

MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Tacit Knowledge in Low-Status Eldercare Work

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Abstract

Cultural failure to recognize tacit knowledge that informs eldercare is key to understanding how and why the labor of workers in this area of professional caregiving, especially those earning low wages, is dramatically undervalued in the US health sector. This essay first explains key differences in credential-based knowledge and tacit forms of health knowledge and then considers how status differentiation privileges credential-based knowledge of clinicians of higher status, such as physicians and nurses, who do not perform the hour-to-hour care for most of our country's elders. Finally, this article suggests the ethical and clinical importance of health care organizations' sources of knowledge and roles in equitably valuing labor to promote quality service delivery, better working conditions, and better pay for workers earning low wages.

Tacit Knowledge in Health Professions

Rapidly aging societies like the United States face a looming labor shortage of care workers.¹ One-fifth of America's population has already reached retirement age.² Adding to demand, high turnover rates among poorly paid home care workers will create millions of job openings over the coming decades.¹ This exodus is driven by society's failure to recognize the value of tacit knowledge that underpins all types of care work—childcare, eldercare, and hospice care. In the case of **geriatric care** (the focus of this essay), long-serving eldercare workers confront an underestimation of the skills and knowledge required to successfully care for the frail elderly and particularly for those with dementia. Yet, intuitively, when a family member or medical staff member informally interviews eldercare workers about a client's well-being, the communicative act implicitly recognizes the importance of such workers' "tacit" knowledge.

In interactive service work, embodied capacities—such as gestures, facial expressions, ways of approaching, and touch—are consequential for delivering quality care. Sensory dimensions of care work require intuitive knowledge of both psychology and physiology learned on the job. Care workers administer care in tune with a patient's temperament while handling the patient's frail body. They tailor care to respond to their patient's moods, not merely to medically diagnosed health conditions.

As an anxious daughter caring for my elderly mother, who is lost in the depths of dementia, I relied on her care workers' firsthand narratives for understanding the

vagaries of her condition. Valuing care workers' tacit knowledge can enhance the quality of formal medical care and aid in the evaluation of best practices for treating seniors with a range of conditions.

Society's failure to recognize the **tacit knowledge** that informs eldercare is key to understanding how and why the labor of workers in this area of professional caregiving, especially the labor of those earning low wages, is undervalued in the US health care sector. To address this social deficit, I first explore how the tacit knowledge of low- and high-status health professions is valued and constructed differently. I then offer a menu of methods for acknowledging and encoding tacit knowledge that can be mobilized to improve the delivery of quality care and provide fair compensation to care workers. By failing to socially recognize and foster the development of eldercare workers' important contributions, the current health care system risks losing valuable and unappreciated sources of knowledge. An ethical point of view demands respect for the full range of competencies that eldercare workers utilize in taking care of the sick and vulnerable in our society.

Building and Valuing Tacit Knowledge

Tacit knowledge refers to knowledge gained by accumulating personal experience on the job that can be difficult to transfer to others via written or oral communication.³ Physicians enjoy the benefits of years of accumulating tacit knowledge that is structured by career pathways. "Tricks of the trade" captures the notion of expertise honed on the job; these include the adjustments necessary to perform a job well and improvisational techniques of addressing problems in situ, all of which become part of physicians' tool kit applied in future cases. Professionals often **communicate their tool kits** through training protocols. Medical school students shadow doctors on their rounds, observing good practices that enable them to gain tacit knowledge, while they glean formal knowledge from coursework. Such a training structure, however, reflects the ability of physicians to monopolize knowledge certification. Even trainees in male-typed skilled trades must complete an approved apprenticeship to practice as an electrician, plumber, or mechanic.⁴ By contrast, in low-status feminized health care work, the lack of a formalized training structure impedes the transfer of tacit knowledge as a valuable resource for enhancing care competencies. Health aides on the lowest rung of the job ladder tend to work in isolation from others, further depriving them of opportunities for communicating their tacit knowledge gained on the job.

How to value care work presents a conundrum. Is care work valued less because of its low educational requirements or because **women perform this work**? According to England et al, low relative wages "cannot be explained [fully] by low unmeasured human capital or a disinclination to bargain for high pay among care workers, because these individual characteristics would presumably affect their pay in all jobs."⁵ Instead, gender bias associated with care work helps to account for unexplained differences. Despite having jobs with no formal educational requirements, cleaners and orderlies in 2021 earned a median hourly wage of \$14.31 and \$14.56 respectively,^{6,7} whereas home health and personal care aides, who must meet some educational or training requirements, earned a median hourly wage of \$14.15.⁸ Home health and personal care aides typically need a high school diploma or equivalent, although some positions do not require it, and workers in certified home health or hospice agencies may need to complete formal training or pass a standardized test.⁸ The definition of care work as unskilled labor reproduces a gendered hierarchy within low-wage jobs.

Care as Undervalued

The low social and monetary value accorded to care work has been attributed to its close association with devalued racialized, female-typed work⁹ and to the unacknowledged and thus unremunerated tacit knowledge on which the emotional and affective labor involved in personal interactive services relies. Although such labor is undeniably important to the health and well-being of individuals, neoclassical and traditional political economic theories underestimate care work by reducing what counts as labor to easily quantifiable activities, such as the physical labor of bathing, feeding, and dressing an elder.¹⁰ This human capital perspective is thus blind to distinctive, intangible aspects of the care encounter by excluding a range of labor activities and competencies vital to the performance of good care.

Health care systems structure occupations in finely graded hierarchies based on the value of assumed competencies.¹¹ In geriatric care, nursing staff with formal training and objectified qualifications (symbolized by credentials and licensing) in addition to knowledge gained on the job are higher in the hierarchy than health aides with little or no training or formally recognized expertise in health care. Moreover, socioeconomic status distinctions correspond to educational credentials and other forms of transferrable and explicit knowledge. Lacking credentials and status, eldercare workers are treated as unskilled irrespective of their actual educational attainment, years of job experience, or possession of tacit knowledge. For these reasons, tacit knowledge is lost to the health care system.

Revaluing Tacit Knowledge

Feminist scholars call for redefining care as relational—as enhancing the capabilities of others and deploying skills of emotional competence and bodily capacities.^{12,13} More than other types of service work, care work produces something novel, as it generates affective relations and well-being.¹⁴ Care work is performed through intimate, face-to-face interaction, during which the care worker enhances the recipient's human capabilities, including “physical and mental health, physical skills, cognitive skills, and emotional skills, such as self-discipline, empathy, and care.”¹⁵ The quality of care depends on the quality of relationships built up over time.¹⁵

In addition to redefining care work, some feminist scholars emphasize the entanglement of normative, economic, and social frameworks of care.¹⁶ In a novel twist, Joan Tronto expands the notion of ethics to encompass many everyday judgments involving attentiveness, competence, responsibility, and responsiveness in caring for others.¹⁷ Yet, as a social activity, care work tends to go unnoticed and become naturalized and “inseparable from the person producing it.”¹⁸ In general, tacit knowledge in care work, including emotional and affective competencies, remains invisible, unacknowledged, and devalued though critical to the care encounter, especially to establishing rapport with and soothing the patient. The art of good care involves enhancing a patient's moods and addressing a patient's physical and emotional well-being through talking and listening.

Other aspects of tacit knowledge enhance the care encounter, such as trust and rapport. Trust is considered essential to fostering relationships through mastery of 4 main elements: (1) consistency, (2) compassion, (3) communication, and (4) competency.¹⁹ Because the quality of care depends on the quality of relationships, the care worker must establish rapport and trust cultivated through attentiveness to the patient's changing emotional and physical needs. Nevertheless, the work of building

trust tends to be overlooked in the care encounter even though its absence can have catastrophic effects if patients refuse to accept the course of treatment because they lack trust in the caregiver.

Overall, through their proximity and intimate contact with patients, eldercare workers calibrate care in real time in response to their patient's emotional states and changing needs. Like an ethnographer, eldercare workers' accumulated knowledge from their "field" experience enables them to form a holistic portrait of the patient's physical, emotional, and cognitive well-being constructed from their intimate and frequent contact with the patient. Sustained observations and extended contact are particularly relevant for patients with dementia, who cannot easily articulate their feelings and health conditions. All eldercare workers, especially live-in workers, command a wealth of largely unmined lodes of data on patients. The COVID-19 pandemic began to magnify this rich loam of hidden labor, as it increased the demand for tasks like cleaning and hygiene routines, emotional labor, and food preparation in private homes and senior facilities, all situations in which safety precautions devolved to the care worker. Restrictions on mobility and intermingling of households left many eldercare workers as the primary point of emotional and physical contact for clients.

Acknowledging Tacit Knowledge

By what methods can tacit knowledge be acknowledged and thus transferred in the training of care workers and in communicative action regarding a patient's health profile? New technologies can create opportunities to develop and transfer tacit knowledge, and such changes in practice can support the effort to revalue care work and eldercare workers.

First, new modalities of communication technology can transform care workers' smart phones into digital journals for recording patients' conditions on a routine basis. Used by other medical professionals, digital templates can provide checklists to input standardized data and designate a space for narrative accounts that can later be uploaded to the patient's web portal for use by the medical team to address the patient's condition.²⁰ From this vital source of data, medical staff can assess the efficacy of and patients' responsiveness to treatment plans, allowing for adjustments in real time to increase the effectiveness of health care. Digital journals, encrypted to ensure confidentiality, if required by the medical profession, would incentivize employers to allocate time to and compensate workers for performing this vital task.

Second, an innovative methodology for video hermeneutics can take into account the content and context of nonexplicit forms of knowledge in interaction. Visualization of sensory and bodily expressions through videography makes available objects and interactions for interpretation by preserving a record of the field in addition to the usual ethnographic notetaking.²¹ Medical schools could add video hermeneutics to their curriculum, dispersing students to observe and interpret data collected through this field experience. Such data would not only deepen the medical community's understanding of best practices for eldercare, but also contribute evidence of the knowledge and skills utilized in the care encounter.

Third, instituting peer-to-peer ongoing education could formalize the transmission of tacit forms of knowledge among eldercare workers. The American Medical Association could partner with unions representing eldercare workers to establish channels for ongoing education and for certification of workers' experience, competencies, and skills.

Certification would have salutary effects for families tasked with navigating a confusingly opaque and often impenetrable cacophony of care options rooted in the fragmented and labyrinthine patchwork US health care system by giving them a yardstick for assessing care workers' skill sets that are necessary for addressing evolving eldercare needs.

Fourth, and finally, elevating health aides to members of medical teams would enhance the status of eldercare workers,¹ as well as enable the collection of vital data about patients' health conditions (affective, physical, and mental health) since care workers possess the most intimate knowledge of how patients react to and recover from health conditions—knowledge which would otherwise be lost to the care team.

In sum, acknowledging tacit skills would foster reevaluation of care work and thus serve to rectify inequitable compensation and to recognize and upgrade the status of this essential workforce, thereby encouraging workers to enter and remain in the field while also improving the delivery of quality care. Treating care workers as vital members of the medical team will dignify both the work and the workers.

References

1. Osterman P. *Who Will Care for Us? Long-Term Care and the Long-Term Workforce*. Russell Sage Foundation; 2017.
2. Older people projected to outnumber children for first time in US history. News release. US Census Bureau; March 13, 2018. Accessed April 18, 2022. <https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html>
3. Polanyi M. *Personal Knowledge*. Routledge & Kegan Paul; 1958.
4. Adler PS. The dynamic relationship between tacit and codified knowledge: comments on Ikujiro Nonaka's "managing innovation as an organizational knowledge creation process." 1996. Accessed April 17, 2022. <https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.541.2708&rep=rep1&type=pdf>
5. England P, Budig M, Folbre N. Wages of virtue: the relative pay of care work. *Soc Probl*. 2002; 49(4):455-473.
6. Occupational Outlook Handbook: janitors and building cleaners. US Bureau of Labor Statistics. Updated May 6, 2022. Accessed July 21, 2022. <https://www.bls.gov/ooh/building-and-grounds-cleaning/janitors-and-building-cleaners.htm>
7. Occupational Outlook Handbook: nursing assistants and orderlies. US Bureau of Labor Statistics. Updated April 18, 2022. Accessed April 25, 2022. <https://www.bls.gov/ooh/healthcare/nursing-assistants.htm>
8. Occupational Outlook Handbook: home health and personal care aides. US Bureau of Labor Statistics. Updated April 15, 2022. Accessed July 20, 2022. <https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm>
9. Glenn EN. *Forced to Care: Coercion and Caregiving in America*. Harvard University Press; 2010.
10. Gottfried H. *Gender, Work, and Economy: Unpacking the Global Economy*. Polity Press; 2013.
11. Boris E, Klein J. *Caring for America: Home Health Care Workers in the Shadow of the Welfare State*. Oxford University Press; 2012.

12. Boris E, Parreñas RS. Introduction. In: Boris E, Parreñas RS, eds. *Intimate Labors: Cultures, Technologies, and the Politics of Care*. Stanford University Press; 2010:1-12.
13. Gottfried H, Chun J. Care work in transition: transnational circuits of gender, migration, and care. *Crit Sociol*. 2018;44(7-8):997-1112.
14. Hardt M. The capacities of democratic citizenship. Paper presented at: 5th Annual Conference in Citizenship Studies; March 27-29, 2008; Detroit, MI.
15. Dowling E, Himmelweit S. COVID-19 and the financialisation of social care. Paper presented at: SOAS Social Policy Seminar Series; February 8, 2022; London, UK.
16. Daly M, ed. *Care Work: The Quest for Security*. International Labour Organization; 2001.
17. Tronto J. *Moral Boundaries: A Political Argument for an Ethic of Care*. Routledge; 1993.
18. McDowell L. A tale of two cities? Embedded organizations and embodied workers in the city of London. In: Lee R, Willis J, eds. *Geographies of Economies*. Arnold; 1997:118-129.
19. Vodicka D. The four elements of trust. *Principal Leadersh*. 2006;7(3):27-30.
20. Gaspar AGM, Lapão LV. A digital health service for elderly people with balance disorders and risk of falling: a design science approach. *Int J Environ Res Public Health*. 2022;19(3):1855.
21. Kissmann UT, ed. *Video Interaction Analysis: Methods and Methodology*. Peter Lang; 2009.

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Citation

AMA J Ethics. 2022;24(9):E883-889.

DOI

10.1001/amajethics.2022.883.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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ISSN 2376-6980