medical hierarchy, practitioners in training, like actors, learn how to play their roles, not only by gaining the required skills, but also through learning mannerisms and behavior that they are expected to display” (94). Within the sanitized sensorium, there are contrasting kinds of bodily performances, affects, and sensibilities required for entry into work. Nursing provides a special kind of case in the context of this study, in which performing a racialized femininity is central to one’s presumed ability to work.

Expectations around affect transform, however, when women transition from intimate labor such as nursing to the cultural labor of performing difference. In intimate labor a woman performs a certain kind of feminized and racialized affect, while in cultural labor she performs a kind of sanctioned difference. The next chapter moves between the space of the classroom and the public stage of multicultural Toronto to look at the double bind that multicultural practice exerts on immigrant women, calling for the erasure of difference in certain contexts and the display of it in others. In the context of the cultural festival, for example, women must perform a kind of radical alterity embodied in the smells and sights of food, music, and clothing. Performances of cultural Otherness are crucial to the state’s multicultural claims of liberalism and inclusivity, yet it continues to exclude immigrant women economically and materially.