"*The Last Human Job: Part 1*" featuring Allison Pugh

Dr. Dipesh Navsaria: [00:00:00] Reach out and Read where books build better brains. This is the Reach Out and Read podcast. I'm your host doctor Dipesh Navsaria, a practicing pediatrician with degrees in public health and children's librarianship. I'm a clinical professor of human development and family studies at the School of Human Ecology, and a professor of pediatrics at the School of Medicine and Public Health, both at the University of Wisconsin in Madison. At Reach Out and Read, we dream of a world in which every child is read to every day. Our show explores how children and families flourish and thrive through a combination of individual well-being, confident parents, supportive communities, strong public health, and good policy. Join us here for thought provoking conversations on these issues with expert guests, authors, and leaders in the field of early childhood health and literacy. Research shows that reading physical books together brings the strongest benefits to children. That's why we're happy to have Boise Paper, a responsible paper manufacturer as the founding sponsor of this podcast through their paper with Purpose Promise. Boise Paper looks for ways to make a difference in local communities. Thank you to Boise Paper for investing in our Reach Out and Read community. I recently read a remarkable new book that really helped put together so many different ideas, concepts, and observations about the world into a unifying framework that, well, I think I told at least 15 different people to run out and read it.

Dr. Dipesh Navsaria: [00:01:30] As the publisher says, with the rapid development of artificial intelligence and labor saving technologies like self-checkouts and automated factories, the future of work has never been more uncertain. And even jobs requiring high levels of human interaction are no longer safe. Our Next Guest’s work explores the human connections that underlie our work, arguing that what people do for each other in these settings is valuable and worth preserving. Our guest today is Allison Pugh. She's a research professor of sociology at Johns Hopkins University. Her writing has appeared in leading publications such as The New Yorker, The New York Times, and The New Republic. Her most recent book is “The Last Human Job: The Work of Connecting in a Disconnected World.” Allison's ideas are so far ranging and so important that for the first time on this show, we've decided to do a two part series on that most recent book. In part one, we're going to go big and talk about what the last human job is, the structures in which it lives, and why it matters. And then in part two, dropping two weeks from now, we're going to apply her theories to our work in early

relational health and learn how physicians, other practitioners, and caregivers can apply these ideas in their everyday interactions with children. Allison, welcome to the show.

Allison Pugh: [00:02:52] Thank you so much. I'm it's a real pleasure to be here.

Dr. Dipesh Navsaria: [00:02:56] So we teased that we were going to start big. So what is the last human job?

Allison Pugh: [00:03:03] Well, the last human job is partly an ironic title because, we may, if people are, you might be forgiven for thinking that there is there are jobs that are impervious to technological advances to being taken over by AI or automation. That's people have written that there's a New York Times op ed columnist who who wrote, you know, the jobs, you know, where people have to connect. I think he said something like, you know, the old fashioned way, human heart to human heart. Those are the jobs that are, you know, going to be free from automation. And ironically, that's not the case. As I think your listeners probably know, certainly the most recent advances in AI, but really percolating for about a decade have been automation efforts to that are targeting therapy, that are targeting education, that are targeting many occupations that might be considered in another era, impervious to those kinds of advances. So the last human job that was really me trying to recall that language, but I don't actually it's really a wake up call for people to understand that, actually, engineers are gunning for this work. Right, right. And what work am I talking about? I'm talking about the work that connects us to each other. So that's therapy. That's teaching. That's primary care physicians. That's actually a whole host of other jobs as well. Anything where you're supposed to see the other person and the other person feel Has to feel seen for your work to be successful.

Dr. Dipesh Navsaria: [00:05:03] Sure, sure. There's a term that you use very frequently in this book that was new to me, this notion of connective labor. Well, what does that mean? And and also what what isn't it? Because I imagine if people just hear the term, they might walk away with potentially a different notion of what it means?

Allison Pugh: [00:05:23] Sure. Yeah. Connective labor is my term for this work of seeing the work that requires the seeing of the other person and that the other person feels seen. And the reason why I wanted to give it a name is because it underlies all this other work that we already know is valuable and important. You know, teaching therapy,

etc.. But all of those occupations have this core kind of task, this core interaction underneath it. And I wanted to give it a name to make it more visible, so that people could see what's at stake here. Because all of these jobs, all of these different occupations that share this common, you know, kind of engine for positive outcomes, they are all being affected by these kind of broad trends to make them more efficient, to make them more, you know, kind of predictable to and and all of these trends, including automation and AI, are affecting all of these occupations.

Dr. Dipesh Navsaria: [00:06:34] Sure.

Allison Pugh: [00:06:34] And I wanted to kind of highlight the thing that these different occupations, these wildly disparate occupations from like hairdressers to funeral home directors to lawyers, you know, like wildly disparate occupations, but they all rely on this connective labor. And so I wanted to highlight what it has. What they have in common and what's at risk.

Dr. Dipesh Navsaria: [00:06:57] Mhm. Sure. Sure. How is this different from kind of related terms? Like we hear people talk about emotional labor and we hear them talk about also emotional intelligence.

Allison Pugh: [00:07:10] Mhm.

Dr. Dipesh Navsaria: [00:07:10] How does it differ.

Allison Pugh: [00:07:12] Right. Like do we need another term. Goodness gracious. Isn't the world full of terms. Do we have to remember another one. And the answer is yes. I'm sorry. You do. Emotional labor is a really important idea that was actually coined in the 70s. Mhm. And it was coined to mean something really specific actually, which was we might think of it as emotion management. Like when you have to control your emotions for a wage. And the person who invented this term coined this term, Arlie Hochschild, used flight attendants as an example. And she found she interviewed a lot of flight attendants and watched them, etc., and found that they were talking about how they had to kind of gin up the feeling of being friendly and happy, so that like as part of their job. Now, today, we might be like, of course, this is this is true of many service professions, but this was really radical and kind of new, new information, new a new contribution in the 70s and early 80s. And it's not the same. I hope you can hear how it's

not the same, because it's more about what's going on inside the person and how they have to control how they feel for their work.

Dr. Dipesh Navsaria: [00:08:42] Yeah, some mismatch there.

Allison Pugh: [00:08:44] Yeah. And my this term connective labor, I was really trying to get at this sense of something that happens between people. So not it's not. And this is actually also I would say, what's wrong with EQ or emotional intelligence.

Dr. Dipesh Navsaria: [00:09:03] Or.

Allison Pugh: [00:09:04] How emotional intelligence is kind of a broader idea of just like kind of being aware of other people. It's more related, I would say, to connective labor, to be sure, than the original concept of emotional labor. But the problem with it is it's conceives of all of this as a skill, and it's all like located inside the individual. And I really wanted to highlight that seeing the other and being seen is a is an interactive accomplishment, and that's important for a number of reasons. But one of the reasons why it's important is because you literally cannot automate that. Sure. Because it's between two human beings. It's like a thing that we create. And if half of that creation is a machine helping you to feel seen, it's Just like kind of by definition, not the same thing. And so I wanted to kind of clarify that.

Dr. Dipesh Navsaria: [00:10:05] What I'm hearing from you is that emotional labor can represent a sort of mismatch between your, your external and your internal. And with the concept of emotional intelligence, it's very much a single individual thing. And what you're trying to capture is the space between them. Right, exactly. Those connections, which is an element at least of what we're often calling now relational health. You know, the health of relationships. And those connections.

Allison Pugh: [00:10:31] Are actually very relaxed about what we call this. I just want us to call it something. So relational health sounds great.

Dr. Dipesh Navsaria: [00:10:36] Yeah. Yeah. It's something we talk about a lot now in pediatrics and on this podcast. So I'm, I'm hopefully making the connection, doing the connective labor for our for our listeners. Even if it's some somewhat one way. So yeah.

So how do we how do we know that it's working when, when connective labor is labor's happening.

Allison Pugh: [00:10:58] Yeah, this is a great question actually, because the question of like the thing that makes it interactive is that the person who's being seen has to feel seen for it to be working. And if they don't feel seen, and that could be for a number of reasons. That could be because the the physician or the teacher or whoever's on the other side doing the seeing is not doing a good job, like they're not attending to the other person. Well, or it could be that the person who is being seen is, you know, kind of maybe wildly wrong in how in, in how they are in a certain dimension that's being seen. Or it could be that they're quite circumspect or closed or, you know, not available. You know, there's a lot of different ways. But, one thing that really does affect how well someone is seeing is actually, it turns out, the working conditions of the person doing the seeing. And we know this from actually other people's research, not mine, showing that like things like stereotyping and bias in physicians, for example, is more likely happens is more likely to happen under conditions of extreme time constraint. It's like kind of a cognitive shortcut that people take. But those shortcuts, especially if it's a negative kind of judgment can be can actually do some harm, can can feel like misrecognition or feel like, you know, you're not seeing me. You're just seeing what you think I am.

Allison Pugh: [00:12:42] And that's way off. Now that's all pretty negative to that story, but the positive part to point out here is that you don't actually like if the people listening are you at all in these professions? You know, they probably already know this, but the but the positive story here is that you don't have to be perfect. Like actually, because it's an interaction, you can kind of try something and the person, the person you're seeing will be like, no, that's not quite right. It's more like this. And then you say, well, how about this? And it's a give and a take. It's a dance between two people or, or several that produces this, you know, kind of sense of being seen. So it's not like you have one shot and that's it. And that dance, that mutuality is part of what creates the kind of magic here. And so, yeah, don't worry. You don't have to be perfect. And in fact, my therapist told me that if they made a mistake and then the the person their client said, no, that's not quite right or you made a mistake, actually. And they said, oh, I'm sorry, I made a mistake. This is. This is how it is that actually made clients open up, feel more seen. The fact that someone would try and correct a mistake. Therapists know this actually, and have talked about the importance and power of therapeutic ruptures that then.

Dr. Dipesh Navsaria: [00:14:16] Get repair.

Allison Pugh: [00:14:17] Redeemed.

Dr. Dipesh Navsaria: [00:14:18] Yeah, yeah, yeah. You know, a lot of our listeners are in child and family facing fields, and they will be familiar with a lot of what you've just said through thinking about parent child interactions. You know, I'm thinking of the famed, you know, still face experiments and things like that, indeed. Right. Where you have these relational ruptures that happen countless times between adults and their children.

Dr. Dipesh Navsaria: [00:14:47] But there's also the redemption that occurs, and you end up with a stronger relationship.

Speaker3: [00:14:50] Mhm. Mhm.

Dr. Dipesh Navsaria: [00:14:52] So you mentioned about you were actually talking about the, the environment as, as well. And I, I definitely heard you when you talked about the time thing. As we record this in winter in the middle of a fairly bad influenza season, I'm thinking about even myself when we have a waiting room full of people, like, with fevers and coughing and your 5 or 6 people behind.

Speaker3: [00:15:18] And it's.

Dr. Dipesh Navsaria: [00:15:19] Really challenging.

Speaker3: [00:15:21] To.

Dr. Dipesh Navsaria: [00:15:22] Do that connective work when, you know, there's all these folks waiting and, you know, the pressure to, you know, move, move further and further. So much of this is about environment. You talk in the book about social architecture of connective labor, and there's three elements. You talk about the mission driven corporate and personal service. Can you say more about what those are?

Allison Pugh: [00:15:47] Sure. That's kind of the important part. The reason why I went into that was because, you know, how well we see the other is not just based on your personality or even your training.

Dr. Dipesh Navsaria: [00:16:04] Or it's not a moral failing necessarily.

Allison Pugh: [00:16:06] Yeah, right. Exactly, exactly. And actually, I often feel like our kind of individualistic approach in our, I would say in our culture, often kind of forgets the ways in which an organization or a culture can shape someone's capacity to see the other. Well. So we often are relying on what I came to see as kind of individual heroes to do this work when it's not actually supported well. So among many primary care physicians that I spoke to, they'll be like, yeah, I'm, I'm working until seven. And, you know, I'm behind. And, you know, they they're just stretched to the utmost of their ability. And it's we rely on their individual heroism to make up for, you know, kind of time demands that are not sustainable. Hmm. So anyway, the the social architecture point was my attempt to draw attention to the different ways we organize this work. And actually all three of them, I think, are bad. And all three of them were kind of captured by this one woman I talked to. I called her Ruthie, who was a physician, and in the course she was telling me I got to know her pretty well. And in the course of our conversations, she told me about kind of her career, which went through, just happened to go through the three, these three kind of major ways in which we organize this work. So the first is this mission driven. She went to she had always wanted to be a physician and always wanted to be to serve the serve the underserved in Appalachia. And so she gets her first job. She goes there and works there and is in his.

Allison Pugh: [00:18:03] So she finds it so meaningful to serve these people. She told me a lot of stories about how the closeness, the deep relationships she forged where, you know, some family is like, doc, you're trying to ride a motorcycle and you, you need some help. And they're giving her lessons. Right, right. You know, she's, like, treating. I remember her telling me some story about a girl who was, like, giving birth in the bathroom, and then she, like, kind of went on and became a nurse on her own. Like, she told stories of grit and extreme duress, of poverty and a kind of an underserved population. And yet, after seven years, she left. And yeah, she left in conditions of extraordinary burnout, because in a mission driven environment. And it's not just physicians, but this could be teachers in a, you know, kind of really strapped public school, or this could be in this kind of environment. We rely on the individual heroes,

and we don't give their institutions the adequate resources to cover the need that they face. So she leaves after seven years and goes to a more corporate environment and finds that, you know, she can it's sustainable in that she can, you know, go home. And those people are not going to, you know, kind of die in the hills without her. And they'll have, you know, adequate care. And she actually told me some funny, funny stories about people coming in and being like, I have Lyme disease. And, you know, I looked it up on the internet and this is what I need. Just write a prescription, you know, like they had zero respect for her. For her.

Dr. Dipesh Navsaria: [00:19:47] Yeah. This is the order I'm placing. Thank you. Yeah, exactly.

Allison Pugh: [00:19:50] So. So it had its its own problems. A kind of more customer service kind of orientation, rather than the kind of deeply sustaining and meaningful work of the mission driven. But she also found it not very like because it was because of who she was serving and kind of the customer service orientation. It felt not very meaningful. And she actually, because of the primacy paid on kind of providing service to largely well-off people, she did start to feel a different kind of burnout, where she was kind of at their beck and call. And so she left that and also was, you know, kind of deeply showed, showed signs of burnout there. But the the story ends pretty well. I mean, she would say the story ends well. She goes and she forms her own practice and she does something that is called direct primary care, in which your your clients, your patients pay a monthly fee. So she says it's more like a gym gym club membership than, you know, kind of a standard medical practice. Direct primary care is related to a, a widespread phenomenon called concierge medicine, where people pay a hefty price tag. I interviewed people who talked about how in Palo Alto it was more like $20,000 a year. Yeah. And so who's going to afford that? And some guy, some doctor told me a joke. He was like, yeah, we call it like, the doctors will pick up your dry cleaning.

Allison Pugh: [00:21:34] Yeah. And the problem with that is, yes, they the physicians have so much time to see the other. And the care, the connective labor they're giving is so artisanal. And and this is kind of personal services to rich people is a very is a growing kind of occupational strata stratum. Sure. Economists note that it's, you know, responsible for, I think, the top ten occupational growth in the United States. So it's like personal trainer, personal investment counselor, personal chef, personal, all those. And so they're they're giving they have a lot of time. They're giving great connective labor.

Mhm. But they are wondering whether they are a servant. They they face an existential crisis. Sure. And that's not exactly what my the physician Ruthie. That's not how she sees her work because she's trying through direct primary care to charge less. And so she's trying to reach a more middle class population. And I contacted her later and she said she was doing really well. So I think it's not quite the same, but it's related. It's this kind of services to those who can afford it in a kind of separate environment from a normal clinic. Yeah. So that's also you can see it growing everywhere. It seems to have taken over dentistry for example.

Dr. Dipesh Navsaria: [00:23:09] Mhm.

Allison Pugh: [00:23:09] Sure, sure.

Dr. Dipesh Navsaria: [00:23:11] This makes me think that if I ever decide to just completely up and quit my job, that I should just go into artisan, personal podcasts, you know, with an audience of one or something like that. Our producer, Jill, will decide if she wants to come along with me for that. So.

Allison Pugh: [00:23:29] Great idea.

Dr. Dipesh Navsaria: [00:23:29] So. So I want to dig maybe a little deeper into this notion of the individual and then the responsibilities of the individual, which I think, as you noted, we in our culture, we tend to really focus on individual values, individual drive, resilience, grit, you know, all those things. And then the systems Questions, right? We spend a lot of time being awfully judgy in our society, right? Particularly around, like, say, parenting, you know? So true. If you loved your kid, you would do x, y, and Z. It's like, well, because I love my kid is why I'm working three jobs so that I can make rent and, you know, all those sorts of things or whatever the case may be. And you talked about how a lot of the social architecture is shaped by the everyday systems that shape it. And you specifically reference things like templates and technologies that affect how people connect. And again, particularly in healthcare, I felt that right about the various things in the system that have less to do with how I connect with a family in front of me, and more to do with the whole structure that's around us in in this encounter or this this visit. Tell us more.

Allison Pugh: [00:24:50] Yeah, I was trying to again, I was trying to trying to figure out, like, as you say, beyond the individual. Like what? What shapes these individuals. If you can assume that most of the people I was talking to wanted to be really, you know, got into this work to see the other and hopefully that and hope that they would be seen. And so what's going to help them do that? So I got the chance to really think about that, because I saw some organizations that did do that well and some that did not. So I wrote a whole chapter on those that do it right, where people, workers and patients or clients or students seem to really benefit from a kind of full version of connective labor. And I tried to figure out what's what's different between those and the kind of social architecture that I was seeing Ruthie kind of pass through. Sure. And I came up with three kind of factors or areas of that seem to matter. One most obvious was what you mentioned time and money and space. And those are I consider those kind of material resources. And those seemed like the, the rock bottom, the thing you had to have. But it wasn't the whole solution. So the other thing that seemed to matter was how how people were put in relationship with each other. Like the the relational design. So for that, I kept thinking about like, kind of visionary leaders. I kept meeting people who were very committed to this and committed, committed to a kind of kind of support of connective labor.

Allison Pugh: [00:26:50] And there was this amazing, charismatic leader. Actually, there was most of these were very charismatic. Charismatic founder of a clinic where people saw patients, could see doctors. Their first appointment was two hours long. And that was just like I say that to people and they're like, what? And then also that same clinic used a kind of expanded vision of a medical assistant. You know, people particularly hired for this expanded vision and also trained. And they would bring patients to see specialists and then sit with them while they saw the specialist and then come back to the primary care physician at the clinic. And so there was this real continuity of care. And I spoke to the medical assistants who were given a different title. And and they were so happy in this job that it was so much more rewarding. So it was kind of a remarkable setting. But it wasn't just that. When I also spoke to a kind of a private school where the the founder, again, fairly charismatic, kind of connected labour practitioner, who talked about how he instituted love in all the corners of this school, and it was a school for boys. So he's like, we do it at the admissions interview because some families can't handle talking about love when you're talking about boys because it's like kind of counters traditional masculinity. So we want to like make sure that these families will be able to handle it.

Dr. Dipesh Navsaria: [00:28:38] Know what they're getting into.

Allison Pugh: [00:28:39] Exactly. But they did it like they he talked about how, oh, I don't like the term safe space. We have love space in here. We don't say you can't say something, but if you say something, you have to kind of own it in front of the people you're saying it to and witness the consequences and talk through if there's a problem, you know, like he just was very articulate about kind of enacting a new kind of emotional space that was kind of extraordinary. And so, yeah, relations, how people are in relation to each other included leaders. It included mentorship. And it also included this thing that therapists and teachers and actually maybe doctors, some doctors know already, which is sounding boards. Yeah. Therapists and teachers, both of them, like when they are in training and sometimes later know that you have to be able to talk to peers about what you're experiencing, to be able to kind of process it and, and think about how to do it better. And what am I learning from this experience? And this is something that's very common in the training for those professions. And I think that that's actually a core aspect of connective labor because it involves kind of human interaction. So yeah, that's another thing. So then the third factor was like a connective culture. And that's related to what that private school founder was talking about, like the enacting of love in all the different places. Yeah. So it's time and material resources, how people are in relationship with each other and a connective culture. And those three things appear to affect help, help to create a social architecture that can support connective labor.

Dr. Dipesh Navsaria: [00:30:36] Indeed, indeed. Thank you so much for walking us through all these concepts. And there's so many wonderful nuances and examples you you have in this book. And I'm excited that we get to continue this conversation in part two of this series. And talk a little bit more about early relational health, about the clinical environment, and how we think about caregivers, too, and how they connect with, with children around them. So thanks. And listeners, please stay tuned for more in part two.

Allison Pugh: [00:31:07] Thanks so much.

Dr. Dipesh Navsaria: [00:31:12] Welcome to today's 33rd page or something extra for you, our listeners. An interesting element of today's guest’s book in their introduction was about empathy and how it has been thought about historically and as well as in modern times. In her book on page 19, she says In the United States, to seeing the

other and being seen has apparently not always been valued. Before the early 20th century, we did not even have a word for empathy. As an empathy historian, I didn't know there was such a thing. Susan Lencioni tells us the concept travelled from German artists and psychologists who used the term einfühlung to describe feeling into objects. To American psychologists who coined the word empathy in 1908, while early on empathy meant projecting yourself into a form or shape. By mid-century it meant the ability to understand the feelings and perspectives of others with the help of popular psychology and journalists. The concept broke out of labs and into the general lexicon, finding its way into advice columns and everyday marketing. Empathy transformed into the meaning it has today of an emotional understanding of the other, in part because we also developed a sense of the other and ourselves as even understandable.

Dr. Dipesh Navsaria: [00:32:36] I feel like I have more empathy now for the whole concept of empathy, and that's today's 33rd page. You've been listening to the Reach Out and Read podcast. Reach Out and Read is a is a non-profit organization that is the authoritative national voice for the positive effects of reading daily, and supports coaches and celebrates engaging in those language rich activities with young children. We're continually inspired by stories that encourage language literacy and early relational health. Visit us at Reach Out and Read to find out more. And don't forget to subscribe to our show wherever you listen to your podcasts. If you like what you hear, please leave us a review. Your feedback helps grow our podcast community and tells others that this podcast is worth listening to. Our show is a production of Reach Out and Read. Our producer is Jill Ruby. Lori Brooks is our national senior director of external Affairs. Thank you to our founding sponsor, Boise Paper, for making a difference in local communities like ours. I'm your host, Doctor Dipesh Navsaria. I look forward to spending time with you soon. And remember, books build better brains.