"Careworkers don't have a voice:" Epistemological violence in residential care for older people

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ABSTRACT

Drawing on feminist epistemologies, this paper attends to the way the reductionist assumptions have shaped the organization of nursing home carework in manners that are insufficient to the needs of relational care. This paper is informed by a study involving nine focus groups and a survey of Canadian residential care workers (141 RNs, 139 LPNs and 415 frontline careworkers). Four major themes were identified. Reductionist assumptions contributed to routinized, task-based approaches to care, resulting in what careworkers termed "*assembly line care.*" Insufficient time and emphasis on the relational dimensions of care made it difficult to "*treat residents as human beings.*" Accountability, enacted as counting and documenting, led to an "*avalanche of paperwork*" that took time away from care. Finally, hierarchies of knowledge contributed to systemic exclusions and the perception that "careworkers' don't have a voice." Careworkers reported distress as a result of the tensions between the organization of work and the needs of relational care. We theorize these findings as examples of "epistemological violence," a concept coined by Vandana Shiva (1988) to name the harm that results from the hegemony of reductionist assumptions. While not acting alone, we argue that reductionism has played an important role in shaping the context of care both at a policy and organizational level, and it continues to shape the solutions to problems in nursing home care in ways that pose challenges for careworkers. We conclude by suggesting that improving the quality of both work and care will require respecting the specificities of care and its unique epistemological and ontological nature.

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Introduction

"I don't know how to fix it all. But treating people as human beings, be them coworkers, patients, or residents would be a good start."—Frontline careworker

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A cup of coffee is misleadingly mundane. Compared to the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) – an instrument that is rapidly being institutionalized in residential care facilities as the next generation of information gathering and care planning technology – a cup of coffee is surely unimpressive. However, the careworkers we surveyed went to great lengths to emphasize the importance of a cup of coffee in creating a space where relations were forged, knowledge gained and care provided. Careworkers told us that it was often over coffee that they learned important details about residents that proved essential to personalizing their care, balancing tensions and mitigating aggression.

The familiarity gained by sharing coffee with residents is exemplary of a "rationality of caring" (Waerness, 1984) that

differs markedly from the reductionist rationality that makes the RAI-MDS possible. Rationalities of care combine emotional, cognitive and contextual dimensions – such as affective proximity, the intimate knowledge of personal details, and the needs of other residents – to enable a situated understanding (Haraway, 1991; Ruddick, 1995). Furthermore, the development of familiarity requires policy commitments, organizational processes and labor practices that differ considerably from those required to institutionalize the RAI-MDS. While these "relational practices" (Fletcher, 1999) are not incompatible with the RAI-MDS, unlike informatics and auditing they have a hard time surviving in an environment where reductionist assumptions shape how care is known, funded, organized and assessed.

This paper contributes to a line of inquiry seeking to address the marginalization of careworkers and the conditions of work within nursing homes: factors that are intimately tied to the quality of care residents receive (Eaton, 2000). Research on the conditions of work within North American nursing homes has traditionally painted a bleak portrait. It has revealed highly regimented work environments, with careworkers following strict routines and often struggling to balance the tension between bureaucratic requirements and the immediate, individual needs of elderly residents (Foner, 1994; Gass, 2004). Research has also found nursing homes to be understaffed and under-resourced (Harrington et al., 2012), with aides struggling to provide adequate bodily care and unlikely to find time to offer social, emotional and spiritual care (Gubrium, 1997; Hung & Chaudhury, 2011). Under such conditions, intimate care is frequently rushed and can provoke violent retaliation from residents (Shaw, 2004). Inequity is also a concern, with those workers providing the bulk of hands-on care sitting at the bottom of an occupational hierarchy and increasingly drawn from marginalized sectors of society (Diamond, 1992; Potter, Churilla, & Smith, 2006).

There are multiple factors that have contributed to the challenging conditions experienced by workers within North American nursing homes (Armstrong & Banerjee, 2009), and likewise there are also promising attempts to improve the care residents receive (cf. Baur & Abama, 2011). In this paper we aim to draw attention to one persistent barrier to quality, specifically the dominance of the reductionist worldview. We argue that reductionist assumptions have shaped the funding, development and organization of nursing home work in ways that impede relational care. And it continues to inform solutions to quality concerns through, for instance, the institutionalization of the RAI-MDS or the increasing regulation and auditing of care tasks. Thus while we agree with Kontos, Miller, and Mitchell's (2010) assessment that the increasing standardization of care planning through the RAI-MDS privileges clinical factors and excludes input from frontline careworkers, in this paper we wish to take a step back and raise questions about the epistemic assumptions that shape these inclusions and exclusions in the first place. We believe that attending to these epistemic assumptions may help us understand why policy changes aimed at improving care can sometimes make carework more difficult (DeForge, van Wyk, Hall, & Salmoni, 2011).

To name the harms posed by the dominance of reductionist knowing we employ the concept of "epistemological violence," and use it to theorize the challenges reported by careworkers in this study. The concept was developed by Shiva (1988) to denote the violence that stems from reductionism's monopoly of knowledge. "This monopoly," Shiva observes, "results in fourfold violence — violence against the subject of knowledge, the object of knowledge, the beneficiary of knowledge, and against knowledge itself" (233). The consequences of epistemological violence are serious and, as the careworker quoted above cautions, the humanity of both workers and residents is at stake. One of the aims of this paper is to follow this careworker's advice, by raising questions around the styles of knowing that are required to treat workers and residents as human beings as well as attending to the organizational and policy processes that support or thwart this. We begin with a discussion of reductionism and its role in shaping the long-term residential care environment, before turning to a presentation and discussion of our findings.

Reductionism and residential care restructuring

Reductionism is more than a way of knowing or a collection of facts (Haraway, 1991; Harding, 1991; Keller, 1992; Shiva, 1989). Reductionism involves assumptions about the nature of reality and the best way to know it. It orients to the world as mechanical, composed of discrete components that can be taken apart and understood in isolation, independent of the whole. Reductionism makes important assumptions about human beings as knowers and the goals of knowledge. It assumes that valid knowledge is a direct reflection of external reality, one that is unbiased by the subjectivity of the knower and unaffected by the cultural, political and economic contexts of its production. Hence "objectivity" – understood as value neutrality, context independence and affective detachment – is a key marker of reductionist knowledge.

Despite claims to value neutrality, reductionism is governed by an ethos of mastery (Daston & Galison, 2007). As originally imagined by Bacon (1620) reductionist science was meant to grant power over nature; it was never intended to foster compassion. The misogyny of a masculine knower taming a feminine – "mother" – nature in Bacon's writings has not escaped feminist scholars (Merchant, 1988). Similarly, from a postcolonial perspective, the violence associated with reductionism has long been apparent, with Nandy (1988) observing that Bacon's vision of progress was inspired by developments in weapon technology. Indeed, Shiva (1988) observes that reductionism emerged and developed in tandem with other projects of Western domination. "The reductionist worldview, the industrial revolution and the capitalist economy," she writes, "were the philosophical, technological, and economic components of the same process" (238). The reductionist worldview thus evokes dreams of mastery, expansion and conquest, which shape not only our thinking but our aspirations and visions of hope (Code, 2006).

Not least, reductionist dreams of mastery have funneled social and economic resources towards curative endeavors and heroic medicine, promising to solve the problem of death one disease at a time (Bauman, 1993). In the context of modern ambitions, nursing homes are scandalous reminders of our inherent vulnerability and our inevitable dependency. Their funding and the status of those who opt for aging care work compared to other health professions reflect this. And hence much of what is possible to do within nursing homes is already shaped, before one even enters the home, by cultural priorities

that fail to account for the centrality of dependency and the need for care (Kittay, Jennings, & Wasunna, 2005).

In addition to influencing the allocation of social and economic resources, reductionist assumptions have also profoundly shaped the internal operations of nursing homes — including the design and regulation of facilities, the relations of power among occupational groups, as well as the ways in which quality and accountability are conceived. For instance, the development of new public management has relied heavily on reductionist science to make care knowable in new and standardized ways. Reductionism is not solely responsible for the rise of new public management; rather new public management is perhaps best understood as a response to perceived inefficiencies, neoliberal cutbacks and a more general shift towards the privatization of health care (Armstrong & Armstrong, 2005). But nonetheless reductionism has provided the conceptual tools to enable and legitimate this style of management. For "if you can't measure it," observes the director of the Canadian Institute for Health Information, "you can't manage it" (CHSRF, 2000).

In their excellent analysis of the links between new public management and reductionism, Rankin and Campbell (2006) analyze the development of patient classification systems as a means of allocating health care resources. Reminiscent of the scientific management of Taylorism, Rankin and Campbell describe how health service researchers defined and timed nursing work, developing typologies that standardized the needs of patients and the responses of nurses in order to predict and control the resources patients would consume. Through a variety of incentives and educational strategies, nurses were trained to adopt the standardized categories developed by researchers. "In each of these new hospital wards, patients' need for care were made equivalent, one patient to the next, one ward to the next" (30). Reductionist assumptions not only made care manageable by excluding personal and contextual properties, but they also transformed relations of power, scientifically determining the time required to care. Nurses, whose knowledge and concerns were comparatively devalued as 'subjective', were forced to make do and/or redefine their concepts of good care along administrative lines.

Despite clear differences between the curative ambitions of hospitals and the home-like aspiration of residential care facilities, similar managerial technologies have been imported into nursing homes with the aim of improving efficiency, quality and accountability (Leach & Gillian, 2011). As we show in this paper, this has not been without significant consequences for careworkers striving to provide the kind of quality relational care that is difficult to quantify and standardize. In what follows, we explore the experience of careworkers, who we understand as laboring on the "fault line" (Smith, 1990) between the very human needs of the residents they care for and institutional processes that developed in the "shadow of the hospital" (Struthers, 2003) and continue to reflect its reductionist logic.

Methods

Setting

This paper is informed by a study of workers in Canadian residential care facilities in the provinces of Manitoba, Ontario and Nova Scotia. Residential care facilities in Canada are defined as facilities with four or more beds that are funded, licensed or approved by provincial departments of health and/or social services (Statistics Canada, 2007). These facilities are also referred to as nursing homes since they are legally required to provide 24 h nursing supervision. Despite public funding for the medical component of care in Canada, at the time of this study 50% of approved residential care beds were in for-profit facilities (Statistics Canada, 2007: 13). However, there are differences across the country (Banerjee, 2009). In Ontario, 63% of beds are in for-profit facilities, this is compared to 41% in Nova Scotia and 29% in Manitoba. Residential care facilities in Canada are typically large, nearing a hundred beds on average (Statistics Canada, 2007:11). In Ontario, just over half the homes have more than 100 beds, and despite their smaller populations Manitoba and Nova Scotia have 38% and 19% of their beds respectively in such large residences. The size and design of the Canadian facilities make them more hospital-like than home-like.

The Canadian residential care workforce is hierarchical, with a clear division of labor (Daly & Szebehely, 2012). Most of the hands-on care is provided by frontline careworkers. These are unregulated workers who operate under a variety of job titles across the country: health care aides, personal support workers, personal care aides, personal care workers, nursing assistants, nursing aides or long-term care aides. For the sake of consistency, in this paper we use the term frontline careworker (FC). Direct care is also provided, though to a lesser extent by licensed practical nurses (LPNs) and occasionally by registered nurses (RNs), though the RN's role has become largely supervisory. There are some variations among provinces and, other than the requirement for at least one RN on staff, facilities make most of their own choices about the number and skill mix of direct care staff.

Data collection and sample

To learn about the workers and their conditions of work within nursing homes in Manitoba, Ontario and Nova Scotia we distributed a questionnaire and conducted a series of focus groups in 2007. The survey sample was designed to be proportional by provincial population and facility ownership type. Ethical approval was received from York University, and access to facilities was enabled by five health sector unions, who identified a coordinating person within each institution to distribute the questionnaire. In order to ensure anonymity and independence, respondents mailed the questionnaire directly to the Institute for Social Research at York University, which was responsible for the sample design, survey distribution, collection and data entry. In total, 948 workers from 71 of the 81 (88%) facilities participated. The returned surveys represented the major occupational categories and included 415 frontline care workers, 139 LPNs, and 141 RNs.

The questionnaire focused on workers' experiences, asking workers about their training; the tasks they performed on an average shift; their workload; social and recreational activities with residents; reporting and documentation; job interest and satisfaction; communication between colleagues and supervisors; as well as exposure to violence and risk. Recognizing that the majority of workers were women, the questionnaire also asked about their care responsibilities outside of work and how

their work impacted these duties. The questionnaire provided respondents with numerous open-ended sections to elaborate, express concerns and offer recommendations. However, beyond data on ownership, location and size which we gathered prior to the survey, we did not gather official data on facility level characteristics such as overall resident acuity, operating budgets, models of care or management philosophies.

An analysis of the quantitative data collected showed a highly gendered work force. The vast majority of frontline careworkers (95%) were women born in Canada (87%). Most workers had extensive job experience, with almost two-thirds working in residential care for a decade or longer. The survey also revealed a number of barriers to care, including: understaffing, working short, heavy workloads, insufficient time to care as well as a high degree of both injuries and violence (Banerjee et al., 2012). Not surprisingly, workers' primary concerns were their heavy workloads (59%), staffing levels (57%), regulation resulting in more difficult work (34%), violence (32%) and low wages (29%). When asked what changes they would recommend, eight out of ten workers called for increased staffing.

Following this quantitative data analysis, nine focus groups were conducted to explore and validate findings (two in Nova Scotia, two in Manitoba, and five in Ontario). Union contacts advertised for participants but did not attend the sessions themselves. Each focus group had between three and eight participants, primarily female frontline careworkers. Participants were not asked whether they had previously received or completed the survey, though one participant in a Manitoba focus group volunteered that she had received the survey but did not complete it (remarking that it came during union negotiations, and she believed it to be a management tactic).

Three experienced facilitators ran the sessions, following a semi-structured interview schedule designed to parallel the survey. Workers were asked: to describe their daily work routines, workloads, flexibility and level of control over their work; whether and how they were able to meet residents' needs; as well as about injury or violence on the job. Survey findings were also presented to participants, and they were asked to comment on any similarities and differences in their own workplaces. These focus groups enabled us to explore questions in greater depth. For instance, focus group participants with a long history in the sector were able to comment on the growth of documentation and its impact on their work, a key concern revealed by the survey. New issues were also brought up for discussion and explored through subsequent focus groups (e.g., the rationing of diapers, Armstrong et al., 2009). The focus groups were recorded then transcribed verbatim.

Data analysis

In this paper our analysis centers on the open-ended survey and focus group data as we are interested in highlighting the voices of careworkers. We attend primarily to the experiences of direct careworkers, which include RNs and LPNs as well as frontline careworkers, for while their duties differ they offer important perspectives on the tensions between the reductionist organization of work and the requirements of relational caring. Indeed, the privilege of reductionist knowledge has particularly transformed the duties of RNs, as their jobs have

become more 'knowledge' based and less about the 'manual' work of caring (Dellefield, 2006).

To analyze the qualitative data from both the surveys and focus groups we used an inductive approach (Morse & Field, 1995). The data was first coded using in vivo labels as well as codes derived from a review of the literature. From these codes a list of categories were developed (e.g. autonomy, working short, blame, routines, trust). The research team met several times during the process to discuss the categories, their relations and begin to identify emerging themes (De Santis & Ugarriza, 2000). These themes provided a framework to organize related categories. Thus, the theme of "*assembly line care*," brought together the categories of "tasked based bodywork," "routines," as well as "lack of autonomy."

Once key themes were identified, we went back through the data to nuance their development and identify negative cases (Patton, 1999). We also attempted to determine if there were any patterns attributable to ownership and size. However, we did not find any with respect to the themes presented in this paper. This is may be explained by the fact that regulations and auditing must be applied equally across institutions to ensure a 'fair' marketplace. Further, given the few male direct careworkers we had in our sample, we did not attempt to analyze qualitative data presented here on the basis of sex. And while the questionnaire did not attempt to capture the facility's models of care, with the growing culture change movement and related attempts to implement person centered care, exploring whether and how person centered care may create processes faithful to the logic of care is an important avenue for future research, particularly as some approaches to person centered care also recognize the importance of empowering workers (c.f. Sheard, 2009). We presented our developing analyses back to workers through professional organizations as well as conferences organized for frontline careworkers as a means of further validating our analysis.

Until these presentations for to workers, reductionism's role in organizing care work was not a research focus. However, two overlapping events drew our attention to the importance of reductionism in generating the barriers to care that we had identified. The first event was the reaction of workers when they realized that the violence they experienced on a regular basis – and had believed to be limited to their facility – was, in fact, systemic. Workers responded with anger and frustration that they were not in a position to be heard, reactions which resonated with experiences captured in our data. The second event was a presentation by the Ontario Ministry of Health and Long-Term Care, describing the new compliance process which had as its center piece the institutionalization of the RAI-MDS across the province of Ontario. The degree to which this presentation celebrated scientific expertise and promised to use technology to inform careworkers about residents' needs contrasted markedly with our findings that careworkers' believed they already possessed important knowledge that was routinely being ignored.

We turned to feminist epistemology to search for theory that could help make sense of these contradictions. We found the theory of epistemological violence (Shiva, 1988) fit our data well and was helpful as a means of organizing our findings. Using the concept of epistemological violence we were able to group together a number of themes that we had already identified on the basis of whether they resulted, at least in part,

from the hegemony of reductionism or the neglect of a rationality of caring. In what follows, we report those themes. We thus note that while our presentation of the data is theory driven, our analysis was not (Sandelowski, 1993). We also note that we do not present an exhaustive description of the way in which reductionism's dominance harms care, simply the main themes identified through our survey and focus groups.

Findings

In addition to the heavy workloads, low staffing and violence explored in previous publications (Daly et al., 2011; Banerjee et al., 2012), careworkers in our study identified a number of concerns that illustrated the tensions between the reductionist organization of carework and the needs of relational care. We present the concerns careworkers raised around their location at the bottom of an epistemic hierarchy and the regimented, task-based approach to care under the theme "*assembly line care*." Under the theme "*treating people as human beings*," we present the challenges careworkers experienced when attempting to provide social, spiritual and emotional care. Careworkers also noted that regulation and documentation were becoming excessive, taking precious time away from carework, and we describe these observations under the theme "an avalanche of paperwork." Finally, under the theme "careworkers don't have a voice" we report on some of the systematic ways in which careworkers' knowledge was lost at both an institutional and policy level.

Assembly line care

In line with previous studies (cf. Foner, 1994; Gass, 2004), residential care was found to be a hierarchical work environment, characterized as almost "*army like*" in some instances, with power highly stratified in the form of a "*power pyramid*" as one LPN described it.

This power pyramid was structured along epistemic lines. We were told that the most prestige was allocated to physicians while frontline careworkers were at the bottom of this hierarchy. In the words of one frontline careworker: "*PSWs [personal support workers] are the frontline caregivers we see all and do all but we are treated very differently. We are only PSWs, we know nothing to a lot of people. But families, nurses and doctors would know nothing without us.*"

The work of frontline careworkers was organized as a series of body-based tasks – e.g., bathing, dressing, feeding toileting – which could be determined by others and scheduled in advance. This contributed to a highly regimented environment. "*You have breakfast at a certain time. You have dinner time at a certain time. You've only got a very limited time to do 'x' number of residents, and therefore you're getting them in, getting them dressed, and getting them back out*"(FC).

Careworkers also reported little decision-making autonomy. Many described a command and control style of organization: "*Everything is told*," wrote one frontline careworker, "*no choice, just do it.*" Careworkers also reported little flexibility in organizing their work. As a consequence they felt caught between completing delegated tasks and meeting residents' immediate needs. "*The higher ups pull their weight around by demanding that you do as they say, not what the resident wants*"(FC). This tension was experienced not only by FCs but

also by RNs and LPNs. As one LPN we surveyed wrote: "*I am a compassionate health worker who believes that we should work for the residents, but all too often they work for us on our tight schedule.*"

Careworkers' descriptions of their work were haunted by images of the factory. Residents were described as being "*pushed through daily routines like an assembly line*" (FC). This notion of "*assembly line care*" pervaded many descriptions of carework and was attributed to multiple intersecting factors, as one frontline careworker with over 25 years of experienced observed: "*I fear that our care is in danger of becoming 'assembly line nursing' due to government demands and lack of government funding, lack of time to care properly for our residents; not just their physical needs but all aspects of emotional care too.*"

The regimented organization had negative consequences for workers. As one RN explained, "*job satisfaction has a lot to do with one's ability to have flexibility in their work schedule and work structure. Control in what you do makes you feel more accomplished at the end of the day.*" Careworkers noted that task-based work routines impacted residents. Rather than caring for people, one careworker observed that "*residents feel like a number on a list of things to do.*" "*The elderly are human beings,*" another felt compelled to clarify, "*not just a number.*"

Treating people as human beings

Another important theme that emerged in our analysis was the near impossibility of providing relational care, that is addressing residents' emotional, social, existential and spiritual needs. Careworkers commonly attributed this to their heavy workloads. However, as noted in the introduction, workloads are constituted by a number of factors not least of which are reductionist assumptions that determine the type of work that matters. Careworker consistently noted that quality should involve relational care: "*Our job does not just include washing and dressing but should also include time to spend talking or socializing with our residents.*"

Despite the move towards instituting resident assessment technology, workers told us that their inability to provide relational care did not result from a lack of knowledge. Workers were able to get to know what residents wanted by building relationships. In some cases strong bonds were formed: "*Some of them become almost family*" (FC). Careworkers were also able to put themselves in the resident's place and imagine what they might want in similar situations, though this did not mean they could deliver. "*It really makes me feel personally bad when I know in my heart how somebody should be cared for, how you know that you would like to receive care yourself, how you believe that your family members should receive care. And when you are in that situation giving care to the residents and you know there's no way you can approach what you feel you should be doing, that is a very disappointing thing. You know you're letting the residents down and yourself down.*"

The relational dimensions of care were reported to be among the most rewarding for workers, and presumably for residents as well. And the inability to provide relational care was a source of great distress. "*It is extremely frustrating when someone is lonely or upset and you have to brush them off because you are responsible for so many residents. How can you choose between talking to someone who is upset or someone who needs changed from a soiled incontinence product? You feel on a daily*"

basis a feeling of disgust and frustration…"(*FC*). Or as another careworker expressed: "*It's heartbreaking when you leave and you know that say a resident has been upset and you haven't had the time to sit and talk to that resident..…It hurts that you don't have the time to sit and deal with this resident's problem. You leave the building. And that goes home with you, you know. If you care about the job and you care about the people you're looking after, this goes home with you.*"

While the time workers had for care did not typically include its relational dimensions, some workers responded by performing unpaid labor, staying late or coming in on their days off. "*I can tell you that there's staff that will physically come back to work to sit with people on their off time off because somebody is going to die alone and they don't want that.*" Or as a new LPN described in the survey: "*I love working with the elderly but there just isn't enough time for one on one or even taking them out for coffee or fresh air. I do take a couple of my residents out on my days off. They really enjoy that.*"

The avalanche of paperwork

Given the above findings, it is not surprising that the quality of nursing home care has become a source of concern. However, the means of accounting for care that have developed in response are themselves shaped by the reductionist worldview, relying on rules, standards as well as counting and documenting to secure quality.

Careworkers identified a number of problems with such forms of accountability. Most commonly, we heard that they were required to engage in labor intensive reporting – "*Even when you cut their fingernails and toenails it's recorded.*" This resulted in, what one careworker describe as, an "*avalanche of paperwork.*"

Many careworkers observed that such documentation took scarce time away from the work of care. This was particularly true for RNs, as one explained in the survey: "*Too much time is spent documenting to meet compliance standards and classifica-tion. I wish I could spend more time with residents doing actual nursing care, i.e. prevention, health teaching, palliative etc. to improve their quality of life.*" Similar concerns where expressed by experienced RNs who were particularly able to comment on impact that auditing and cutbacks have had on their profession: "*I chose Nursing almost 32 yrs ago when RN's were in abundance and nursing was actual hands on direct care. Now I am buried in paperwork, compliance + MOH [Ministry of Health] regulations. The real enjoyment has disappeared from this noble profession.*"

Careworkers described many standards around tasks such as toileting and bathing, which were enforced through such documentation. But they noted these accountability practices often missed interconnections and context. As we heard in the last section, in order to meet compliance requirements, care often had to be sacrificed elsewhere, particularly the relational care that is harder to quantify and document. Careworkers also observed that the structural and contextual conditions of care, such as staffing levels and workload, were often overlooked by such regulations: "*We keep getting more paperwork, more computer work,*" wrote one LPN. "*But we don't seem to get more help.*"

Careworkers indicated that while it was possible to document task completion, such reporting did not capture *how* these tasks were performed. Similarly, documents could

reflect the number of baths a resident received but not the quality of conversation nor the performance of this intimate act. Such tensions between the objectivity of documentation and the subjectivity of care were often raised. Taking the example of dining, one RN observed in the survey: "*There is no consideration given for the residents' enjoyment of their meal, all they care about is the order in which food is served and that it is done properly.*" Another LPN we surveyed expressed the contradiction this way: "*It's not the food or personal care they appreciate most, it is the time you spend with them – even if it is a simple hug or a listening ear. Most days there is inadequate time to do so, as we are constantly focused on Ministry [of Health] needs and policies under the watchful eyes of management.*"

Despite the use of documentation as a means of account-ability, careworkers observed that documentation was often inaccurate. For instance, differences were noted between scheduled staffing and actual staffing, with working short a common occurrence. Forms were also completed in a rush contributing to inaccuracies. And workers told us they would show up for workplace training, sign the attendance form and leave shortly thereafter, as they did not have the time to attend the full session. Similarly, workplace violence typically went unreported. Also salient was the perception that this documentary reality was more important than lived reality. As one RN we surveyed remarked: "*I often feel the bottom line, or how it looks on paper is more important than what actually gives residents a better quality of life.*" Another LPN wrote: "*All management wants is for all the paperwork to be in order, even if it's the resident who suffers in order to make that happen.*"

Careworkers don't have a voice

Careworkers viewed themselves as important sources of knowledge. However, they noted that there were few oppor-tunities or processes to integrate their knowledge into decision-making at organizational and policy levels, resulting in various harms.

At the organizational level, one recurring theme was the lack of dialogue between staff, which was noted as essential for updating colleagues on changing residents' status and needs as well as for building collegiality. Some careworkers noted that structural conditions, such as the elimination of overlapping shifts or insufficient staff, created barriers to communication.

Lack of dialogue between careworkers and management was also observed. This resulted in mistrust and a perception that managers were unaware of the conditions on the floor. "*Management sit in their…offices and do not see how things really are,*" wrote one LPN. "*It is not fair to the staff, but is especially not fair to the residents.*" Or in the words of an FC: "*Health care aids/PSWs have no dialogue with their supervisors …This creates a 'care less' attitude, which affects the residents. I miss the team-work, respect towards each other.*"

Other knowledge gaps were identified. Careworkers felt that current policy did not reflect the reality of carework. "*The people with authority need to work on the floor and along with us to really understand our workload and frustrations,*" wrote one frontline careworker. "*Then maybe they would really listen to us and ask us for our input for better resident care and less staff burn out.*" Speaking of Ministry regulations, another frontline careworker with over fifteen years in the field was quite blunt: "*I feel sometimes people who make rules for the [Ministry of*

Health] are uneducated…I feel these rules should be made by people who have worked in these facilities." Careworkers also felt government officials were unaware of the consequences of their decisions. "*I feel the government should visit these facilities and actually see how hard we work and what it is like for a resident. They would see how the cutbacks have affected the time you get to spend with a resident*"[FC].

The disconnect between those who have knowledge of carework and those who design policy was observed to be a fundamental barrier to quality. As one LPN explained:

The health care field is steadily getting worse because no one asks the people who would know what would work – the people who work daily with these residents. The Department of Health makes decisions – from people who sit behind a desk, as management – most of us have zero input and have to bear the brunt of their ridiculous 'solutions'.

Finally, it is worth noting that some of the careworkers quoted above did not suggest they should be directly involved in decision-making. They expressed frustration that their voices were not heard, yet rather than demand inclusion in the policymaking process they suggested policymakers temporarily occupy their position. "*There should be a 'law' that EVERY member of parliament should live in a nursing home for 90 days and be giving care and meals just like it is now on a limited budget that 'they' allow. I am 100 percent positive things would change overnight…*" (*FC*). We suggest the perception that careworkers do not have a place at the decision-making table may be indicative of how deep their epistemic marginalization has become. Indeed, when asked for recommendations, one frontline careworker flatly refused: "*No. There is no point. PSWs don't have a voice.*"

Conclusion

In addition to heavy workloads, low staffing and inadequate training presented in previous papers (Banerjee et al., 2012; Daly & Szebehely 2012), this study identified additional barriers to the provision of quality care from the perspective of careworkers. Strict routines and task-based approaches to care resulted in what careworkers termed "*assembly line care.*" Insufficient time for the relational dimensions of care made it difficult to "treat residents as human beings." Accountability, implemented as counting and documenting, led to an "avalanche of paperwork" that took time away from care. And hierarchies of knowledge contributed to the devaluation of careworkers, reflected in their low pay, low status, exclusion from decision-making and the perception that they "don't have a voice."

We suggest that these findings may be understood as instances of what Shiva (1988) terms "epistemological violence." This concept points to the harmful effects of the hegemony – the taken-for-granted dominance – of the reductionist worldview, as described in the introduction to this paper. The hegemony of reductionism, according to Shiva (1988:236), results in a number of exclusions: ontological in that the relational properties of reality are neglected; epistemological in that other ways of knowing are not recognized; and sociological, resulting in a loss of power of knowers whose expertise does not fit the reductionist

worldview. These exclusions are apparent in the experience of residential careworkers in this study and those of others (cf. Diamond, 1992; Foner, 1994; Gass, 2004). For instance, as seen in their struggle to find time to attend to the relational needs of residents (ontological), their exclusion from decision-making (epistemological), and their low pay and occupational status (sociological). Attending the hegemony of reductionism helps explain the persistence of such findings.

Epistemological violence expands our understanding of the violence that careworkers are routinely exposed to (Morgan et al., 2008). However, while epistemological violence results in very real harm, it is unlike physical or verbal violence in that it is an impersonal form of violence, akin to structural violence (Galtung, 2005) or institutional sexism (Acker, 1990). Epistemological violence does not require the explicit intention to cause harm and its agency is indirect. This is because the hegemony of reductionism works through individuals and structures, shaping, for instance, the repertoire from which solutions to problems in long-term care are imagined. It thus appears sensible to import strategies such as lean production from the automobile industry (Baines, 2004) or auditing practices from the financial sector (Power, 1999) to organize residential carework. And these strategies appear sensible so long as the effects of these decisions remain invisible. However when we attend to perspective of careworkers, their distress is compelling, and epistemological violence allows us to name this as violence — a preventable form of harm.

Of course, we are not suggesting reductionism is solely responsible for the challenges that careworkers experience. Indeed, the workers in this study reported that insufficient time and inadequate staffing were the most significant barriers to care (Banerjee et al., 2012). And heavy workloads, inadequate funding and growing for-profit provision have been identified by numerous studies as posing significant barriers to quality (Harrington, Olney, Carrillo, & Kang, 2012; McGregor & Ronald, 2011). However, we are suggesting that the hegemony of reductionism contributes to these challenges not least by diverting attention from structural conditions such as public funding levels or for-profit ownership and focusing attention narrowly at the level of facilities and, more specifically, on individual care tasks (Banerjee & Armstrong, 2015). Thus delays in responding to residents' call bells, for instance, result in recommendations that standards for response times be determined and monitored (BC Ombudsperson, 2012). The reductionist lens encourages such technical solutions, promising to solve one problem at a time while missing the structural conditions such as understaffing that shape the context for care. Reductionism is certainly not the only factor contributing to the "ritualistic" turn to rules, science and technology that Braithwaite, Makkai, and Braithwaite (2007) observe plaguing the sector. Such 'solutions' are politically expedient; not least they avoid raising challenging ethical, political and economic questions. And the hegemony of reductionism enables these solutions not only to appear sensible but also to be celebrated as innovation.

Addressing epistemological violence requires us to both recognize the specificities of care and to design policies, institutions and practices that are faithful to its logic. There is a rich and growing tradition of feminist scholarship outlining care's unique ontological, epistemological and ethical qualities (Armstrong, 2014; Code, 2006; Lloyd, 2004; Mol, 2008). It

suggests that care does not emerge from the clockwork universe of reductionist science, in which human mastery over nature was thought possible. Instead, it takes a less aggressive view towards human mortality, yet by no means is it passive. This line of research is working to outline the kinds of policy changes that will be required to enable caring institutions and caring practices to thrive, with promising implications for long-term care (Eckenwiler, 2012; Mol, Moser, & Pols, 2010; Neysmith & Aronson, 1996; Perkins, Ball, Whittington, & Hollingsworth, 2012; Williams, 2011). For instance, instead of "becoming obsessed with proving and accounting," what is recommended by care theorists such as Mol (2010:278), is that "we trace and articulate ways of attending to quality that are already at work within care practices," and learn from and build on these.

We conclude on an optimistic note, considering the example of the Mate Mio, a process in Norway designed to address particularly challenging resident behaviors through the use of video recordings (Moser, 2010). Recordings are not used to document care but to improve care by developing an understanding of what works and then building on this knowledge. The process draws on familiarity and multiple perspectives as well as diverse skill sets to iteratively produce a situated understanding. However, the knowledge produced is not to be transported to centers of power for auditing nor is it expected to endure, as truth or fact. It is to be used by careworkers in a contingent and pragmatic manner – for as long as it works. In this process careworkers' voices are heard, but it would be a mistake to understand this as primarily a means of including workers. Rather listening to careworkers is an *outcome* of respecting the logic of care, which transforms the terms of discourse, and specifically who has knowledge worth hearing.

Recognizing the specific qualities of care allows us to better understand *why* such processes are successful in providing better care and it also suggests *how* existing and/or additional resources might be better spent. It also helps us understand why policies and procedures to improve care so often fail (DeForge et al., 2011). And it is our hope that by drawing attention to epistemological violence in nursing homes we not only contribute to making visible harms which too often remain hidden but also help create openings for the development of authentically caring solutions, which may improve the lives of nursing home residents and their careworkers.

Acknowledgments

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