NARRATIVES OF PATIENT CARE AIDES ON THEIR WORK AND HEALTH:
A FEMINIST ANALYSIS

by

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ABSTRACT

The Canadian labour force is segregated on the basis of race, class and gender, with immigrant women from "Third World Countries" being largely relegated to jobs in the lower echelons of the labour force. In order to examine the health implications of being relegated to lower echelon jobs, narratives of ten female patient care aides (nursing assistants) who are immigrants were analyzed, guided by the feminist method of institutional ethnography and Black and other anti-racist feminist writings. It was seen that the women in the study used numerous strengths and strategies to maintain their own health while endeavouring to give good care to the elderly. Contextual themes of racism in Canadian society, a hierarchical health care system, economic uncertainty and the immigration experience informed their working experiences and health.

It was concluded that segregation of jobs does have negative health repercussions, and that patient care aides and registered nurses should join forces to challenge and deconstruct racist ideology and job segregation. The working environment as target of health promotion and health policy was suggested as a strategic focus for nursing practice, education, administration and research. Other implications for nursing were discussed.
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CHAPTER ONE: INTRODUCTION

Introduction to the Problem

The Canadian labour market is stratified and segmented on the basis of race, class and gender. Immigrant women of Colour, who comprise over 50% of the growing immigrant population from "Third World" countries are overrepresented in the lower echelons of the labour market (Arnopoulos, 1979; Bolaria, 1988; Boyd, 1987; Ng & Das Gupta, 1981; Ng & Estable, 1987). Although there has been a dramatic increase in the immigrant population in Canada in the last two decades, the experiences and health needs of this population, especially those who are termed "visible minority women" and who are working in the lower echelons of the labour force are not well known (Ng & Estable, 1987). While some authors describe the "heavy utilization" of health care resources by immigrant women (Ford, 1990; Sauter, 1992), others point to the underutilization of health care resources or barriers to health care utilization by this population (Anderson, 1985a; Palacios & Sheps, 1992; Weitzman & Berry, 1992).

Purpose and Questions of the Study

The purpose of this study was to attempt to ascertain the health implications of being consigned to a job in the lower echelons of the labour force, an issue about which there is little information at present. The problem
the study sought to address is the paucity of information about the experiences and health concerns of immigrant women who work in the lower echelons of a labour market which is segregated by race, class, and gender. (Note: The use of the terms "segregated", "race, class, and gender", and "immigrant women of Colour" are discussed under 'Definition and Discussion of Terms'). In order to address this issue, the study examined the experiences and circumstances of ten female patient care aides (nursing assistants), an occupation which is considered to be in the lower echelons of the labour force, and which is predominantly occupied by immigrant women from so-called "Third World" countries.

A qualitative study was carried out, guided by the method of institutional ethnography and Black feminist and other antiracist feminist writings. The following questions guided the study: "How does this occupation affect the health of its members? Does the fact that it is a segregated occupation have a bearing on the health of its members?" Answers to these questions were sought through a review of literature pertaining to the health and experiences of immigrant women of Colour and through analyzing personal narratives of the women themselves.

**Significance of the Study**

This is an important topic for nursing for several reasons. Firstly, gaining an understanding of the working experiences of immigrant women is a key to
understanding the health status and needs of this population. Secondly, patient care aides are fellow health care providers with registered nurses, for the growing numbers of elderly and infirm clients in long term care. It is doubly important, therefore, for nurses to know the needs of this group. As one writer observes: "Humanizing institutional care for those who can no longer be cared for at home or cannot manage independently requires careful attention to the needs, risks, and tasks of both care receivers and givers" (Paltiel, 1989; p.12).

It is also important that nurses recognize the very hierarchical and segregated nature of the health care industry of which we are a part, and that we are cognizant of how oppression on the basis of race, class and gender ultimately has implications for everyone involved (Chater, 1994; Glenn, 1992; hooks, 1984). Such an understanding may indicate the need for nurses and other health care providers to work towards changing social institutions and processes which result in job segregation.

**Background to the Problem**

**Immigration Policies and the Labour Market**

Due to a declining birthrate and aging population, Canada has long had to recruit immigrant labour to maintain its population and meet its labour needs (Khan, 1991; Richmond,1992). Until 1951, Canadian immigration laws were explicitly racist (Agnew, 1993; Das Gupta, 1994a; Ng & Estable, 1987; Taylor, 1991), giving preference to white immigrants from Britain, Europe, and
the United States (U.S.A.). By 1967, however, the government was forced to make changes in the quota system to allow immigrants from "non traditional" (i.e., non-white) countries: Canada was no longer attracting as many immigrants from the "traditional source countries"; more labour was required by the burgeoning tertiary sector of the economy (Richmond, 1992); and people of various national origins demanded nondiscriminatory immigration laws (Das Gupta, 1994a; Manpower and Immigration, 1974). By 1990 about 70% of immigrants were from "Third World" countries such as Africa, Asia, South America, and the Caribbean (Statistics Canada, 1991).

The government of Canada has portrayed non-white immigrants as both an economic boon and a potential problem, and government policies have reflected this ambivalence. While the White Paper of 1966 underscored the need for increased numbers of immigrants and an end to discriminatory practices (Samuel & Woloski, 1985), the Green Paper of 1974 (written during the beginning of a recession) suggested that social tensions arise due to diversity of origins among the Canadian population, and advocated a tightening of immigration controls (Manpower and Immigration, 1974).

Health of Migrants

It is assumed by many writers that immigrants suffer more illnesses or are at more risk of developing illnesses than the non-immigrant population (Dyck, 1992; Franks & Faux, 1990; Karmi, 1991; Khoo & Renwick, 1989;
Meleis, 1991; Meleis, Lipson, & Paul, 1992; Palacios & Sheps, 1992) though precise information about this is lacking. Speakers at a World Health Organization conference on migration (Kliewer, 1992; Siem, 1992) emphasized the need for more research concerning the health problems of migrants, pointing to the potential economic gain to the host countries to be derived from such research, as well as the potential alleviation of suffering among migrants.

In writing about health or social problems immigrants may face, many writers focus on the problem of adaptation or problems of adjustment on the part of the immigrants (Berry, 1992; Khoo & Renwick, 1989; Lalonde, Taylor, & Moghaddam, 1992; Lee, 1994; Manpower and Immigration, 1974; Meleis, 1991; Miedema & Nason-Clark, 1989; Siem, 1992). Some writers, on the other hand, look beyond the adaptation process of the immigrant, and focus on social structures which may be contributing to or actually generating health problems or other problems (Anderson, 1985a; 1985b; Anderson & Lynam, 1987; Anderson, Blue, Holbrook & Ng, 1993; Bryan, Dadzie, & Scafe, 1985; Dyck, 1992; Li, 1990; Torkington, 1995; Weitzman & Berry, 1992).

**Social Construction of the "Visible Minority" Person**

Based on the 1981 census (Beaujot, 1991) the Canadian government created the classification of "visible minority" to refer to non-white immigrants (Bannerji, 1993a; 1993b; Beaujot, 1991; Carty & Brand, 1993; Depass, 1992). A number of anti-racist feminist writers (Anderson, Blue, Holbrook & Ng, 1993;
Bannerji, 1993b; Cassin & Griffith, 1981; Fyfe, 1994; Ng, 1981; 1986) and others (Solomos & Back, 1994; Van Dijk, 1991) have examined the term "visible minority" and "immigrant" and have concluded that they are tools used by the state in the construction of a category of people who are "different" from the norm (which, according to the state, is white) and therefore need to be treated differently from other Canadians. Moreover, the term encourages people to "see" a difference between themselves and this category of "others", and then attach social expectations to that difference. These social expectations include problematic behaviour, deficiencies, non-assimibility to norms, and even, conversely, invisibility (Bannerji, 1993b; Carty & Brand, 1993). The term aids in the production of immigrant women of Colour as a commodity in the labour market destined for the lower echelons of the Canadian labour force; i.e. it makes it seem "natural" that the labour market should be stratified on racial or ethnic lines (Ng, 1984; 1986).

Stratification and Inequalities in the Labour Force

Most researchers recognize the stratified and segregated nature of the labour force, and the fact that immigrant women of Colour tend to be overrepresented in the lower echelons with little chance of upward mobility (Arnopoulos, 1979; Bannerji, 1987; Boyd, 1987; Estable, 1986; Ng & Estable, 1987). Ng (1984; 1988) advocates further study of the institutional processes which continually reproduce this stratification and segregation in the
labour force. Other writers (Liff & Dale, 1994; Tomaskovic-Devey, 1993) also point out the need to understand and challenge the role of organizational structures, cultures, and politics in sustaining job stratification and concomitant inequalities. A paper by Anderson, Blue, Holbrook & Ng (1993) suggests that inequalities based on racism and genderism result in conditions of work which are detrimental to health, and that health care professionals must recognize and seek to remedy such inequalities.

Stratification in the Health Care Workforce

Health care is a subsector of the rapidly growing tertiary sector of the economy in Canada (Richmond, 1992). In a conference about occupational health (Sauter, 1992) it was pointed out that "stress and constrained opportunities" were endemic to the growing number of health care occupations to which "women and minorities" are being consigned. One of these occupations, that of patient care aide (nursing assistant) is the largest single category of health care workers, and is one of the fastest growing occupations in North America (Diamond, 1992; Glenn, 1992). It is also considered to be an occupation on the lower echelon. Indeed, the health care industry as a sector of the labour market is so visibly stratified (Glazer, 1991; Glenn, 1992; Hoffman, 1991; Sacks, 1990) that "uniforms are not needed to distinguish those at the bottom of the pay and status scale" (Sacks, 1990). The health implications of such stratification and segregation, however, are not so clear.
Health Implications of Labour Market Stratification

Studies such as the Framingham Heart Study (Haynes & Feinbeib, 1980) have shown that some occupations, such as clerical work, appear to have characteristics (eg high stress, low control) which result in health problems among the women who work in that occupation. The Framingham Heart study has given rise to a large number of studies about the health of working women, most of which, however, consider only the question of gender (eg Aston & Lavery, 1993; Barnett, Davidson, & Marshall, 1991; Carver, 1989; Davis, Marbury, Punnett, Quinn, Schwartz, & Woskie, 1983; Ebi-Kryston, Higgins, & Keller, 1990; Ford, 1990; Hessing, 1992; Johnson, 1989; Lennon, 1987; Lewy, 1991; Messing, 1991; Muller, 1986; Paltiel, 1989; Ponee, 1989; Stuart, 1981; Tierney, Romito, & Messing, 1990; Waldron & Jacobs, 1989) and not the role of racial and class oppression in the lives of women. Those studies which do consider these issues (eg Stevens, Hall & Meleis, 1992a) usually do so in an "additive" manner (i.e., in a manner which implies that some women are oppressed only by gender, while others are oppressed additionally by racism and class position). As Black and other antiracist feminists have begun to make known in recent years however, the issue of gender oppression is intricately interwoven with, and cannot be considered separately from, the issue of oppression on the basis of racism and class (Agnew, 1993; Anderson, Blue, Holbrook & Ng, 1993; Collins, 1990; 1991; Glenn, 1992; hooks, 1984; 1989;
Women's experiences and health in the workforce are affected by a system of domination held in place by the triple yoke of genderism, racism, and class oppression. This is particularly apparent in the lower echelons of the workforce.

**Discussion and Definition of Terms**

In this section the use of the terms "Black feminist", "race, class, and gender", and "immigrant women of Colour" are discussed, followed by definitions of job segregation, patient care aide, and resident.

In this study **Black feminist** refers to a political (i.e. anti-racist) stance, rather than racial or ethnic origin. There is a variety of terms used by Black feminist and other anti-racist writers to refer to themselves and to other women, and as yet no agreement has been reached on any one term to define women who have various origins such as Africa, Latin America, Asia, or are Canadian-born. Bannerjee (1993a) uses the term "non-white women". Carty uses the term "women of Colour" to "indicate a common context of struggle based on shared systemic discrimination in the Canadian social and political context" (Carty, 1991; p.18). In this study the latter definition is adopted, and since the participants are immigrant women the term immigrant women of Colour is used.

**Race, class, and gender** are socially constructed categories. That is, they are social categories applied to people, and rationalized on the basis of some biologic commonalities (both alleged and real) which are then held to be socially
determinant. Historically, for example, British colonizers justified their plunder and subjugation of nations by claiming to be a superior race; at the same time they characterized the working classes of Britain as being inherently inferior. These ideas continue to be used in present day times to justify or rationalize social inequalities. The opposite view, which is taken in this study, is to challenge inequalities based on these socially constructed categories.

"Job segmentation" and "job segregation" are terms used in the literature to refer to hierarchically ranked labour markets in which there is little or no upward mobility for certain categories of workers. "Job ghettoization" is also a term used to describe this phenomenon (Das Gupta, 1994a; Ng & Estable, 1987; Weitzman & Berry, 1992). Some authors use the terms segmentation and segregation interchangeably: eg. Collins (1991) refers to "urban labor markets segmented along lines of race and gender" and the "de facto segregation of the labor market". Others use either the term job segmentation only (eg. Glazer, 1991), or the term job segregation only (Armstrong & Armstrong, 1994; Sokoloff, 1992; Tomaskovic-Devey, 1993; Xu & Leffler, 1992). Since most authors in the literature search for this thesis use the latter term, in the rest of this study (unless the author referred to is using a different term), the term job segregation is used to refer to the observed overrepresentation (Arnopoulos, 1979; Boyd, 1987) of immigrant women of Colour in the lower echelons of the labour force.
Patient care aide is a term used to designate an employee of a health care facility who carries out direct resident care, specifically, aids in the activities of daily living such as eating, washing, transferring in and out of wheelchairs and beds, etc. In different facilities throughout Greater Vancouver people in this occupation may also be known as longterm care aides, care aides, personal care attendants, resident care aides, or nursing assistants. The term nursing assistant used in the U.S.A. is roughly equivalent to the terms patient care aides or nursing assistants as used in Canada, although working conditions in the two countries, such as wages, are not exactly the same. In this study, the term patient care aide, or care aide is used, as those are the terms used most frequently by the study participants.

A resident is a person who lives in a longterm care facility. Occasionally residents are referred to as "patients" by the narrators.

Summary

In this chapter, the problem of paucity of information about the health needs and perspectives of immigrant women in the lower echelons of the labour force has been introduced, along with a brief introduction about the method used in the study to address the questions arising from the problem. The background to the problem of health of immigrant women in Canada has also been introduced, and the significance of this topic to nursing has been
explicated. In the next chapter, relevant literature in this area is reviewed. In the third chapter, the methodology of the study is explained in more detail. In the fourth chapter, findings from the study are presented, and a discussion of these findings, in light of current literature, follows in the next chapter. In the sixth chapter, the researcher discusses the implications and recommendations for nursing in the areas of practice, teaching, administration, and research.
CHAPTER TWO: REVIEW OF THE LITERATURE

In this chapter, bodies of literature which pertain to the purpose of the study are reviewed. Very few studies deal with the specific topic of the world of patient care aides or nursing assistants. The few studies that are directly relevant are vivid descriptions of nursing home environments (Bohuslawsky, 1989), ethnographies which focus on the political economy of nursing homes (Diamond, 1992) or studies which focus on the quality of care provided by nursing assistants. While some of the above studies acknowledge that job segregation exists (Diamond, 1992), or racism at the workplace exists (Aitken, 1993), none of the studies explore in depth the relation this may have to the health of the personal care attendants. Therefore, in addition to the above studies, other studies about the experiences and health of working immigrant women of colour are reviewed. Studies are critically evaluated to determine the present level of knowledge concerning the questions of this study, and to identify gaps in knowledge which the researcher has attempted to address in the present study.

Review of Relevant Research Studies

This section begins with a review of studies about nursing assistants. A review of studies about the health of working immigrant women follows, and then a review of some quantitative and qualitative studies about the experiences of working immigrant women.
Studies About Nursing Assistants

In this subsection, two qualitative studies (Diamond, 1992; Aitken, 1993) about nursing assistants are reviewed in some depth, followed by a short review of some quantitative studies.

Diamond (1986; 1992), influenced by feminist writings, critical medical sociology, and the theoretical framework of Dorothy Smith (1979; 1987), identifies his study of the political economy of the nursing home industry as an institutional ethnography. Using the qualitative method of participant observation and starting from the everyday experiences of nursing assistants and nursing home residents, he sought to answer the question of how nursing homes operate as industrial enterprises in the United States (U.S.). He discovered that the labour foundation for the emerging institution of the nursing home industry was based on the "conflation of race, class and gender". Nursing assistants are mainly minority women who are paid only slightly above minimum wages; the industry is embedded in the organizational model of business; and the industry draws upon the international labour market of third world women (Fuentes & Ehrenreich, 1989; Ng, 1986; and Silvera, 1989, 1993; also write about this latter issue, which certainly seems relevant to the health care industry of Canada).

Although the author is sympathetic to the women he portrays it is probably not quite correct to state that the study represents "a collective story
told by residents and nursing assistants" (Diamond, 1992; p.6). Rather than narratives from the standpoint of the nursing assistants or residents, the study appears to represent a collection of the impressions of the author as he took notes of what was said and done in the homes during the time that he worked there as a nursing assistant. Many of these impressions about nursing assistants centre around their work, which Diamond notes is largely unrecognized and unrewarded; the author alludes to possible health implications from heavy work and long hours and notes that these health implications must be seen as related to the segmentation of labour (Diamond, 1992; p.121).

Surprisingly, the author (Diamond, 1992; p.189) blames the hiring of foreign nurses from the Philippines for "cultural misunderstandings" between nursing staff and residents (a theme which also arises in a study of nursing assistants by Heiselman and Noelker, [1991]). He does not, however, notice any "cultural misunderstandings" between residents and nursing assistants, even though many of the latter were immigrants from Africa, the Caribbean, and Mexico; he notes that nursing assistants communicated well with residents. One would presume, therefore, that misunderstandings between registered nurses and residents were probably due to the more distant relationship of nurses to residents, compared with the closer relationship of nursing assistants with direct resident care.
Aitken (1993; 1995) also uses the institutional ethnography method in her study. Although the purpose of her study (to examine the problem of inflexible care giving routines) seems not to emerge from the standpoint of the nursing assistants themselves, the author reveals in the rest of her study that she is partisan to their problems. Stress and physically demanding working conditions are cited. Racial tensions are also cited, although not elaborated upon. Like Diamond (1986;1992) the author acknowledges that most of the work that nursing assistants do is invisible and unrecognized; relations of ruling render nursing assistants silent and subordinate.

The few other studies about nursing homes and nursing assistants that the latter author was able to find, and that this researcher was able to find (Caudill & Patrick, 1989; Chichin, 1992; Garland, Oyabu & Gipson, 1989; Grau, Chandler, Burton & Kolditz, 1991; Hare & Pratt, 1988; Heiselman & Noelker, 1991; Waxman, Carner, & Berkenstock, 1984) are quantitative studies which seek to address the problem of quality of care given by, and high turnover among, nursing home staff. Some of these studies do provide information that may be relevant to the present study: eg the study by Waxman, Carner and Berkenstock (1984) suggests potential agency of nursing assistants through their "high amount of rebellion and cohesion noticed by researchers".

While these studies about nursing assistants do give some potential insights into the situation of patient care aides, it is clear that this insight would
be incomplete without a review of studies dealing specifically with the topic of immigrant and other minority working women. In the next subsection, therefore, studies about the health of working immigrant women are reviewed, followed by a subsection in which studies concerning the social construction of ethnicity, and the gender and racial segregation of jobs are reviewed. Studies which approach racism or ethnicity as an "additive" problem (Hall, Stevens & Meleis, 1992; Meleis, Lipson & Paul, 1992; Stevens, Hall, & Meleis, 1992a; 1992b) are not included in the review, as they do not clarify the relationship of racism to health problems in this student's opinion (The "additive" approach to racism was described in 'Background to the Problem'). These latter studies do, however, contain useful information about methodologies used, which are reviewed in the section under Methodology.

**Studies About Health of Working Immigrant Women**

In a quantitative study of immigrant homecare nursing assistants in New York (Weitzman & Berry, 1992) 387 immigrant women were given questionnaires about health status and health care utilization. The purpose of the study was to ascertain the health status and needs of working poor, immigrant women, and the authors chose the occupation of homecare attendant, since it is an occupation "traditionally filled by poor, minority, and immigrant women who lack career alternatives". The authors found that even in comparison to other poor or uninsured people in the population, immigrant
women were more likely to have fair or poor health, but less likely to utilize health care services. The authors conclude that there are more structural barriers to health care for immigrant women, and moreover that structural conditions may give rise to poor health.

Of the original sample of 493 attendants interviewed by the authors, 71 attendants born in the United States (U.S.) were eliminated; the authors do not specify whether these women were minority or not. One wonders how the health of minority or black U.S. born home attendants would have compared to that of the immigrant homecare attendants. Also, one wonders whether the 12% of the study participants who were from the former Soviet Union (which is not a "third world" country) were as equally constrained from finding alternate careers eventually as were the immigrant women from Haiti, the Caribbean, Central and South America, and the Dominican Republic.

Anderson (1985a), influenced by the theoretical perspective of Dorothy Smith (which will be described in more detail in the section under Methodology), studied the experiences of immigrant women within the context of the health care system and the broader social context. The author adopted a comparative case study approach to examine the concerns about health, and experiences during help seeking, of IndoCanadian and Greek immigrant women employed in the lower echelons of the Canadian labour force. The comparative aspect of the research design enabled the author to discern whether being a visible minority
woman affected the women's help seeking experiences, and she found that it did. The author advocates structural changes in the health care system, such as health care delivery by community groups closer to the immigrant women.

As part of the same research project lasting two years (Anderson & Lynam, 1987), the authors explored the meaning of work for immigrant women employed as cleaners and janitors (14 Greek and 21 IndoCanadian) and sought insights into the relationship between work and health of these women. This, and a later analysis (Anderson, 1992) showed that the women perceived negative and positive aspects to their jobs, and many experienced health problems. The authors urged that in order to effectively approach the health problems of these women, more understanding is needed about social organization and ideological structures that may be giving rise to problems and negative experiences among them.

In their 1993 paper, Anderson, Blue, Holbrook, and Ng examined the dilemma of managing chronic illness in the workplace and problems in seeking health care, which were greater for the Chinese women in the study than for the EuroCanadian women. The authors stress that the complex circumstances of women's lives, such as poverty and marginality, must be taken into account by health professionals, who too often "decontextualize illness".

Bryan, Dadzie, & Scafe (1985) conducted a feminist participatory action
study over four years among black, mostly immigrant women in Britain. Using a combination of history analysis and narratives, the authors demonstrate the combined effects of racism, discrimination against women workers and the steady loss of health services for working class people. Black women are concentrated in the least prestigious and most arduous areas of work, in a health care system which relies on the labour of black immigrant women, but paradoxically does not provide adequately for the health needs it generates among the women working there.

Bolaria (1988) notes that racial minority immigrant women in Canada are in effect constricted to low status, low paid, and unhealthy working environments such as janitorial work, nurses' aides, dishwashers, etc. Besides the physical demands and dangers of the jobs, interpersonal subordination, humiliation, and the threat of unemployment all contribute to physical illness and psychological distress. The author considers that the health status and health care of these immigrant workers must be analyzed in the context of the organization of the labour processes affecting them.

Studied about Experiences of Working Immigrant Women

Drawing on the theoretical perspective of Dorothy Smith, Ng (1981) conducted a study among immigrant women in Vancouver to discover how ethnicity is socially created and reproduced by and for these women during their everyday interactions with the outside world. A limitation of this study was
the fact that it was based on secondary analysis of data from a previous study about wife battering among immigrants (although the author had included a large assortment of questions in her original interviews in anticipation of secondary analyses). Although references to interview quotations and data from fieldnotes support the premise that the concept of ethnicity is operative during interactions of immigrant women with Canadian urban surroundings (i.e. is socially constructed), the study does not clarify how this came about. The study, however, was preliminary to the author's next groundbreaking study (Ng, 1984; 1988) which examines how the category of immigrant woman is socially constructed.

In her next study (Ng, 1984; 1988) the author examines "one moment" in the process whereby the category of immigrant woman is constructed as a social entity which is slated for a distinctive kind of labour in the Canadian labour market: i.e. through the focal point of an employment counselling agency for non-English speaking and black immigrant women, the study demonstrates how this agency articulates with the Canadian state to produce immigrant women as workers for the lower echelons of the labour market.

The studies by Ng (1984; 1988) and Diamond (1986;1992) are similar in that they use the method of participant observation and the method of institutional ethnography as outlined by Dorothy Smith. Both studies begin with the everyday experiences of immigrant women (immigrant and U.S.-born
"minority" women in Diamond's study), and proceed from there to illuminate the larger organization of social relations in which those experiences are embedded, but which are not immediately visible to the researcher or subjects. While Diamond (1986; 1992;) concludes by advocating changes in minimum wage laws, Medicaid, etc., Ng's study leads us more directly to challenge structural inequalities. The latter author advocates more research to investigate the institutional, structural, and social processes which maintain the occupational hierarchy.

Most of the above studies of immigrant women in the lower echelons of the labour force involve subjects who do not speak English. Anderson and Lynam (1987), however, do mention that the IndoCanadian women spoke better English than the Greek women. The fact that most studies involve non-English speaking subjects may reinforce the commonsense notion that ascription to the lower echelons of the labour force is due to lack of skills, including language skills. This in turn probably tends to obscure the role that institutionalized racism plays in the segregation of jobs. The present study of the experiences of personal care attendants, who all speak English well, should help to clarify the bearing that job segregation itself has on experiences and health of immigrant women of colour.

Other studies (Geschwender & Carroll-Seguin, 1990; Jayaweera, 1993; Liff & Dale, 1994; Russell & Wright, 1992; Sokoloff, 1992; Tomaskovic-Devey,
1993; Woody 1989) show that the process of job segregation or structural constraints on the basis of gender and race operate even when language acquisition and other skills are present. Although most of these other studies have taken place in the United States and Britain, it is probably safe to assume that the same process operates in Canada, although the specific mechanisms whereby it operates are just beginning to be identified by authors such as Ng (1984; 1988).

In his quantitative study of 795 employees in North Carolina, Tomaskovic-Devey (1993) found that there was strong support for his hypothesis that job segregation is due to social closure at the job level. Social closure is essentially the process of maintaining advantage by exclusion. Discrimination, the author thinks, is primarily a means of creating and preserving advantage, rather than a product of beliefs or socialization. Das Gupta (1994b) agrees with this position when she states that the proponents of "cross cultural understanding" as a strategy, seek to imply that discrimination is attitudinal or a product of misunderstanding, and they obscure the fact that it is an issue of power sharing. Tomaskovic-Devey (1993) acknowledges that his study is limited to inferences about, rather than observations of dynamic processes (a limitation that a complementary study using qualitative methodology might have remedied). The author notes that some job attributes (eg closeness of supervision, task complexity, possibility of promotion, job
insecurity, degree of autonomy, etc) are known to affect job satisfaction, self esteem and mental health. He notes that minorities are mainly segregated within jobs with negative attributes. It would have been interesting and informative if the author had been able to test whether there was a correlation between health and these negative attributes.

Ralston (1988; 1991) following the conceptual framework initiated by Dorothy Smith and Roxana Ng, examines the lived experiences of 101 South Asian women working and living in the Atlantic provinces. She makes the point that the destination of the immigrant woman, the type of work she does, and her work experiences are influenced by the uneven capitalist development of the Canadian economy. Some of the women in this study reported that they experienced more racial discrimination in Toronto than in the Atlantic provinces. This would correlate with the premise by Tomaskovic-Devey (1993; p.171) that more aggressive discrimination takes place when minorities become numerically a larger competitive threat in the labour force. This is noteworthy, as statistical studies of immigrant women in Canada (Arnopoulos, 1979; Boyd, 1987) which point out that immigration from third world countries has increased dramatically in the last two decades, also point out that the majority of these immigrants have settled in the major metropolitan areas of Ontario and British Columbia. Concomitantly, it is mainly in these metropolitan areas that "visible minorities" have been identified as "problems" (Brand, 1993). While the commonsense
notion is that diversity itself causes the problem (as suggested by the Green Paper), feminist women of colour (Bannerji, 1987; Brand, 1993; Collins, 1990; Glazer, 1991; Glenn, 1992; hooks, 1984; 1989; Liu, 1991; Ng, 1994) and other anti-racist authors such as Tomaskovic-Devey (1993) make clear that it is a question of maintaining privilege on the part of a dominant group and that racism stems from state policy (Li, 1990).

Silvera (1989; 1993) conducted her well-known qualitative study of working class Caribbean women working as domestics in Toronto, using the feminist method of oral history. The author emphasizes the strength and agency of the women who tell their stories, and indeed, she participated in some of their successful struggles against deportation. In the introduction, the author points out that the lived experiences of these women, until now voiceless, takes place in the context of a system where racism is embedded, and which thrives on the labour of women of colour from third world countries. Her study demonstrates the power of direct quotations from narratives in establishing credibility (Sandelowski, 1986) and evoking sensitivity in the reader.

Summary of Findings in the Literature Review

In this chapter bodies of literature concerning nursing assistants, working immigrant women of colour, and the organizational context of the labour of immigrant women of colour have been reviewed. In reviewing this literature it becomes evident to the reader that working conditions to which non-
white immigrant women and other minority women are ascribed, do have implications for health. It is also evident that research about the experiences of these women is in the pioneering phase, and that much more information is needed about experiences of non-white immigrant women in various occupations in order to draw any conclusions about their health concerns and needs. For instance, it is still far from clear what the health concerns of these women may be and whether health outcomes are the result of characteristics of jobs to which immigrant women are ascribed, or whether the process of being ascribed to segregated jobs itself may have health implications. It is also not clear what the exact mechanisms are by which immigrant women of colour are ascribed to certain jobs, and what their feelings and experiences surrounding this process may be. In reviewing the studies above it became evident to this researcher that the method of institutional ethnography, from a feminist perspective, had the most potential to yield information about "how things work", while illuminating the everyday experiences of the women in a way that would foster agency in challenging organizational structures in which their experiences are embedded and which are giving rise to the problems they are experiencing.

As professionals we must question the underlying assumptions of our practice which are often taken for granted (Anderson, Elfert & Lai, 1989; Fernando, 1992). For instance, we have yet to question in a thoroughgoing manner the presence of race, class, and gender bias in the foundations of our
knowledge (DeMarcos, Campbell, & Wuest; 1993). In this study the researcher has attempted to explore the presence of race, class and gender bias in health care institutions, while contributing to an understanding of the health needs of immigrant women who work in the lower echelons of the labour force. The methodology by which this task was undertaken is discussed in the following chapter.
CHAPTER THREE: RESEARCH METHOD

This chapter begins with a description of the setting of the study, and a description of the participants. Following that is a discussion of the method of research used in the study and then a detailed description of how this method was carried out during data collection and analysis. The chapter concludes with brief discussions on ethical considerations, and limitations of the study.

The Setting and the Participants

Ten patient care aides participated in the study, and were interviewed over the course of two months by the researcher. All participants were immigrant women working in a number of medium to large sized long term care facilities in the Greater Vancouver and the Lower Mainland. Having previously worked as a staff nurse in a hospital which had closed two years ago, I had acquaintances from that hospital who now worked in various other facilities as Registered Nurses (RNs), housekeepers, and licensed practical nurses (LPNs). These women were able to contact, on my behalf, patient care aides at their facilities who were willing to take part in this study.

The criteria for inclusion in the study were: female, working as a patient care aide (nursing assistant, care aide), having immigrated to Canada at some period in their lives, and willing to take part in the study. Most interviews took place in the homes of the participants. One interview took place in my home, and two took place in a restaurant. Interviewing the participants in locations
away from their facility settings ensured that their jobs would not be jeopardized, and that the participants felt free to disclose things that they may not have wanted others at work to know.

The ten participants ranged in age from 30 years to 48 years, and came from various countries: Philippines, India, Fiji, Africa, the Caribbean, China, and other South and East Asian countries. Study participants had been in Canada for periods of time ranging from two years to twenty-five years. (Most had been here between four to nine years). All had completed at least a high school education in their country of origin (except for two who had completed high school here in Canada), and some had been professionals in their home countries. Two of the women were single with no children, two were single parents, two were married or partnered without children, and four were married and had children.

Methodology

The study was guided by the theoretical perspectives of institutional ethnography and the writings of antiracist feminists. Feminism as a perspective has only recently been adopted by researchers within the discipline of nursing (Parker & McFarlane, 1991), and there is some debate among scholars of diverse disciplines about whether or not it constitutes a distinct methodology (Bhavnnani, 1993; Cancian, 1992; Gorelick, 1991; Hammersley, 1992; Harding, 1987; Roman & Apple, 1990; Rosser, 1992; Williams, 1993). Proponents of
feminism as a methodology argue that only through this distinct approach can the principles of feminism be realized: a non-hierarchical research environment; research by and for women; research which accounts for the situational context of women's experience; and research which challenges inequalities and emphasizes agency among those being researched. Black feminists and other antiracist feminists (Agnew, 1993; Bannerji, 1987; Collins, 1990; 1991; Glenn, 1992; hooks, 1984; 1989) have enriched this ongoing debate by pointing out that gender oppression cannot be considered separately from oppression on the basis of race and class; i.e. feminist research must take into account the interlocking nature of genderism, racism and class oppression in the experiences of oppressed women - experiences that derive directly from the colonialism and imperialism suffered by the nations of origin of many women.

Institutional ethnography is a feminist research strategy which derives from critical social theory, feminist sociology, and marxist materialism, and goes beyond mere appearances of social life to make apparent the material conditions and social relations structuring them (Roman & Apple, 1990). As explicated by theorists who have conducted studies using that method (Diamond, 1992; Ng, 1984; 1988; Smith, 1987), institutional ethnography starts with the everyday experiences of women's work as a pivotal entry point to understanding the larger organizational structures in which those experiences are embedded. True to the tenets of the feminist perspective, this is a
committed stance: "through this ethnographic process of inquiry we explore further into those social, political, and economic processes that organize and determine the actual bases of experience of those whose side we have taken (Smith, 1987; p.177)".

Thus, this study has not produced a description of the experiences and health needs of immigrant women of Colour in an isolated or "objective" manner for the purposes of better health care administration or for some other preconceived "need". Rather, using the feminist perspective of institutional ethnography as a guide, I have sought to understand, in a very preliminary way, the "complex of relations organized around the distinctive function" (Smith, 1987) of health care, with the standpoint of the everyday world of personal care attendants providing an entry point for gaining this understanding.

Conducting an ethnography implies immersing oneself thoroughly as a participant observer in a setting (Roman & Apple, 1990; Spradley, 1979) for a relatively long period of time (the researchers cited above spent at least one year in the field). Since such a length of time was not within the scope of this study, I used a modified form of institutional ethnography: that is, I conducted primarily unstructured ethnographic interviews (supplemented with field notes taken during interviews) among a small number of study participants (ten), and in analyzing the data strove to derive themes which had meaning from the standpoint of the participants of the study (Atkinson & Hammersley, 1994) and
which helped to clarify the "social relations organizing the worlds of their experience" (Smith, 1986; p.15).

Smith (1987; p.190) states that in her study of parenting, no attempt was made to code or identify common themes in the narratives. She describes, however, the process by which she and her colleague identified a central theme of the parents' work around their child's homework, and then the process through which the researchers linked this theme with the subthemes of differences produced among children at the elementary level of schooling, leading to differences at the high school level, which in turn eventually led to differences in "credentialed statuses on the labour market" (Smith, 1987; p.203)." Since at the present time, data analysis in feminist research methodology has not been well described or delineated by researchers, in the present study, I have analyzed narrative and field note data according to research protocol described by other recognized qualitative researchers (Anderson & Jack, 1991; Hall & Stevens, 1991; Oiler, 1986; Sandelowski, 1986; 1993; 1994; Spradley, 1979) as well as by Smith.

Collection of Data

The ethnographic interviews took the form of narratives, a method that allows women to place themselves as subjects (Silvera, 1989; Smith, 1993), allows women to express a multiplicity of experiences and world views (Etter-Lewis, 1991), and is well suited to blending the subjective with the "system-
wide" context (Stivers, 1993). While the use of narratives does not automatically ensure a non-hierarchical or empowering research environment (Geiger, 1990), through skilled listening (and questioning techniques) on the part of the researcher, narrators may "feel more free to explore complex and conflicting experiences in their lives" (Anderson & Jack, 1991; p.23). Studies using structured or semistructured interviews, on the other hand, frequently use women's experiences to validate existing conceptual frameworks in social science (Anderson & Jack, 1991; Smith, 1987) rather than going beyond conventional explanations to reveal inherent strengths (rather than deviances) that many of those feelings and experiences represent (Anderson & Jack, 1991). The use of narratives is a particularly appropriate method for nurse researchers who already have experience and training in helpful communication.

Each study participant was interviewed initially for approximately two hours, and was encouraged to tell her story about experiences of becoming and being a patient care aide. A set of open-ended questions (see Appendix A) was used as a guide or prompt when needed: questions such as "Can you tell me about how you came to decide on becoming a patient care aide? What was it like for you before you came into this job (in Canada? back home?) What are things like now?". An attitude of active listening was adopted during the interviews, with frequent paraphrasing and clarifying to discern meanings.
These narratives were taped and transcribed verbatim by myself, and then went through a process of data analysis (to be described later). Along with interviews, data consisted of fieldnotes (i.e. contextual data) taken during and after interviews: eg nonverbal communication, the setting or context of statements, activities of other persons present during the interview, etc. (Lincoln & Guba, 1985; Rodgers & Cowles, 1993; Sandelowski, 1994). After I had completed the first six interviews, I then began second interviews with the first participants, as well as starting initial interviews with four new participants. By this time data analysis was well underway, and I was beginning to verify with the first participants (and with my thesis advisor) my emerging conceptual framework, and to clarify points, and enrich the data. With subsequent participants, I was careful to begin interviews with open ended questions in order to avoid premature closure, and to satisfy myself that no new themes or subthemes were forthcoming. As the work progressed I met with participants who expressed an interest in seeing the work in progress and the end product, and sought their feedback. This was in keeping with the feminist standpoint, and helped to ensure adequacy of inquiry (Hall & Stevens, 1991).

Before interviews began, there were several stages to be negotiated as an "outsider" entering the field and gaining the trust of the "insiders" (Kauffman, 1994). A relationship of trust was established between researcher and study participants through my credentials as a nurse in the Master's program of the
nursing school, and also by my status as acquaintance of one of their coworkers. Trust was also established by my use of open ended questions at first which showed my interest in the participant as a person; and initially I avoided sensitive issues such as problems at work. This initial stage of entering the field as an outsider and establishing rapport was important in order to ensure that I was accessing the reality of the participants' worlds and presenting a credible description of the women's experiences in terms of what was significant to them (Hall & Stevens, 1991). It was also important for me to assure the participants that they would not be further exploited by the research process itself (Cannon, Higginbotham & Leung, 1988) by, for example, having their knowledge appropriated for some other agenda (Anderson, 1991; Bannerji, 1993b; England, 1994; Roman & Apple, 1990).

Analysis of Data

As mentioned earlier in this chapter, there was a dilemma to be faced in the analysis phase of this study, since this study follows the feminist method of institutional ethnography and anti racist writings, yet there has been no unique method of data collection and analysis delineated by those who have undertaken such studies. Therefore in this study I have utilized methods and categories of data analysis recognizable to other qualitative methods compatible with the feminist approach such as ethnography, grounded theory, and phenomenology. I have documented below the process of analysis in order to
establish adequacy and credibility of the research process both from the standpoint of the discipline of Nursing, and according to the principles of feminist inquiry.

I went through three main phases during analysis of the narratives, which may be seen as: Level 1 - Investigating the particular phenomena; Level 2 - Investigating general essences; and Level 3 - Apprehending essential relationships among the essences (Hutchinson, 1986; Oiler, 1986). These phases are analogous to Spradley's (1979) symbols, domains and themes; all three phases took place simultaneously most of the time.

The analytic stage of the study began in a preliminary way after the first interview, at which time I read through the transcript of the narrative line by line, and wrote discerned meanings, or substantive codes in the margin on the right hand side. Subsequent narratives were read and reread and analyzed line by line for similarities and dissimilarities; I completed the first interviews in a state of excitement at the wealth of data. I then began to see definite similarities and recognizable themes (constituent elements or categories) emerge. This involved condensing some codes together from Level 1. After four interviews, a conceptual framework began to emerge which I felt, however, was premature; eg I was imposing "health concerns", a habitual concept (Oiler, 1986) as a theme, which I later discarded in favour of more consciously clarified concepts closer to the actual lived experiences of the participants. I wrote symbols in the
left margin to mark themes (eg C for social closure). After six interviews a more comprehensive conceptual framework began to emerge which the first six participants and the following four participants recognized as valid. Besides "checking it out" with study participants, I also conferred with my thesis advisor from time to time. In the third phase of analysis, relationships between themes, or an overall pattern had emerged and was explored with the help of current literature in the field.

During the analysis stage of the study, it was important to maintain an "audit trail" (Lincoln & Guba, 1985; Rodgers & Cowles, 1993) so that readers could see the cognitive process that the researcher had gone through and could monitor the adequacy of rationale for decisions and dependability of the research processes (Hall & Stevens, 1991). Besides field notes, an important part of the audit trail was a record of methodological methods used, in which inquiry decisions were identified, explicated, and supported. For instance, as the central theme (well-being of PCAs during commitment to the elderly) emerged from the data, the focus of the interview questions changed; i.e. while initial questions were open-ended, later questions asked for more details related to the emerging central theme (Rodgers & Cowles, 1993). This process was documented in a methodological "log book" maintained on the computer.

Credibility (Sandelowski, 1986) was established by verifying transcripts, shortened versions, and composites with the study participants, and by
including frequent direct quotations from transcripts throughout the write-up of the study.

Also important was confirmability (Sandelowski, 1986): evidence that as the researcher I was aware of my own subjectivity and of myself as participant in the study and was taking this reflexivity into account during the process of data collection and data analysis (Hall & Stevens, 1991; Lamb & Huttlinger, 1989; Rodgers & Cowles, 1993; Sandelowski, 1986). This was especially important, in a feminist study, in terms of striving for non-hierarchical interviewer/interviewee relationships in which I could become aware of the actual standpoint of the participants. To this end I recorded my reflections, conjectures, impressions, difficulties, and my own perceived biases, etc. in a "reflexive journal" (Lincoln & Guba, 1985; Rodgers & Cowles, 1993). I used a notebook for this purpose and wrote in it frequently, so that "fleeting impressions" were caught and developed further (Rodgers & Cowles, 1993).

Through the above strategies, and guided by the method of institutional ethnography, I was able to analyse the data and develop it from the level of "appearances of things" to another level of understanding. That is, starting from the descriptions or narratives of the everyday experiences of the participants as a pivotal entry point, I became aware of the organizational contexts surrounding and informing those experiences, which had not been immediately apparent at the beginning of the study.
Ethical Considerations

Before starting interviews, permission was obtained from the "University of British Columbia Behavioral Sciences Screening Committee For Research and Other Studies Involving Human Subjects" (Appendix D). Prior to contact with the researcher, each participant received a letter of introduction describing the purpose of the study, how it would be conducted, and she was given the choice of whether or not to participate (Appendix A). Signed consents were obtained from each participant prior to the interview (see Appendix B). Each participant was assured of confidentiality, assured that the researcher would take pains not to jeopardize the participant's job situation, and that she could withdraw at any time from the study. During the analysis of the data, participants were assigned a code name rather than their real name, and only myself and members of my thesis committee had access to transcripts of the interviews. Transcripts were kept locked in a file cabinet, and after transcription of each interview, the tape was erased.

Limitations of the Study

One important limitation of the study is the inherent hierarchy of the researcher/subject relationship in general (Anderson, 1991; Bhavnani, 1993; Campbell & Bunting, 1991; England, 1994; Roman & Apple, 1990), and the particular hierarchy which was present in this study: i.e. my background as a middle class registered nurse from an AngloCanadian background meant that I
had a position of privilege compared to study participants who were immigrant women in the working class. From the standpoint of the study participants, as a R.N. completing a degree I could possibly be in a position of authority over them in the hospital structure sometime in the future, thus some potential participants may have been hesitant to participate, or some may have censored their narratives for that reason. Another related problem is the ethical question of undertaking an academic study about oppressed women: "even feminist research too easily tends to reproduce the very inequalities and hierarchies it seeks to reveal and to transform" (Patai, 1991). These problems may have been partly resolved through maintaining a written record of the reflexivity involved in the interview process as described above, and by seeking frequent verification from participants about the work as it progressed. Unless and until the results of this study may be linked with amelioration of the situations of the study participants, however, these problems must remain as a limitation of the study.
CHAPTER FOUR: PRESENTATION OF THE FINDINGS

In this chapter the findings of the study are presented, guided by the method of qualitative data analysis as explicated by feminist researchers. The narratives were analyzed and emergent themes delineated. Numerous direct quotations from the narratives of the participants have been selected to illustrate the central theme and the other related themes, with brief explanatory introductions or interpretations made before and after such quotations. The central theme identified by the researcher was the well-being of PCAs during the process of commitment to the elderly. There was an interactional process of taking in or maintaining energy for strength and strategies while endeavouring to give good care to the elderly (See Figure 1 page 42). This process took place in and was informed by the contexts of the immigration experience, racism in Canadian society, the hierarchical health care system, and economic uncertainty, which are identified as contextual themes.

The chapter begins with a section on the contextual theme of the immigration experience. This is followed by the central theme of commitment to the elderly and then the related themes of difficulties of the job and strengths and strategies brought to the job. The contextual themes of racism in Canadian
Strategies and Strengths
• empathy
• making meaning of work
• overlooking
• speaking out
• forming groups
• spiritualism
• managing
• aggression
• humour

Figure 1. Using Strengths & Strategies to Get Around Difficulties of the Job
society and the hierarchical health care system are included under the discussion of attitudinal difficulties of the job, while the contextual theme of economic uncertainty is included under the discussion of social closure. The themes of racism and the hierarchical health care system could perhaps have been more appropriately included under the discussion of social closure, but since racism and hierarchy, as perceived by PCAs, take the form of attitudes discerned in others, these contextual themes are included in the discussion of attitudinal difficulties.

Specific examples of health problems experienced by the participants are introduced under the subthemes of physical and mental stress, and the difficulty of social closure. As will be shown in the discussion of the findings in the next chapter, however, all themes and subthemes which emerged from the narratives had implications for, or relevance to, the health status of the participants.

Quotations from transcripts are extensive in order to transmit the credibility of the narratives, and to evoke in the reader the feelings which were also evoked in the researcher by the women's stories.

The Context of the Immigration Experience

The ten women who participated in this study had emigrated from diverse countries including the Philippines, India, Fiji, Africa, the Caribbean, China, and other South and East Asian countries. Most had been in Canada for
periods of time ranging between four to nine years, with one participant having arrived two years ago, and three others having been here for fifteen, twenty, and twenty-five years. The decision to migrate had been made by either the participants and/or their husbands (or in the case of two participants, their parents) and was not always voluntary. Some participants described an especially difficult period during the first few years after arrival in Canada. Nevertheless, most participants now considered Canada to be their permanent home, though they still referred to and had continuing ties with back home. A subtheme of loss and gain during the transitional period of the immigration experience could be discerned in the narratives of most participants (the concept of loss and gain is adopted from Campbell, 1987). These aspects of the context of the immigration experience are now explored.

For two of the participants, the need to migrate had been due to dangerous circumstances back home.

I wanted still to stay, but we have a lot of problem with us, the military rule came in and there is a lot of fighting. I thought I would go to my home town, settle down and just be happy, because then I will be okay in my home town, I don't need to pay rent, I don't even need to buy food. But you see us here working, starting life again.

One of these participants felt that in choosing to migrate to Canada perhaps her present choices were more limited than if she had settled in another country.

Maybe we would have gone to another country and lived a more decent life than what I am now, living and working like a donkey. I would choose to work if I want to, or maybe work part time, you know. I would still want
to work, but maybe part time. But now I have no choice.

Both participants who had been forced to flee their countries hoped to return to their home countries eventually.

Another two participants had come to Canada because of their husbands' decision to emigrate. Although these women described difficult times in the first few years after emigration, both now had become reconciled to staying in Canada permanently and even preferred to stay. These words describe some of the difficulties experienced initially by one woman upon arrival in Canada:

It was a big change. I was a professional [back home], although [back home] everyone gets the same pay, doesn't matter if you are a doctor or engineer or anything, the same pay, but you get - people respect you all the time. When you come here you have no English and I have to go to work in a factory to make some clothing. So it's quite a shock for me. And I was so frustrated because I have no English, people don't understand you, you don't know how to start, you are new, new things here. It's really a shock for me. I mean, from psychological, and everything, it's really a shock.

Another two participants had accompanied their parents to Canada during early or pre-adolescence, and had attended high school here. Both women had maintained at least some ties with their countries of origin. The remainder of the participants had migrated of their own accord because of difficult economic conditions back home. Some of the latter participants described a spirit of risk taking, curiosity, or adventure as part of their motivation to migrate.

It's for curiosity, ambitious, and, perhaps certain goals that you want, that
you want to know other people and other countries, you know, and that's my purpose.

I came with the intention to stay maybe for a year, to see how I like it, and how things work out, and if things don't work out then I go back home.

Most participants came here with the hope of having a better life in the future:

You're always thinking to have a better life, to have a better salary, and all this, you'll be able to do something, and your children will be born in some country where there is no fear, there is no poverty, you know, [like back home] where you have to really scratch and save like you have been doing.

Many of the participants described the losses they had endured with migration, especially the participants who had not left of their own accord.

I come to this country, I have lost so much, I have lost the family, I have lost my country, and whom I am, how people value me, all those things I lost. And I lost my job as a nurse as well, when I came here. And my experience.

Some of the participants who described loss described it in terms of losing former status, respect from others, or losing value as a person.

You know, the thing is, when you come from a different country as an immigrant you come here and you lose all your value, value as a person. And when nobody knows what you are, they think that you are just a bloody immigrant, who doesn't know it, is dumb. If you don't speak English it is worse, because then people will think you have never gone to school and don't know anything. Even if you speak with an accent, you're still the same. And people don't value what you know and what you have, you know?

A big loss, a big loss [loss of husband's former job back home]. Here, there is no status. There, when you do a big job, people look up to you, a lot of respect there. Different. Entirely different. Here, people don't care for what job they do, it's only if they earn very well, that's how it goes.
Money is the thing that controls, that rules here. Not education and family, no.

Even those who had migrated of their own accord felt occasional regret about leaving their countries.

You tend to think "Oh why have you left?" You know, your country, your job, where you were something, you know? You lose that confidence in yourself, it is something like, it is something like regret comes to your mind. You have been something, and here you are- you feel that you are not.

I didn't really mind leaving, but sometimes you kind of get a little, you know, lonely not being with your family.

Most of the participants could perceive gains along with losses from migration.

At the time of the study some participants perceived mostly loss from the immigration experience, others perceived mostly gain, while others could be seen to be on a continuum between loss and gain.

I have lost almost everything. The gain...as time goes on, we'll see. At the moment I cannot see it.

You lose a lot, and you gain. It's half and half, I guess.

I think there was a lot of gaining, a lot of things that I gained. We have freedom here, freedom in religion and everything. It's a good place to live. It's a beautiful place.

Even the participant who saw mostly losses from the immigration experience was beginning to see some gain, however slight.

But I think back again, I've learned to do everything on my own, whereas when I was at home I had a lot of help. That was a good feeling. This is what happens in a small community, people help each other. They would just come. But here now, I have learned to do everything on my
own. You have to learn to rearrange yourself and do everything on your own. Maybe you have to trust yourself almost a hundred percent.

Whether or not the participant had made the choice herself to migrate, or whether she was perceiving primarily losses or primarily gains from it, the immigration experience had imparted to her a resiliency, and evidently a perspective on life and work different from that of people who had never migrated. As will be seen in the following sections, this unique perspective permeated the whole process of giving and receiving energy during commitment to the elderly, and overcoming difficulties or obstacles in the job.

"The Good That We Do": Commitment to the Elderly

The central theme identified in the study was the well-being of PCAs during the interactional process of commitment to the elderly. Patient care aides utilized a large number of strengths and strategies during the process of overcoming difficulties of the job and endeavouring to give good care to the elderly, and also derived strength from this work. The reciprocal nature of the helping relationship between patient care aide and resident is illustrated by the comment of this participant:

I feel so good when they get well, as if, you know, something good has happened to me. So the same thing now, when it comes to this personal care, when I wash a resident, comb their hair, brush their teeth, and if there is makeup I put a bit of makeup on her if she is a lady. I feel so good, and I feel also that I have brought back their dignity to the resident who can not do it themselves. They feel like a person again.

The satisfaction or sense of well-being derived by participants through the
process of commitment to the elderly appeared to have several components, illustrated by the subthemes of: satisfaction from making others happy; feelings of attachment or bonding with residents; receiving appreciation; pride in being able to manage difficult residents; learning from residents; and increase in self confidence. Another source of satisfaction from the job was the opportunity for interactions with people at work. These subthemes will now be explored.

**Satisfaction From Making Others Happy**

Virtually all participants described the satisfaction derived from making residents in their care happy. There was an intrinsic reward from making another person happy, not readily apparent to someone such as the researcher who had been brought up in a materially acquisitive culture in North America.

You make them happy, you are always in their heart. So I think if you give them good care, they give you something. Yeah. I mean something from spiritual, it's not really money or something like that, you know.

What I'll do, I do it with my own heart and soul. Somebody says can you please help me, I go there and help them, I don't say "Oh I am going for my break". That's the way I am; it's very rewarding when they're happy.

But I still love my job. I love it, you know. If I didn't maybe I wouldn't continue doing it. I like the elderly, deep down I still love the elderly. I like talking with them, sometimes they talk about when they were children growing up, and their young days. You tell them kind words, happy little words, things to make them happy.

**Satisfaction from Attachment or Bonding**

Feelings of attachment or bonding between resident and care aide were very rewarding both to the residents of the facilities and to the study
participants.

And then there was one man, a patient, if I don't come [one day] he is so unhappy. I say "John, why are you unhappy?" He says "Where have you been?" I say "John, it was my day off, so I am coming back now", and then he is happy.

So it's just like, you know, if they're happy, then you're happy. And they come to love me, they likes me, so I like them too, right?

Several of the participants described how they even missed the residents on their days off or when they went on holidays.

You can really get- I love, I just adores, you know, looking forward to go to work, yes, and seeing them every day, and dealing with them and things like that; and some days when you're home and you're bored you can't wait to get back to work, and sometimes again you wish you don't have to go back there to work, you know, but sometimes again you really miss them.

Receiving Appreciation

Receiving appreciation from residents for the care given was part of the reward of the job, also.

So you know, these kinds of relationships make you like the job, when you are going to the job. You know you are going to meet people who appreciate your work.

When you help somebody and they can't help themselves and when the patients look at you and say "Well thank you very much I wish I could do that", it makes you feel good. It's so hard when they can't help themselves.

Appreciation expressed by families of residents was rewarding, too.

Today there was a lady who came to see one of the residents. She kind of praised the job. She was saying "You should be happy and proud for what you are doing, what you are doing is a good job", she said. She
was talking to me.

I heard a lot of, you know, from other people, from families, they would say if there were no PCAs what would happen to those old people. We are appreciated.

**Having An Ability to Manage Difficult Residents**

Some participants derived a feeling of satisfaction and pride from being able to manage aggressive or difficult residents when others could not:

Well, sometimes if you find one resident so aggressive, because I have so many incidents that I find so interesting that some of the residents, they can't get them up. They can't get them dressed up. But when I get in their room, and I talk to them, when I get up from that room, they are in my back, walking. I mean, up already.

This person, like she's really scared to come out of her room, and it's a challenge, she doesn't want anyone to come in her room, but she lets me in.

And then there were a number of residents, when I go to a resident when she sees me she is so happy, she says "Oh you have come", so happy that I am around, because when I'm around I talk with her, you know. But when other people go she refuse to sit up or stand up, she makes a lot of noise.

**Learning from Residents**

A number of participants found that they could learn useful and interesting things from talking with the residents.

I talk to patients who are okay, and I come to know a lot of things from them too.

What they have experienced they are telling it to you. You know, their families, their kids, their children, everything. Their experience. They share it with you. I mean through them, I learn lots from them.
Increase in Independence and Self Confidence

Some participants reported an increase in self confidence and independence since they started working in the job.

He [husband] says I should be glad of my job, you're independent, and I am very assertive. I am more bold now, he says, since I started working. He says I'm bossy too.

I think when you work you build up a lot of confidence, because sometimes there are situations where until you get the nurse you have to be there, like in charge. Suppose somebody falls, and until the other girl goes and gets the nurse you have to be there and know what to do. There are sometimes things where we have to think and do the best.

Interactions With People

Other sources of satisfaction from the job included the opportunity for interactions with people at work.

I like working with people rather than [office type work]. I feel good in their company. Because when I come home I am in a different, you know, I am with the children.

I got a bit lonely in that great big house, I like being around people. I said "Well, I think it's time for me to move on to something else". So I heard about this course, the nurses aide course.

I don't know why but I just love being there, I just love being there. It seems like if you're at home, well, it's nice to be home too, but sometimes it's much better there. I get bored at home, even if I have lots to do I still get bored, so if I am there [at work] 8 hours is nothing.

The following participant was in the process of trying to establish a professional business outside work. Interactions with people working in the longterm care facility provided a welcome relief to more problematic interactions encountered
in the other milieu, where there were "lots of politics", people do not "say something directly", and "you have to think what do they mean". Relations with PCAs at work, on the other hand, were more straightforward.

I work here, I'm happy you know, because here I found that in the care aide job, because everybody joke all the time, usually, you know, if you really work with some people they are really nice, you really feel all day, people are not really complicated.

For many participants, interactions with people at work was in some ways a substitute for the daily interactions with people back home which had been extensive, and which most participants greatly missed:

I like people and I like company. If you don't work here [in Canada], life is boring. Not like back home. There you have your friends, you have your relations, I mean life is not boring there, because there are people in and out all the time. So I work mostly for economic reasons, and also to, partly, is to avoid staying home.

We have our own business back home. We have a grocery store back home, and everyday I met people, people coming and see you, talk to you, visiting, we sing, we dance, you know, we cried, yeah, we laugh, we run, we walk. I mean, it's also like what I'm working now.

In summary, the participants clearly derived satisfaction from their jobs and felt committed to the elderly. Numerous difficulties of the job, however, posed obstacles or challenges to exercising this commitment, and to exercising to the fullest extent the capabilities of the participants. These difficulties or challenges are described in the following section.
Difficulties or Challenges of the Job

Difficulties of the job, which impinged on the enjoyment of the job and commitment to the elderly, could be seen to fall into three general categories: physical and mental stress, attitudes of others, and social closure. (The concept of social closure, adapted from Tomaskovic-Devey, 1993, is defined in that subsection). Getting around or through these difficulties required an expenditure of energy which probably detracted from the amount of energy available for enjoyment of the job and commitment to the elderly. Furthermore, the whole process could be seen to be taking place in the contexts of the hierarchical health care system, racism in Canadian society, and economic uncertainty. These subthemes will now be examined more closely in light of the data obtained.

Physical and Mental Stress

Most participants described the work of a nursing assistant as physically and emotionally very demanding.

As you know our work is quite heavy and stressful. It depends on how strong you are. It's the health, mostly you must be physically fit to do our kind of job, and mentally fit too, otherwise you can go crazy too. But mostly the body has to be fit. Well, I don't think in our jobs they should make us work until sixty. Sixty years would be a little too much on the bodies to do our kind of job. Maybe 55 would be fine.

Many participants complained of the time pressure, or pressure to keep to a schedule of work in their facilities, especially during certain periods of the day:
It is really difficult to get them ready for breakfast, it is a rush hour, this is what bothers me, that I don't think anything can be done about. It's heavy because I don't think that you can give very, you know, very good quality care.

We work shortstaffed. So we run around like crazy people. we try and do our best, to do our care, the best care for the residents, but if they want us to be on time, we can't be, and that's where the conflict occurs, and that's the way it goes, and sometimes some of the residents think "Oh well, N__, I didn't know you were like that", and it's hard. You have to treat them very, very much like they would like to be treated. I try, try to do my best.

It is like the time. It seems like you want to get them up before 9:00 for breakfast, and everything is still topsy turvy, you don't know what to do, you are under pressure. Rushing is not very healthy, that's why there's so much accidents, because everybody's rushing. That's what I feel to everybody.

Some participants described how emotions of upset, angry, or demanding residents could affect the care aide.

Emotionally, well, I'm very emotional with the elderly. I feel what they feel. Sometimes, they get upset if they get a care aide where she's not happy doing them, you know, and then they're going to put all their emotions to you, you can feel it, you know

If someone demanding too much, it make you anxious and sometimes angry too. Then your whole day just ruined

Sometimes some patients are demanding, you know. They just keep ringing the light and then you go there, and what should I say? Not that they really need something, urgently, you know, they just have to keep demanding, some patients are like that; it makes it a bit hard.

Many families of residents were appreciative of the care their relatives were receiving; some families, however, were not, and this caused feelings of indignation in the participants and made a demanding job seem even more
demanding.

The families are so demanding. How much you do, it's not enough. They try to pick on the slightest fault and then, you know, run up to the highest person. We have some on our floor like that, too. Slightest thing they complain and complain and complain. Because they should know. Maybe they're guilty, because they can't take care of - they should be happy that their husbands or sons or wives or whoever are being looked after, fed, washed, so many times a day. So what more do they want, like? I think people should appreciate it, because ours is a demanding tough job.

Although interaction with residents often resulted in feelings of attachment and satisfaction with the job, some participants described instances where a resident, feeling abandoned in long term care by his or her family, had overwhelming needs which were impossible to meet solely by staff. This resulted in feelings of distress among some PCAs.

And then you get attached. Like for instance there was this resident, she would ring the bell many times; so when I am in her room five minutes she would ask me twice or three times to change her position. I'll do it, then if I'm tired I say "Mary I've just changed you". Okay, so she was fond of me, she was a really nice lady. Then the day she died I felt so bad, you know, I felt so bad, as if - I was on night duty, I didn't sleep. Because, you know she wanted so much, and then, you know, she was very friendly, too.

Many participants described the special difficulties of working with demented residents.

The ones who are very old, and let's say demented or who are confined to bed, this you must have strong nerves, because you can never know their reactions, can never know how they will behave, what is their mood and all these things.

Well, it's a very depressing place. I like almost all the patients. But then
there are some who are too demanding, like confused, and then sometimes you get so—I don't know what words to use, but then you get so tired. Some of them will say over and over again “What can I do? What shall I do now?” They don't know what to do. Lots of them like that.

Many of these demented residents were verbally and physically abusive at times, and this took its toll on the caregivers.

I just don't feel to say something good to some elderly who has hit me or who has scratched me, and I won't say it, I don't know whether it is wrong. An aggressive resident. I don't show my anger, but deep inside I am not calm.

I get so used to it, the abuse, you understand; it is something you have to deal with. When these things happen, sometime, you know, you so tired and stressed out, you just say I'm just kind of fed up, I just hate working in this place sometimes.

We have some sexually abusive patients too. Some of them physically. Most of us feel the same way, the abuse of us, and some have got hurt too. Especially the kind that always hits and kicks. I have got hurt, too, right here in the chest. And maybe with old age they have memory loss, confusion. And some are angry too. Some of them who are with it are very angry that they are put in facilities.

A large proportion of the participants described actual or incipient health problems probably related to the physical and mental stresses of the job.

Well, I think it was about last year, you know, this pain in the hip area, you know. I can't tell, it could be my work, you know, walking and standing. You just have to hope for health and strength everyday. There are so many people hurt themselves, yes, sometimes.

Well, for this kind of job, you've got to be strong, so you've got to have the energy, and with my condition, I can't take sugar, so sometimes I feel very weak, not so weak so as to faint, but I feel really weak, not strong. Because our job is, from the time you go you are on your feet the whole shift, except for your break time, you sit a little while. So, not like office jobs. Not just the feet, the hands too, the whole body works, lifting,
moving, pulling them up and down the bed, you know.

I won't just overwork myself. Sometimes you have to rush, you have to, plus you have to run here and there to bring [the resident] back. But I would ask for help, you know, because I already have bursitis on my shoulder.

Some of these patients, they are very strong; we had one guy on the floor who was so strong, if he grabbed us- one girl had her wrist so badly hurt from him, he grabbed hold.

For some of these actual or incipient health problems, the participants had sought repeated treatments from the health care system.

I'm taking antiinflammatory, nothing else I can take, because I've taken so many things already. Cortisone shots, acupuncture, it's there.

Some participants considered that they could not find appropriate treatment from the health care system.

I find earlier that I was getting really emotional, I kind of getting this emotional problem, and I said I should really maybe go see my doctor, but I said "Well, he's a man, what is he going to do for me?" you know - I go and I explain to him, he's going to talk with me and what can he do? So I said I have to try and deal with my emotional problem and it could start from stress because of things you have seen and can't do anything about. So eventually I just deal with it myself.

Many participants used self help remedies such as giving one another massages, reading self help manuals, meditating, talking things over with friends, or otherwise dealing with health problems on their own.

When I come home, sometimes I take Tylenol, I'm so exhausted, my legs, because you run from one end to the other end. I'm so tired lately. I'm just so exhausted.

I do body mechanics, but sometimes when we're using already these
mechanical lifts, like one patient who suddenly came down, she was so heavy it was just terrible; so I stressed up a little bit, but then I just do hot baths and that's it. So far, so good.

On the other hand, some participants enjoyed the physical activity of their job, and preferred it to more sedentary jobs. They considered physical work to be good for health rather than a hardship.

Some days you get tired, you aches from the whole day, but then I love my job because at least I keep moving. I don't like confining jobs, that's not good for health. I love my job because I keep moving and it's good exercise.

In general, PCAs health I think it's good, because although it's physical work, sometimes the physical work makes people more healthy, so for me I think usually PCAs are healthy in general. I think 85% of them are healthy.

The following participant thought that being happy at work conferred relative immunity from feeling physically stressed.

Physically it's very stressful, because you need all the energies and everything, but if you are happy with your job you don't feel all those stuff.

**Difficulties from Attitudes of Others**

Attitudes of others which were difficult or problematic for the participants included those which were obviously related to the general contexts of racism in Canadian society and the hierarchical health care system. Relationships with coworkers (RNs or other PCAs) in the longterm care facilities could also be problematic at times, though the problematic was not obviously related to
Attitudes Related to the Context of Racism in Canadian Society

Some participants described experiences of racism while on the bus, walking in the street, applying for jobs, or while attending schools and many had also witnessed racist incidents involving other women of Colour.

There is still some, sure there is. When it comes to jobs, there is racism for sure. Like, you know, school, we’re gonna go into a school and you are applying and trying to write an English exam; they look at you and think "Oh well, you must be, you know, not so intelligent".

One participant who had described incidents of racial harassment stated that she preferred racist attitudes to be open rather than covert.

Lots of it [racism]. Especially among the older people, but you can't blame them, because they come from a certain time period of history. But at least one thing, one thing good about the older people is that they tell it off, they are not subtle. These are two different. For instance, one resident she used to say you nigger. But at least they are more open, though. They tell it off, rather than what's happening now, the younger generation, they don't, they show polite face, but then they're racist too, you know. It's better for people to be frank and open, then you can know and be cautious and have your space.

Not surprisingly, both covert and outright racism was also evident at times in the workplace for most participants. Sometimes these attitudes seemed to originate from management:

I'll give you a good, very good example [of racism at the workplace]. We had scabies going around at work. And an RN, a manager, said "Well, I think the scabies came from a third world country". It was very degrading. It seems like somebody who is uneducated would talk like that. Insulting. I mean blaming different, I mean, black people, [saying] we're not clean and blah, blah, blah, which is not true. We're very clean
people. So there's a very good example of racism right there, and it was not too long ago. Favouritism at work, too, sometimes.

Sometimes racist attitudes were discernible in some nurses:

It's as though as if [this nurse] trying to put me down by saying "Oh well, she's coming from a poor country, so like working in here we can just treat them, walk on them, step on them," you know.

Sometimes racist attitudes took the form of insults from residents.

Then you should be fit mentally, to put up sometimes when they swear and use all those words. They can swear at you and call you names, and foreigners, too. We get insulted a lot by some of the patients. Some of them even call me nigger, too. I don't take it that seriously, but some of us, yes, do get offended.

Because of the segregated nature of the occupation, it was not always possible to discern if an action was racist, or based on class difference:

It was Christmas, and I - I think that's not racism so far, the doctor gave Christmas presents for all the RNs, all the RNs have Christmas presents and there's no present for the PCAs.

The insidious nature of racist attitudes caused feelings of suspicion and hostility in some participants.

It can cause that emotional problem, seeing things happening, and frustration, you might end up take it out on someone, and then it cause temper, and you never know what can cause from there. Because sometimes I see this dislikeness, and I feel it could related to racism; they don't say, but you know deep down it is, and I can really tell what a person will be thinking without have to ask the person, or hear that the person say this or that. They said action shows, and from the action of a person towards you can tell what that type of person is, or if their racism sneakingly or whatever, you can tell.

So when they get in their group, when they're with one another, that's maybe what they're talking, that's how we want to treat them, you never
Attitudes Related to the Context of the Hierarchical Health Care System

Many of the participants felt a lack of appreciation for their work and an atmosphere of blaming and finding fault which seemed to originate with management.

I know in nursing, the administration, the bosses, you know, the big nurses, they don't appreciate your work. You never, never - "Oh this thing was not done this way. You forgot to send this, you forgot to do this". But they don't know the good thing which you have done. They just point out what you have forgotten, your weakness.

Management seemed to care only that the physical work was done, but did not care about or take into account the relational aspect of the PCA job.

We think differently than the administration, they want to put work like machinery, over feelings. Because they want the work done, doesn't matter whether you have these feelings for anybody or not.

One participant felt that when she expressed her opinion to management, as a care aide, her input was not welcomed.

I said sometime you have to tell the care aides that they have done something nice. You have to praise them, you know. Blaming them always is not right. So they walked right out, they were very angry with me that I had talked like that, that I was saying that as a care aide.

There appeared to be a lack of communication or caring on the part of management, or a lack of ability to communicate in a way which affirmed the personhood of the PCA.

This kind of communication is very inhuman, I think. You know the kind of communication they teach in books, nobody talks like that in real life!
You know we are becoming like computers, because a computer will repeat like that to anybody. You see, there is no humanity in that.

It would be nice if they would listen to us. First of all they don’t acknowledge, they don’t acknowledge that you are there. Sometimes they say hello, sometimes they don’t, they walk right by you, and that’s kind of...that’s kind of sad. You don’t feel like you belong in the environment. Just lately I’ve been very disappointed in the whole situation of their not respecting us, and what our needs are.

The following participant described how she felt during interactions with people in supervisory positions, or higher "grades".

They do try to hide the fact that they are superior but anyway they do show it, you do feel it, you do feel inferior. You can’t defend yourself from this feeling, because you are new here, you are from another country and all these things. Even if the ones who are higher, even if they don’t show it, but you feel it in every word that they will say.

Some participants thought they could discern attitudes of superiority in some RNs

Some of them, not all of them, think "We are higher. Our job is higher and they [the PCAs] are lower jobs". On our floor three RNs [have that attitude]. We know by how they talk, and sometime when we ask for help, we know how they answer.

Some participants felt supervised by RNs and felt such supervision was not necessary nor desirable.

Mostly in my mind, we work as our responsibility, because this is our job, this is our responsibility, you know. If they give us an assignment, these are our patients, this is our responsibility to change them and to turn them. The RNs, they don’t have to say [tell] us.

I feel that extended care RNs, they think they’re in charge of everything, they think they’re the bosses, I just feel that way.

The two participants above thought that there was a difference between
attitudes of acute care RNs toward PCAs, and the attitudes of RNs in longterm care toward PCAs. They attributed this difference to the fact that in acute care, RNs did some of the same type of work as the care aide, whereas in longterm care they did not.

More responsibility in acute, but they don't act that way. They're so helpful. They work together.

In acute care the RNs they do the same job, RN and PCA work together, they don't think like that, they have to do the same work.

Feelings of Low Status

Some participants were conscious of the low status and even stigma attached to their jobs through the attitudes of others. This caused feelings of indignation, embarrassment, and perhaps shame.

It is the kind of job that perhaps you would not talk about it, because the society would look down upon it, you know?

Like low status; for me, I'm okay with this job, but I just feel when I talk to some of my friends, they all look down on the job, I don't know why. You know, everytime they asking me "Oh we hear it's very physical and it's very dirty". I say "I'm okay with it".

Do you know, I never told my husband [what I do in my work]. One time my son was saying "Oh mom, you give baths in the hospital?" And I say "No, no". I never talk to other people about it.

Relationships With Coworkers

Moodiness or grumpiness in coworkers could cause feelings of depression in some participants.

If it is the residents alone, all is fine, but some day if nurses or PCAs or
anyone, they might not be in a good mood, and everything is just going wrong for you, people is moody against you; so some days it can be really just not your day. It kind of make you feel down and depressed by it.

I call these people split personality. Nice one minute, the next minute they're sulking, the next minute they might be different again. So it's kind of hard to deal with people like that, very hard.

I think for nursing, people should be more humorous lovable personality, not moody and grumpy.

Relationships with RNs.

Relationships with RNs in the Facility could be either helpful, or problematic. Participants found some RNs to be helpful both in attitude and actions:

Some RNs are helpful. Well, some of them, they're nice to you, they're going to ask you for some help, they give and ask do you need help, are you okay? I mean things like that, even though you don't need help, just to ask are you okay, do you need help, it sounds, I mean, it's an uplift to me.

When there are some RNs who are kind of very helpful, it makes most of us, the care aides, happy again. Some of them are very good, too. They help a lot. Some of them are really nice. Especially some of the younger ones, they do a lot.

while other RNs were perceived as not being helpful:

Now most of the nurses will do their share, what shall I say, mingle with the residents, give them a helping hand, but some nurses don't; they keep paging you all the time, which I don't think, is not very right. I think the RNs, too, should sometimes answer lights, or wait for us to come rather than just paging and paging. At least they can see what's wrong with the person, to see if the person has fallen, or it's an emergency, or whatever, then page us. What I say is that everybody should be part of the team.
The ones that I work with are quite nice. I know on different units there are some who are so hard to work with, too demanding, no help. This is from my past experience and this is what I heard from staff who have worked with the other RNs. Very demanding, no help, no understanding. I would say about 50% are helpful.

Sensitive communication between RN and PCA was thought to be important.

I think it depends on the nurse. Some nurses, they are really help, some nurses they are not. Some of them make a PCA feel upset, uncomfortable, something like that. About 60% of them are helpful, like they communicate with the PCA, they are not just like, um, you should do this kind of thing, you should do that thing. And talk to you, and you know, and when you are busy they try to do something for you. So it's a communication thing, I think. It doesn't matter you do something or not, communication is really important.

Relationships with other PCAs

Relationships with some PCAs could be mutually supportive, while relationships with some others could cause difficulties at work. For example, there was a difference between the treatment of PCAs who were permanent staff compared to treatment of casuals or newcomers, which resulted in the perception of a division between casual and regular staff.

There is a boundary between the casual and the regular. Mostly the regular are sent for inservices, how about us casuals? We're not called for inservices. We are all the same, you know. There is the division.

Conflict and avoidance of conflict between regular staff and casual or newcomer was described by seven of the participants who found such conflict or potential conflict very distressing:

You must have solid nerves, not only because working with elderlies is a big challenge, but working with other people. You have to work with
people who have been used to do it in their way. So I am a casual; while working with a full timer, she's used to the people, she's used to the place, she's been working maybe ten or twelve years there, so that I think in her mind, they feel it should be done in their way. Now if you are the submissive type you will always have to bear. But if you are not the submissive type there will always be conflict. So here I find problems. I think I am the submissive type, and I avoid conflicts, but I feel anger, and it's a great stress on me.

Being a casual is very difficult, because even if you are familiar with the floor, [if] you are not regular staff there, people always - not always, like some people they are really respectful [but] some people they don't, they are bossing you all the time. They think that you don't know anything. And also some regular staff take advantage of the casual, especially if you are nice, you don't say anything, right, it can be more difficult for you.

Two participants alluded to possible feelings of frustration or entrapment on the part of regular staff who were bossy.

Those antique people, where maybe they're fed up already, you know, and sometimes jealousy. They have been there since the start of that facility, they have all these feelings, it's just like power abuse, I call it a power abuse, because they are on the top, they are already there, they have the seniority and everything, right? Yeah. They want to do it their own way. But it doesn't work, because we need to change, because we need a healthy environment, but this is it.

The following participant found that female regular staff could be more difficult to work with than male regular staff.

Most of them are really bossy, especially some floors, I don't know why. I think the difference is because on [that] floor more males work there; I work with the guys, they are not bossy, they just work with you, then, whatever you do, you just do yourself, nobody bothering you. But ladies, they always like, you know, ask you to do this, ask you to do that - I don't know why.

One participant, on the other hand, complained that some casual staff did not
do their share or did not do the job properly.

The staff I work with, most, well 50% are full timers, and we have a lot of casuals, which, some of them are kind of lazy, and they don't do their work, so you end up picking up their work, too.

Some participants indicated that a floor in a facility might have factional groups.

Such groups created feelings of suspicion and mistrust among coworkers.

There are little groups together, you know. There are groups that they are a clique together, that togetherness; you have the little sneaky group, you have the groups that might be very open, or you have the bad group, again. So it's vice versa. You might have three gangs, one good gang, and two that are bad gangs. So you can know them differently, because you have to be careful, that's all.

I am very different than all, but they're both, both sides are good to me, but I've always noticed this, is if anything happens, they share among them, they don't let us know, like? but somehow we come to know.

I always help anybody, I don't care. When it comes to work I will support them, I will be with them, and I will help them, that's how I am, when they are new, especially. [But when I tried to help the new girl] my work partner looked at me and said "Don't give me a headache". That's because she didn't want me to tell her but one of her own people came, she would. Which is, I don't think is very fair.

Several participants described instances where managers would accept gifts from some PCAs who would in turn receive preferential treatment in the form of requested days off, or not being reprimanded as much. Some PCAs were considered "informers" who regularly reported to managers about other PCAs. It is possible that such activities may have contributed to the formation or maintenance of factional groups.
In this subsection, attitudes in others which caused difficulties to the participants at work have been examined. Many of the difficult attitudes were related to racism or the hierarchical health care system. Some of the difficult attitudes in others, on the other hand, may have been related to the effects of social closure, which is explored in the following subsection.

Social Closure

In this subsection the concept of social closure is defined, and its meaning in terms of the participants' experiences is explored. The context of economic uncertainty and its relationship to social closure is illustrated, followed by some comments and narrative excerpts pertaining to social closure and health.

The Meaning of Social Closure

The concept of social closure is adopted from the conceptual framework of Tomaskovic-Devey (1993), who was influenced by Weber and Parkin. This author defines social closure as:

The means by which superordinate groups preserve their advantage by tying access to jobs or other scarce goods to group characteristics (Tomaskovic-Devey, 1993, p.9).

In this study, social closure was the perception by PCAs that as immigrant women of colour, they had little or no access to other kinds of occupations.

The women in this study had become care aides through a variety of routes and circumstances. Many had taken the care aide course on the advice
of relatives or friends who had immigrated earlier and who had advised them that the course would offer them the surest chances of employment. One participant, for example, a graduate of business administration back home, had started to take computer courses upon her arrival in Canada, but was persuaded by her sister that she would have better chances of employment after taking the care aide course. She was now considering taking courses in preparation for the RN program. Most participants expressed an interest or desire to be doing something different if they had the chance:

Why are you doing this? Why don't you have something better? And you want to do something better, but this better needs time and money and everything.

There was a range of perceptions or beliefs, however, about the possibility of changing occupations: a few believed that they did have some choice of occupations in the future; a few believed that perhaps they had a choice; some believed that they did not have any choice.

Of the two participants who believed that they did have a choice in occupations, the following participant was in the process of establishing her own professional business in the community related to her work back home:

I still like here better than [back home]. We have more choice to try something, like career change and lifestyle, everything. Because [back home] if you working somewhere, you stay there forever, you cannot change your job. Or if you want to change job, you have to have some relationship with someone, they are in power. Here, normal people, ordinary people they can choose whatever they want to do. Even like 60, if you want to change you can change anytime.
The above participant disclosed that her attitude toward her PCA job would be different if she were not able to choose another job in the future:

If I think I have to be there for ten years, maybe it's frustrating for me. Because I think it is temporary, nothing bothers me. It's okay.

Another two participants believed that they would be able to change to something else in the future, and had a plan in mind, which they would carry out when they were able financially. The first of these two participants had had a professional career back home, and believed that at least in principle everybody is free to choose the type of occupation they would like if they have the necessary qualifications, but since she herself did not have the necessary qualifications, she felt that she was not able to test whether or not in actuality this was true.

Everybody has the equal opportunity to do something. If I look at it generally like that. If I want to go to college now, if I have got the means to do it, there is no barrier for me. If I have the necessary certificate I am sure that I will be accepted. I don't have what is needed for me to have a better job. I don't have it so I cannot tell.

Like the three participants above who believed that in principle everybody is free to choose any occupation, the following participant also believed in the same principle. She had taken courses toward social work and then social work aide, but had not been able to continue with this due to having children at home. At present she expressed reluctance about going back to school because she would be older than the rest of the students. She was considering
doing some courses by correspondence. She felt optimistic that she would be able to carry out her plan of establishing a nursing home of her own.

We do have a choice, like it's freedom of speech, freedom of, you know, everything here. You just have to put your mind to it.

A fourth participant also believed that in principle everybody is free to choose the type of occupation they would enjoy, through the availability of free education for children.

We have freedom here, you have free education, but [back home] your parents pay for it. Sometimes a parent [back home] is poor so they can't send their children to school.

The actual job-seeking experience of the above participant, however, had been nonetheless disappointing. Although she had taken courses in psychology and sociology in a community college and had obtained good marks, and had even passed a first year English course, she did not pass the Language Proficiency test, and so was unable to continue her plan to take Nursing. She did not appear confident that she would be able to further her situation in the future, as she now believed that "my brain isn't functioning anymore":

There was no choice. I was disappointed in my situation. I took the English test and I didn't pass it, so I was hurt about that, too. And I've got good enough English to do whatever paper work, right? I mean, you don't have to do much, write a book to report and chart. And they have this English requirement, and it's just- some people just pass it by luck, and some people just fail by luck, that's how it goes. So I didn't pass. You know, it kind of breaks up your heart a little bit. Because I want to be a nurse, an RN.

Another participant thought that perhaps she had a choice of occupations in the
future, and stated that she was thinking of taking courses toward the RN program "if God permit". Other participants did not believe that there was a choice of occupations for themselves, either in principle or in actuality.

You go into a kind of a job like a care aide where we end up. It is like a big thing where everybody goes into. I know at the moment we have no choice, when everybody is being employed as a care aide.

The one thing is that we need the work. Here it is very hard to get jobs. So what can we do? Nothing. For live we have to work. In Canada, you know, whatever, any job if we get, so we have to do that. If we don't work, if we can't get a job, then how we survive here?

I came for contract worker, it is specified, what kind of job you are specified, and then you are specified that you are not allowed to enroll in educational institutions. That's frustrating, but it's the policy, so we have to go with the policy.

The last participant above had migrated to Canada as a domestic helper. When her contract was over she had subsequently taken courses in preparation for the RN course, but had been unable to continue because of financial obligations toward her mother. She now considered herself to be too old to go into the RN course.

The Context of Economic Uncertainty

Newspaper and media reports of a general climate of economic uncertainty further increased the perception in some of the participants that their choices in occupations were limited.

Right now I just hang in there because we don't know what is going to happen next. With the job situation, you know, I was listening to the news the other day, where they said that so many top jobs will be
cutting by 1996, how many total will be out of jobs, so I said "My goodness, what else can you think of turning to?"

The women perceived that as PCAs and immigrants they were especially vulnerable to economic uncertainty.

If you have to do it, you just have to do it. You have to, because you never know what can happen tomorrow morning. Because if they started laying off or anything like that, we would get off quicker than them; it would affect us first, they would start laying us off first.

Social Closure and Health

The perception that they had no choice in occupations gave rise to feelings of powerlessness in some participants.

There's lots of lots of things that bothers me in that place that I have to just keep to myself, you know. It's hard, but you just have to live with it, you know, what can I do?

It's hard to deal with it, but, well, what to do in order to keep a job, you just have to, you know behave, like.

The limitation in choice of jobs meant that the women could not make use of previous knowledge and training, nor could they exercise their intellectual capabilities.

Sometimes you feel you can't make use of your knowledge. You can't use your knowledge and you can't use your mind. I mean you use your mind, but you don't use your mind a lot.

In their present job, many women felt that there was no opportunity for independent decision-making nor allowance for personal initiative.

You are under tension that you don't feel independent, don't feel independent to do it in your own way, or to think as you should, you
know, these are the negative sides to it. Sometimes you want to try in a different way to see how it works, or to be independent, you just don't have to follow somebody who is, as if he's the boss, is the leader. You want to be independent, to try on your own, to do something on your own, but I think you are hindered.

The above constrictions in choice resulted in feelings of tension and anger in some participants and in feelings of powerlessness among others; these feelings in turn were translated into or accompanied by other health problems identified in the subsection under Physical and Mental Stress.

**Summary of Difficulties of the Job**

In this section, difficulties of the job have been explored. Physical difficulties or challenges of the job were intertwined with emotional aspects of the job: for example, hurrying to keep to a schedule probably exacerbated dementia or aggressive behaviour in residents, which in turn, caused tiredness or frustration among participants. The two contextual themes of racism and the hierarchical health care system appeared to be closely interrelated. Attitudinal difficulties in others often appeared to derive from racism and the hierarchical health care system, though this was not always obvious. Some attitudinal difficulties encountered by the participants may also have been related to social closure: i.e. difficult attitudes in others in the workplace sometimes seemed to originate from feelings of frustration in others or perceptions in others of being confined to their jobs. Social closure meant that some participants perceived little choice in the type of occupation they could aspire to, and this perception
appeared to result in feelings of powerlessness, tension and anger in those participants, which in turn may have been related to their health status.

**Strategies and Strengths We Bring to the Job**

The narratives demonstrated that the participants had brought a large number of strengths to the job, and that in order to get around or through the difficulties of the job, they employed numerous strategies and strengths. These included: love of people and ability to empathize, making meaning of work, counteracting stigma, managing aggressive residents, overlooking versus speaking out, not letting things matter, humour, seeking interaction with others, spirituality, forming groups for mutual strength, and planning other options.

**Love of People and Ability to Empathize**

A major strength of the participants was love of people.

I like people, I like looking after people, I don't know for what reason. I like working with people rather than [office type work].

I like being around people..deep down I still love the elderly..I used to do volunteer work at this hospital in extended care for awhile.

The participants described an extraordinary ability to empathize with the elderly.

Emotionally, well, I'm very emotional with the elderly. I feel what they feel. It seems like, it's just like I'm thinking about myself, if I own their shoes and somebody just treated me like that, how you feel?

I am very sensitive, like if you cry there I'll cry here. I always think that I'll be like that too, like putting myself in their position, I'll be old one day, sooner or later I'll be old, right? And I want everyone, like whoever treats me good, you know; treats me good.
They need their pride and dignity when they, before they die. Before we die we probably would need it too, you know, just to keep our pride and dignity and also self esteem.

Oh it must be a hard life to get old, you know, in pain; it must be so hard for them. After I live through the hardness of life and reach to that age, well, you should be enjoying life.

Many of the participants expressed feeling for elderly people in their care similar to feeling they have or had for elderly relatives back home.

At least in my case I always think of my mother that I have not been able, have not been in a situation to look after her, and with these things in mind, I think, I try my best to look after these people as if I am looking after my parents. So whatever I will say to them I think comes from the heart, you know.

And any of these old folks is like one of their relatives at home, their own mother, own mother in law. We call them Auntie or Uncle. One resident for example, if you call him Uncle he feel so good, he has no any other relatives now, so we call him Uncle, and he feels very happy.

[Back home] usually family members take care of elders, so every time I see the elders it's just like my mother and father. In our culture, usually the young generation always take care of the older generation, so when you are working there, I feel something different. That's why I want to give something to them.

Many participants felt saddened to see elderly people in Canada living in institutions, whereas back home the norm was to care for elderly relatives in their own homes. In facilities in Canada, the elderly did not receive the same levels of respect and affection as the elderly back home; many of the participants, therefore, wanted to compensate the residents in their care.

I feel a little bit sad for all of this. Because for me, I think when people enter older age, they should be respected more than young people,
because they spend a lot of time, they contributed to the society, family, everything, so they should be respected the most. Should be.

Especially in our country, like we hardly put anybody in a nursing home. I think it's okay for them to be in a nursing home as long as they get the proper care and love and affection. That's what they need, you know, in the remaining years of their lives. So that's what I thought, and I thought I'll work there.

So I like taking care of them, because when you think about it, the poor things, sometimes I kind of grieve to see them in there, they have to give up their beautiful home and come into a place like that and it is so hard, you know, so sometime you really felt it for them dearly.

We really respect the elderly, you know. We don't even call them by names, first thing. We never call people by their names. If they are older we either say Uncle or Auntie or Gramma or something like that. So when I came here, it was shocking to see elderly people like, neglected, like no family to see them. It was kind of sad.

Making Work Meaningful

Making meaning of their work was an important coping strategy for the participants.

It is more than a job, because not only that, psychologically, when you speak with a resident nicely, you are doing the same job the family would have done. Apart from you washing, giving care, and making that person a person again in the sense that they feel representing, you give them back their morale. I think that the job of the care aide as such, really, you almost replace the family because in the long run you know their needs. You know what they like, what kind of food they like, what drink they want, everything they want.

I like helping. Most of the patients are weak and they can't help themselves, so it's a good thing to help them because we believe in doing good, merit, we call it merit. Of course, we are paid, we are not doing it free, but this is also a meritorious job, according to what I see nursing itself. Helping. You can't call them helpless without money, but helping the helpless where they can't do it themselves, they can't keep
themselves clean.

Making a difference with the elderly, i.e. meeting needs that they could not meet on their own was a reward in itself, and was also part of the making meaning of work.

So I came to enjoy it. I love it, because I found that the elderly needs the help. It's how you do it; it's you who is making the difference for them, right? If not us, they couldn't dress themselves, right? They couldn't feed themselves. It's just like you are making a difference for them all day long, you know, everything.

Counteracting Low Status or Stigma

In the beginning, when participants first started in their jobs, some were taken aback by the direct care aspects of the job. This difficulty was countered by the strategy of "getting used" to it.

When I see the patients dribbling and like feces, you know, I started getting nervous:[I thought]"Oh my goodness I have never done this, I don't know if I have the stomach to do it, I don't know if I like this". But I get used to it. Now it doesn't bother me. You gradually get used to it.

At first I didn't like [the job] because it was (grimacing) [dirty]. I thought what kind of job is this? Later on we are used to it, because it's our job.

Direct physical care, moreover, was connected with the low status of the job, which also had to be counteracted. In order to counteract the attribute of low status and stigma, participants underscored the importance of the work, and the paradox that some people should look down upon such important work.

At the same time, you know, they don't know that the work you do is so great. It is really great. Would you like to remain unwashed? Because everybody is looking down upon that kind of thing? Yeah. I think it is a
great job that the care aides are doing. Which should really be appreciated by most people. Because for instance, if you leave your grandmother there you are not going to care for your grandmother anymore, and somebody wash your grandmother, take care, brush her teeth, make her representing, I think that is very great. If they are paid money I think sometime it is more than the money which is paid, don't you think so?

I think our job is important. Yeah. If there were no care aides and nurses, what would happen to the people who can't do anything for themselves? It's not a classy job, not a high job, but then it's an important useful job, I think. And you don't see us come and warm the chairs and get paid. We are on our feet doing the best we can.

**Strategies for Managing Aggressive Residents**

All of the participants had developed or learned strategies for dealing with aggressive residents:

But then when I feel, like touch, then they will calm down. That's what I've noticed for myself. It's just like they're so aggressive and everything, and I just touch them, you know, and talk to them, and calm them. That's why they said I'm so calm, but although I'm under pressure I'm still calm.

I don't know, maybe the way you talk to them, the way you approach them, a gentle approach, especially in the morning; maybe the tone of your voice, lower the tone of your voice; and I guess smile, and I talk to them eyes to eyes.

If these strategies did not work, which was rare for a few of the participants, then they would leave the resident until he or she had calmed down.

**Overlooking Versus Speaking Out**

Participants described how they had learned to overlook or ignore relatively minor difficulties of the job.

You have to learn to be tough and forget about it, you know. Just get
into that habit of saying "Overlook the thing, overlook it", you know. Just pretend you see and didn't see, or pretend it happens and didn't happen, you know. That's the way of form of things, you know. You just have to pretend, just get it out of your mind, because if you keep thinking about it, thinking about it, then it going to get in your life, you know, and that's not going to be good.

Partly, this was a matter of being able to recognize when things were not worth getting angry about.

Unless something really, really bother you, I will speak out. But if just minor, forget it, ignore it. Why make yourself feel unhappy, right?

If you don't take anything seriously, it's just for the moment, for the time being that it is there, and who knows, they forget the next moment, and you know, what's the point of you remembering it for the rest of your life? And you know, holding a grudge against the person who said it?

Participants pointed out that if you were too nice and did not say anything, then you could be pushed around. If, on the other hand, you spoke out too readily then other people would consider you to be a difficult person.

Especially like if you are nice, you don't say anything, right, you can more difficult. If you are, you know, you speak out, or you just say something right away, then people say "Oh no, oh you are.."; yeah this is my experience.

Sometimes, however, a situation might reach the point where things could not be overlooked, and the participant felt she had to either speak out or leave the room.

Twice she asked me that same question. I mean the next time she ask me that question, I'm really going to insult her, because I'm going to be really pure and clean, I'm going to say "This is the third time you asked me". I'm going to really insult her. Because it's though as if she's trying to put me down by saying "Oh well, she's coming from a poor country".
One time I just get out, because if I'm gonna stay in that room, I don't know what gonna happen.

Sometimes it was a matter of just biding your time and speaking out at a more appropriate time.

She was talking very loudly when the doctors were all hearing. I was very mad with her. I kept quiet. Then the next day I talked about it then, I said "Why did you shout at me like that in public? I think that was very unprofessional, you know. It was terrible. You don't need to do like that".

Some participants were able to get through the dilemma of overlooking versus the danger of speaking out by letting their feelings be known through nonverbal messages, as explained by the following participant:

I'll help, you know, but if I find you're very lazy and I'm getting tired and stressful I don't go and make report about it, but then I start to get really upset, so then it does give them the idea "Oh maybe I should do more, I should do this or do that". Because you know, I'm a jovial and happy person before, so they know when I'm like that, that might give them the idea. Sometime it help, sometime it doesn't help. It all depends on the individual.

Not Letting It Matter

Closely related to overlooking was the mechanism of not letting things matter. Whereas participants overlooked things that were not worth getting angry about, they adopted the strategy of not letting things matter when, although the issue was important, they had the feeling that they could not change things. Therefore, through this strategy, they suppressed even the desire to have things different.

You could talk until you're dry, it's not going to make any difference. So
what is the point, you know? So it don't really matters to me, it don't really matters to me. If because I going to let it bother me then it going to be a stress and then you going to end up get sick.

No it's okay. Yeah. Because we have to.

Well, but that we have no choice, you know, we have to do the confused and the not confused ones. So it doesn't make any difference to me.

Just as meeting the physical challenges or difficulties of the job required an expenditure of energy, mental mechanisms such as overlooking, pretending, and not letting things matter also required an expenditure of energy.

I think that sometimes it takes some energy. It's not that you didn't feel something, you feel something already, but you have to ignore it.

It does [take energy] because we have to suppress it. You have to suppress it. Whereas it is there, it bothers you, but you try to push it down. Like something is coming, and you push it down. You have to use up energy, yeah, yeah, yeah.

Using Humour at Work

Most of the participants consciously used humour at work and considered humour very important in counteracting moodiness or depression in self and others.

But for me, like I said, whatever, even if you are not smiling, I will make you laugh. If they are in a bad mood, I just say come on, come on; you know, I just bother them. I got lots of sense of humour. And I like people with a sense of humour, too. It helps. It's easier, the job is easier because we have a heavy job, you know, and we need a sense of humour. If you don't have that one, it would be a long time you're dead (laughs).

Well, it's a very depressing place. It's depressing, but then at the same time, so many things happen, and you take it in a lighter way, in a more
humorous way. I do a lot of laughing at work. So we don't go into that negative thing, but we kind of make it looking positive, sometimes we have things that can make you start to laugh.

A sense of humour was useful for counteracting physical or verbal assaults from residents.

Sometime we go and talk with the girls and they will be saying "Oh this person, look what they did to me this morning", and I look what happen, you know, and I say, "Oh my goodness this is a crazy place". And sometime I laugh it off.

She liked chocolate cake. So I used to say to her "How come you don't like brown people, but you like chocolate cake?"; I used to always tease her. I kind of laugh like the way they say it, it sounds funny.

and a sense of humour generally made the day go better.

Oh I tell you, some days when I have some really good working we have fun together, we laugh and we talk and I said "Oh what a day, we should always be like this". It can make your day when you have your really good ones.

**Seeking Interaction With Others**

Forming friendships with people at work was important to some participants. While some participants said they had no time for social interaction with coworkers outside work, some considered their coworkers an important source of social support.

We have made friends now, not only in work time, we go out, or visit each other, and arrange parties. We really have quite a good relationship, now, the girls, some of the girls, anyway. They are like family. See, because here we don't have family. So anything happens, the closest is the coworkers whom I'm very close with, like several girls I am very close with. Something goes wrong, these people will be there for me.
Seeking interaction with residents was also used as a strategy to make one feel better or less stressed:

When they're happy it gives me satisfaction, like if I do something and they thank me a million times, that gives me satisfaction. I mean, I'm happy going home, I don't think Oh I haven't done this or I haven't done this or whatever, right? It gives me satisfaction, I'm happy, you know, this gives me less worry and less things to think about.

I spend more time with the residents that I can really talk to. Yeah. I spend more time with the residents, rather than thinking about the problems.

**Spirituality as a Strength and Strategy**

All of the participants identified spirituality as an important resource and an important part of who they are. A sense of spirituality (which did not necessarily include religion) provided comfort and strength for some participants. For some participants it provided rules of behaviour. Spirituality sometimes took the form of wishing for deliverance from present problems or wishing for future happiness. For most participants it was an important part of identity, energy, and health.

I don't know how far you believe in spiritualism, but I believe that there is some kind of a force with us, too. Like some people we would call angels, some, guardian. I have dreams of climbing hills, somehow I go, I walk like this, the hill is like this, and my legs are like this, walking this way. You overcome any obstacles if you have the will, if you have the strength.

If you don't have the spirit, then you can't work it out with somebody else. Spirituality give you strength from yourself, within you, it's within you. Because as I said no matter what religion you are, even though you don't have any religion, but if you have the faith in you, you know, it's
within you, it's within us.

Spirituality provided rules of behaviour:

It is not that going to church or a temple to sit there to make prayers is so much important, but to do good to others, to think always in a positive way, not to feel bad about others, anger- these are the things you must control, you know; you must like what you are doing and then you must control your anger; you must always think in the good way, in a positive way. I always remember, spirituality is a way of telling you how to behave in some crisis, in life. The way of behaving in life so that you, yourself, you feel clean, you don't feel evil.

Well; I know my life, my work makes a little bit easier because I'm Christian, and you're supposed to love everybody, no matter what they are, so that helps quite a bit; every individual's different, and you're supposed to love them the way they are.

Spirituality was often equated with helping others:

Just like, say for instance, if you know that a person is depressed and the person will phone you and the other person would say, you know, telling you their problem, and then you tell them some kind words, and something to make them feel happy, you strengthen them; and after they have been through they will say "You have been a great help to me and I appreciate it so much, I feel so different when I finished talk to you, and so I thank you ever so much for your advice and your concern"; and it make you feel like you helped someone; it's helping someone, you know, spirituality right there.

I think that the spiritual is maybe when you talk to somebody nice, you have touched the spirit already, this is my feeling. When you treat them nicely you have already touched their spirit. I have found that you don't separate the spirit very much from the body. They go hand in hand. That is just how I feel, that the spirit go hand in hand with the body. My spiritual kind of thing, perhaps I portray it as I say, doing good to others, and then I think good things, because I find that, you know, I bring something. Not only for the body, but for the spirit also.

Sometimes expressions of spirituality revealed very deep feelings about
difficulties the women were experiencing, and yearnings for deliverance from their problems.

I had a dream, where I could not get across this dirty river, a brook carrying away dirty water. I did not know how to get across. Then a woman with long white hair took my hand and my son’s hand and took us safely across.

It is only the Lord himself can change this world. It will not get any better, it’s going to get worse, you know, until the second coming of Christ. But I tell you at the end time, all these things have to come to an end. We will have peace, we will have- all the problems will be over when He comes again.

Spirituality also promised an eventual reward from helping others:

I tell the girls when we die we will become angels in heaven.

This is my spiritual need, if I take care of someone, and respect them, I feel that my spirit will get something. You feel you are exist, you are, um, valued. So if, you know, you have money at home you feel sometimes you just have no value, something like that. You have to do something for the people or society.

They are more tolerant, like kinder. Maybe because they believe in rebirth. They are trying to be more kind. Most of those girls, they don’t like hurting. They are so kind, especially to the patients, I’ve seen. If somebody wants water, even if they are going out they will come back, because they think that if they don’t do it right, they’ll suffer in the next world.

I don’t look at the world, other people in a negative view, always positive. I don’t put anyone down, I don’t criticize anybody. I don’t ask for credit for what I do; if it comes my way, it comes my way, if it doesn’t, someone’s up there looking upon me. Live and let live and you make somebody happy, you know, there’s rewards after.

One participant described the connection between spirituality, culture, family identity and health:
As a care aide all of them have got different culture, and then the culture makes the spiritual needs of individuals so different. Well, what I mean, like for instance, our culture, we believe that if we have our own relatives, like your grandparents, their spirit always with you. Do you see that? They are always hand in hand with you. So you see, that is part of the spirit connection. Spirituality is part of energy, it is part of wellness, you know. That's how I feel like. We believe that if the spirit get out of you, that's when you die, when the body separate from the spirit.

Forming Groups at Work for Mutual Support

At the workplace, people formed social groups. Usually the groups provided mutual protection and feelings of strength for individuals. These groups were often (though not completely), formed on the basis of country of origin.

Maybe in the beginning it starts with individuals, then the groups come in, you know. But that is to protect them, I think. They feel that if they gang together they feel stronger. In case other groups come to bother them. It's not easy being alone, you know, you've got to have a gut, because people will point at you, unless you can talk for yourself. Within those groups if you want, you can have friends too, if you are interested, because other people will be drawn in for one reason or another, you know. It is up to you.

Belonging to a group, or team, meant that an individual could not be singled out for blame.

Some of them, they're supportive, we help each other, it's team work which is nice; that's the very, you know healthy for our work, for our job. You're supposed to be, you support each other. If somebody's fault, it's everybody's fault, it's not only one. You don't have to say "Oh she did it", because sometimes - nobody's perfect. You always commit mistakes, so if one makes a mistake, it's all of us, you know. You wouldn't say if someone's fall on the floor, somebody's doing it, you would say it's on the ____floor. So we have to work together.
There was reciprocity among members of a group, and between groups:

You know, if we are good, they are good to us. If I am good to them, they are good to me, so no complaints. Friendships, mostly. Friendships I think, because if we have to do a good job, so if we help them, they help us. So we have to work together.

Some participants emphasized that a whole floor might be unified as a group:

I have no problem with anybody. Most of us are okay. We are there to help each other. I think most of the care aides are good that way. Not like other floors, where I hear there are factions. Most of the other floors I hear there are factions, but not on ours. Everybody is like together. We may have our differences, but still, we try to be united and together.

**Planning other Options**

One strategy for dealing with economic uncertainty was to plan for other options in case of layoff from the present job. Two participants were in the process of changing to other occupations: one was studying for her RN examinations, and the other was beginning to establish a business in the community related to her former work back home. Two were planning to establish nursing homes of their own in the future, as the following participant described:

I've seen a lot of old people in nursing homes, where I don't think they're really happy, like I've known this person who is at this nursing home where I work, he didn't like bread everyday, he goes "If only I could get my own roti", you know, and all these things gave me an idea, and I said, "You know I should open up a nursing home, at least a few people will be happier in their old age".

Several women thought that they could probably obtain jobs as care aides in the community in the future, since the aged population is growing, and health
care policy appears to be shifting resources to the community. Several of the women worked on a casual basis at more than one facility. All participants had dreams or ideas of doing something different if they had the chance.

I would like to do early childhood education if I had the chance.

Sometime I think if my parents were here, I grew up here, then if I study then I can do something else. I can go to university here, as I did .[back home]. I like sciences, biology....I would study about health, mostly about health. So sometime I think, I'm saying to my younger one, "Oh you're lucky".

I don't mind upgrading but then I would have to quit the job, and if you quit the job it's hard to get back a full time job. That's another problem. They should have it part time. That would help a lot of us.

It would be so good. I would really love it if there was another field of work that we could get into, something that to, you know, keep us busy, something to help people more. Sometimes you wish you had something else to look forward to, something you would enjoy, helping people. It's interesting to do something else, you know, that you don't have the stress everyday of going to the same job for years and years.

Summary

In this chapter themes and subthemes which emerged from analysis of the data have been presented. An exploration of the context of the immigration experience provided a beginning point to comprehend the work experiences of the women who participated in the study. The central theme of commitment to the elderly, which emerged during analysis of the narratives, demonstrated in the participants outstanding abilities to empathize with people, and to derive satisfaction through helping relationships with others. In caring for the elderly in
longterm care facilities, the participants perceived that they gave something of themselves to those in their care, and in return received rewards which were mostly intangible. As it related to health of the participants, this process could be seen in terms of giving and receiving energy.

The theme of difficulties of the job revealed aspects of the PCA job which required numerous strengths and strategies on the part of the participants to maintain their own health, and to provide quality care to the elderly residents. The contexts of racism, the hierarchical health care system, and uncertain economic conditions delimited the range of occupations the women could choose. Also, these contextual themes were seen to situate and inform their experiences at work, and to have probable implications for their health. The significance of the findings of the study and the implications of the findings for nursing are discussed in greater depths in the next two chapters.
CHAPTER FIVE: DISCUSSION OF THE FINDINGS

This chapter begins with a consideration of aspects of the immigration experience which imparted to the participants unique perspectives on their work with the elderly, and related to the central theme of commitment to the elderly. This is followed by a short discussion of the significance of the central theme to nursing. Next, under the subtitle of Difficulties of the Job, the impact of the job on the health of the participants is discussed at some length. This discussion is divided into three main sections which reflect the original questions of the study: "How does the job of PCA affect the health of its members?; Is the PCA job a segregated job?; Does the fact that it is a segregated occupation have a bearing on the health of its members?" This is followed by a discussion of strengths and strategies evident among participants to combat racist, gendered and class discrimination.

"The Good that We Do": Commitment to the Elderly

Immigration Experience and the Central Theme

Many of the strengths and strategies brought to the job by the PCAs in this study could be attributable to the unique perspectives derived from having known, and then migrated from countries where prevailing social values and social norms were different from those prevailing in the Canadian health care system. For instance, an unexpected finding was the immense satisfaction the
participants gained through interactions with the elderly residents in their care. Diamond (1992) mentions that nursing assistants in that study formed attachments with their clients, and two studies (Chichin, 1992; Weitzman & Berry, 1992) indicate the importance of interpersonal relationships between homecare workers and their clients, but the centrality of this theme in longterm care facilities has not been previously explored. Also previously unexplored is the link between the caregiving strategies of the PCAs and their experiences of migration. Following is a discussion of three subthemes found in the narratives which relate to this.

**Importance of Relationships**

Although the participants had come from diverse countries, there was a consistency in describing high values attached to relationships between people back home, which contrasted with the perception that relationships between people are undervalued in Canada: as one participant observed, "money rules" here. Rather than attributing this difference in values to cultural differences, it may be more appropriate to think of it in terms of differences between prevailing social values in towns and cities of unindustrialized countries on one hand, and prevailing values in a major city of an industrialized country on the other hand. Simmel (1971; p.325) characterized mental life in a metropolis as different from that of the small town "which rests more on feelings and emotional relationships...in the steady equilibrium of unbroken customs". His
observation seems congruent with the descriptions of participants about life back home. This point, about rural or urban origins of people, has implications for understanding the immigration experience, and about the teaching of cultural diversity in nursing.

Most participants described the importance of relationships back home, and the extensive day to day human interactions and interdependencies which for the most part were missing here in Canada. Many participants tried to replicate the interactions they had known back home through sensitive and lively interactions in the workplace, both with coworkers and with the elderly residents. They established longterm relationships with the residents, and supportive relationships with each other. These relationships enriched an otherwise impoverished emotional environment for residents and attenuated what were otherwise often difficult working conditions for coworkers.

Empathy With the Elderly

The participants were able to empathize to an extraordinary extent with the residents in their care, partly because they identified these residents with their elderly relatives back home with whom they had been close; and perhaps also because like the elderly in facilities, they too had undergone losses. Just as the elderly in facilities had lost their familiar homes, daily contacts with family members, previous status and sense of identity, so too had most of the participants lost these things. The situation of the elderly in facilities in Canada
was clearly dissonant with that of the elderly back home, where most elderly relatives were valued, respected, and cared for in their own homes. The participants wished to help residents in facilities regain their self respect, dignity, and value as persons. Thus they were helping to meet what authors such as Paltiel (1989) have pointed out as a need - to humanize care for the elderly in facilities.

Merit in Helping Others

Social or spiritual values back home imparted merit for helping those who are weaker, and reward for being kind to others. These values influenced the work with the elderly, and helped to give the work meaning. Another prevailing belief was that happiness derived from making others happy. In practice, all the participants described feelings of happiness and well-being upon making elderly residents or coworkers feel happy. Undoubtedly this had positive implications for health, as did the frequent use of humour at work, the benefits of which are beginning to be recognized in current "scientific" (i.e. biomedical) literature.

Significance of the Central Theme to Nursing

The finding of this study concerning the central role of commitment to the elderly and satisfaction from making others happy is quite significant for nursing. In essence, the participants were describing the central role of nursing, which is the caring or helping relationship. The nursing role of helping and caring is often seen as or has actually become subordinated to that of more
technical roles. Partly this is due to the greater economic emphasis on and prestige associated with technological interventions in health care; most certainly it is also due to the social devaluation of "women's work" (Jacques, 1993).

As one participant mentioned, management did not take into account the relational aspect or caring role of the PCA job. This is not uncommon in hospital settings, where caring work occurs outside the organizational definition of "real" work, and is invisible within scientific/managerial discourse (Jacques, 1993). Yet as researchers in sociolinguistics are beginning to point out, talk and relational development have important implications for psychological health and well-being of elderly in longterm care facilities (Coupland & Ylanne-McEwen, 1993). Narratives revealed that while some RNs in longterm care valued the relational or caring aspect of the nursing role, of which direct care is a part, others apparently did not. It may well be that in longterm care facilities, it is the PCAs who are doing the real nursing at least some of the time.

Although the central role of caring in nursing has often been undervalued, nursing theorists (eg Benner, 1989; Leininger, 1991) are currently trying to establish its legitimacy. Similarly, in the political field, many unions representing women are striving to establish the value of "women's work" through the concept of "pay equity" (Armstrong & Armstrong, 1994; "Pay equity at heart of strike", The Vancouver Sun, 1992). It remains to be
seen if these developments will result in more merit being attached to the caring or helping aspect of the nursing role, both within and without the profession.

**Difficulties or Challenges of the Job**

**How Does the Job Affect Health of Its Members?**

It is evident from the narratives of the participants that their occupation does have repercussions on their health. The job was, as the women described it, physically and emotionally demanding and stressful.

The physical activity of the job in itself was not bad for the health, as three participants pointed out. These participants considered the physical activity of the job to be, in fact, good exercise and good for health. The introduction of numerous mechanical lifting devices on the floors had lessened the chances of injuries during lifting and transferring activities, as long as proper lifting procedures were followed. When participants felt rushed to keep to schedules, however, accidents still happened, such as sprains and strains to muscles and tendons. Many participants noted that keeping to a time schedule was onerous and stressful and often led to accidents on the job. Aitken (1993, 1995) also considers that the rigid schedule and fast pace which nursing assistants must adhere to causes injuries and less satisfaction with the job. Feelings of tension or stress from trying to keep to a schedule on the part of the care aides could then be sensed by the elderly residents, who would
consequently often be more demanding or aggressive. A common hazard of the job was physical assaults from often unpredictable, demented residents. Repetitive movements required by the job, such as winding beds up and down, made care aides prone to tendonitis as well. Most had present, past or incipient health problems which seemed to be related to their work, including tendonitis, sciatica, bursitis, sprained wrists, backaches, diabetes, migraine headaches, tension, depression, and emotional distress. Similar symptoms and injuries among hospital workers have been noted by other researchers (Davis, Marbury, Punnett, Quinn, Schwartz, & Woskie, 1983; Lewy, 1991; Messing, 1991), though comparative prevalence between different hospital occupations does not appear to have been examined.

Physical hazards of the job were, of course, linked to emotional state. As one participant remarked, "physically it's very stressful, but if you are happy in your job you don't feel it". The reverse, then, was probably true: that if one was unhappy or feeling tension or emotional stress, then one was more susceptible to physical stress.

The health care system did not appear to be optimally responsive to the needs of the women. Either the women felt barriers, or treatments were ineffective and did not address the source of the problems, as noted by other studies about health of migrant women of colour (Anderson, 1985a; Bryan, Dadzie, & Scafe, 1985; Torkington, 1995). It is clear in the findings of this study
that the source of problems which were impinging on the health of the participants was related to the segregated nature of their occupation, which was the mediating link between, and was reinforced by, the interlocking nature of genderism with racism and hierarchy (class). Therefore the findings are now discussed from this perspective.

Is it a Segregated Job?

Bolaria (1988) cites the nursing aide job as an example of the type of job to which immigrant women of Colour are constricted in Canada; other studies (Diamond, 1992; Weitzman & Berry, 1992) indicate that immigrant and minority women in the U.S. are similarly restricted to this and other types of low echelon jobs. Data from the present study confirm that most women in this study were, indeed, restricted to their present jobs through a variety of circumstances and routes. It was a job which promised certain employment in a shrinking job market where other jobs they might have chosen seemed inaccessible. Most of the participants had been counselled by family or friends who had previously immigrated that the care aide course would give them the best chance for employment. Once employed as a care aide, many were reluctant to give up the relative security of a full time job in order to train for anything else, since they had no assurance that they would be able to get a job in the new occupation, once graduated. Moreover, the onerous demands of the job did not leave much time or energy to devote to taking other courses, and the constantly
changing schedule of the shift work interfered with the possibility of taking other courses even on a part time basis. Those who were working on a casual basis felt that they could not afford to make plans of any kind, as they must keep themselves available in case shifts were offered to them.

Thus the findings of this study support findings in literature that immigrant women of Colour are largely confined to lower echelon occupations in the labour market in Canada (Bolaria, 1988; Henry et al., 1995; Ng, 1984; 1986; Ng & Estable, 1987). This occupational segregation cannot be explained by lack of language and other skills, as all women in this study were proficient in English, certainly at a level adequate to take university and other courses. It is noteworthy that one participant had even passed a first year English course at college, but was prevented from continuing because she failed the English Placement test. It is of personal interest to this researcher that my daughter, who has an Indian first and last name, also failed the English Placement test, even though she had passed a number of first year university courses with high marks. The English Placement test as a possible mechanism for the consignment of immigrant women of colour to lower echelon jobs is a topic which merits further research investigation. Just as Ng (1984; 1988) identified immigrant counselling services as "one moment in the process by which immigrant women are commodified for lower echelons of the labour force", the English Placement test may prove to be another such moment. As Henry,
Tator, Mattis & Rees (1995; p.174) state about educational institutions and structured inequality:

"[there is a] strongly held conviction in Canada and other Western democracies that educational institutions play a central role in providing an environment that fosters the attainment of life opportunities for all students. A significant body of evidence, however, demonstrates that educational institutions have preserved and perpetuated a system of structured inequality based on race".

Some of the participants themselves demonstrated a belief in this "strongly held conviction" although their experiences did not bear out the belief. Mechanisms of job segregation in various social institutions need to be examined more closely.

**Negative Attributes of the Job and Health Implications**

The participants identified both positive and negative attributes of the job. The attributes they identified both coincided and differed from those identified by researchers in the field (Bolaria, 1988; Tomaskovic-Devey, 1993), were related to job segregation, and had implications for health according to those authors.

Tomaskovic-Devey (1993) identifies four main accepted criteria for measuring social attributes of a work organization which directly affect job satisfaction, self-esteem, and mental health. These are: closeness of supervision (close supervision versus substantial workplace autonomy), task complexity (routinized activity versus complex and challenging jobs), degree of
internal labour market opportunity (from completely vulnerable to the external labour market, up to substantial opportunities for promotion within a job ladder), managerial authority (ability to make decisions to change organizational practices), and having supervisory responsibility (having direct control over other workers' labour).

Participants identified some negative attributes of their jobs which coincided with the above criteria, specifically: high degree of closeness of supervision, routine activity (e.g. "putting work like machinery over feelings"), feelings of vulnerability to the external labour economic market, little opportunity for independent decision-making, and little or no impact on or ability to change organizational practices. Attributes which the participants considered important to a job, but which were mostly absent from their jobs, included being able to use one's mind and intellect, being able to use one's initiative, and opportunities for upgrading or attaining different jobs in the human service field; all of these coincide with the criteria used in the above study.

Other negative attributes of the job identified by the participants included: atmosphere of blaming or finding fault, interpersonal subordination (and at times humiliation), stigma and low status, fast-paced work schedule, verbal and physical abuse from residents, and job insecurity. These support the findings by Bolaria (1988) who cites physically dangerous working environments, humiliation, interpersonal subordination and the threat of
unemployment as attributes of lower echelon jobs to which immigrant women of Colour are consigned, and which are linked to physical illness and psychological distress.

The participants did not indicate that they considered it important to have supervisory authority over the work of others (although perhaps the "bossy" regular staff among the PCAs considered this a positive attribute). More likely this criterion derives from attributes ascribed to white upper middle class males in previous studies cited by Tomaskovic-Devey.

Other positive attributes of the job identified by participants included doing socially valuable work, helping people or making people happy, opportunity for positive interactions with people, physical activity, and adequate pay (i.e. relative to other jobs available to participants). Except for adequate wages, none of these are included in the criteria for positive attributes used in the Tomaskovic-Devey study. Again, this represents a disparity between different criteria (and diverging social values) of what constitutes positive attributes in a job.

In the following subsections, three negative attributes of the job as identified by the participants, will be examined further. These are (a) social closure, (b) closeness of supervision, and (c) stigma or low status of the job.

The Attribute of Social Closure

Torkington (1995) states that good health is possible when various social
factors are present, one of which is the ability to choose the job one enjoys. The author describes a continuum where some people come very close to the attainment of good health as judged on those social factors, while others, such as black migrant women in Britain, are far removed from the possibility of attaining good health. The assessment of the author appears applicable to the situation of immigrant women of colour in Canada.

Social closure, or the perception among participants that they had little or no choice of occupations in the future, appeared to have emotional repercussions. Since most participants perceived that they had little chance of changing occupations, and were insecure about retaining their present jobs, many participants felt that they had to put up with stressful conditions: "stress from things you have seen and can't do anything about". As identified by the participants, stress or tension could arise from lack of opportunity for independent decision-making, closeness of supervision, and attitudes of others. Attitudes of others which caused distress, and which were connected to social closure included racist and hierarchical attitudes, ascription of low status and stigma, bossiness, moodiness, and an atmosphere of blaming or finding fault. Excerpts from several narratives demonstrated the distress of the women at instances of humiliation, and interpersonal subordination.

Economic uncertainty contributed to the perception of social closure, which in turn contributed to feelings of powerlessness. It appears that women
who perceived themselves to have no choice of occupations in the future suffered more health problems than those who perceived that they did have some choice. Length of time in the job could also have been a factor in the development of health problems. Since this study is a preliminary investigation, however, definite conclusions cannot be made on the basis of these findings, and further research into these questions is needed.

Closeness of Supervision

Participants described discomfort and even distress at the degree of supervision over their job, which emanated from management, but was more directly manifested by frequent requests and directives from some RNs and PCAs. Close supervision by regular full time PCAs seemed to cause more discomfort than that by RNs, perhaps because it was constant: ie as members of the same teams, regular full time PCAs were always together with the participants whereas RNs (as Aitken, 1995, also points out) were often not present in the same rooms.

Among other PCAs there was a tendency by some who had been in the job longer as regular full-timers to assume "ownership" of the workplace, and exercise power over the newcomers or casuals. It was noted by one participant that some of the full-timers were maybe "fed up already" and possibly jealous. Perhaps they were reproducing the same conditions to which they had been subject when they were new on the job. Or perhaps they were giving vent in
the only safe or acceptable manner available to them, to the frustrations that they themselves experienced from the restrictions of the job. Giving support to this last point is the fact that of the three participants in this study who complained about other PCAs not doing their job properly, all believed that they had little or no choice in occupations in the future. Also supporting this point are articles by nurse theorists (Wilson & Laschinger, 1994) who consider that behaviours and attitudes of bossiness derive from organizational structures in which individual employees are not empowered: ie that powerless individuals sometimes resort to wielding control over others and are more rigid and rule-minded.

One participant who found supervision from full time PCAs bothersome noted that when working with male care aides (of whom there were only a few) she did not notice this problem of being bossed around and talked to disrespectfully, i.e. that the problem was more acute on floors where predominantly women worked. It is possible that the men did not feel the problem of social closure as much, perhaps because they had more options and were not constricted by gender segregation. The problem of closeness of supervision may also be connected to the intersecting nature of racism, genderism, and class oppression, which is examined more closely later in this discussion.

Related to the difficulty of close supervision is the atmosphere of blaming
or finding fault. Excerpts from the narratives indicated that people formed social
groups initially in response to perceived threats in the environment, specifically
to protect individuals from danger of being blamed for work not done properly.
Factionalization, or hostility between groups, may have been caused by or
evacuated by practices of some managers of listening to reports of "informers"
and of practicing favouritism. Certainly this may have exacerbated the
perceived atmosphere of blaming or finding fault, which a number of
participants found stressful. The atmosphere of blaming or finding fault also
probably originates in large part from traditional organization of hospital
management in which it is assumed that people need to be directed in order to
do their job well. This contrasts to the newer philosophy of Total Quality
Management (TQM) in which it is assumed that individuals will do excellent
work if they have the proper resources, and controls and discipline are
deephasized (Perley & Raab, 1994; Tebbit, 1993).

The issue of close supervision is an important question to explore and to
resolve, as it very obviously impinged on the satisfaction of the job for most
participants. Also requiring more investigation is the unpleasant but unavoidable
fact that some women oppress other women. This is an issue that does not
seem to have been addressed very much in the feminist literature (though
Glazer, 1991, does argue that the struggle for pay equity on the basis of gender
does not address inequities and relative privileges based on racial/ethnic and
class divisions at the hospital workplace); it is an issue which certainly needs to be addressed in the nursing profession. The following statement by bell hooks (1989) is relevant:

a new terminology must accurately name the way we as black people directly exercise power over one another when we perpetuate white-supremacist beliefs (p.113).

Likewise, RNs and PCAs need to examine ways in which they may be perpetuating ideologies of domination. Concomitantly, however, the issue of class needs to be included in the examination and discussion of oppression of women by other women. While many studies examine oppression on the basis of either genderism or racism, and some studies examine the interlocking nature of both genderism and racism, few studies thoroughly examine the intersection of all three factors of racism, genderism, and class oppression; ie the factor of class is usually broached only in a cursory manner. It is clear that to illuminate the everyday working experiences of the participants in this study, we must see those experiences as being embedded in a context that is constructed by the interlocking nature of all three factors of racism, genderism, and class oppression.

The Attribute of Stigma or Low Status

The social status of the PCA job is intricately connected with the status of the occupation of nursing as a whole, just as segregation of jobs is concerned with all three issues of racism, genderism, and class oppression. It is
a very important issue, therefore, for both RNs and PCAs, and one which pertains not only to immigrant women but to working women who are born in Canada as well.

It is now becoming recognized that social status is one of the important determinants of health (along with income, housing, employment, safety and education), and that women are concentrated in lower status occupations (Province of British Columbia, 1995). The latter document for the most part discusses women's health apart from the health of immigrant men and women of Colour whose problems are portrayed as mainly arising from inaccessibility of health care resources rather than arising from social determinants of health (another example of constructing "otherness" in our thinking). We know, however, from the findings of the present study and other studies cited in it, that immigrant women of Colour are concentrated even more in lower status jobs within those occupations designated as women's occupations. As Torkington (1995) points out about black migrant women in Britain, immigrant women of Colour in Canada are concentrated at the lower end of a continuum of decreasing determinants of good health, of which social status of one's job is one determinant.

It was interesting and perhaps significant that participants described differences in attitudes between acute care RNs and RNs working in extended care. Two of the participants thought that the difference was due to the fact that
acute care RNs had to do some of the same type of work as the care aides, whereas the extended care RNs were to a large extent exempt from that kind of work. One explanation, (following the conceptual framework of Tomaskovic-Devey), could be that attitudes of superiority in extended care RNs were part of a social closure process, wherein some RNs were striving to maintain the advantage of not having to do duties currently performed by PCAs. Glazer (1991) supports the view that job segregation protects the class-based and racial/ethnic privileges (which are relative privileges only, I would add) of some women workers; ie that

segmentation is a solution of sorts for registered nurses, protecting the class-based and racial/ethnic privileges of some women workers. Splitting tasks among different grades enhances the status, earnings, and self-esteem of RNs, because non-professional tasks are shifted from them to lower-grade workers (p. 353).

In Diamond's (1992) study he noted "cultural misunderstandings" between registered nurses and residents, which this researcher attributed to a more distant position between RN and resident compared to that between nursing assistants and residents. (Aitken's study [1993] also suggests a more distant position of RNs to direct resident care). Although in Diamond's study the RNs were Philippine, Glazer's argument of racial/ethnic and class privilege still holds: immigrant RNs tend to be concentrated in longterm care, whereas the more prestigious positions in acute and critical care are predominantly held by non-immigrant RNs.
Another explanation, alluded to by Glazer, may lie in the area of self esteem. One’s work is integral to one’s sense of self, or self esteem (Meisenhelder, 1986), and self esteem is linked with prestige or social status of one’s work (MacKinnon & Langford, 1994; Meisenhelder, 1986; Mortimer & Finch, 1986). It is well known that hospital personnel who work with "high technology" derive prestige from the use of that technology (Province of British Columbia, 1993). By extension, then, nurses in acute care and critical care who assist in the administration of technological and pharmaceutical interventions derive more prestige through their work than do nurses in longterm care, where the emphasis is on the helping relationship rather than technological interventions. Some RNs in longterm care, therefore, may be suffering from lack of prestige and self esteem relative to RNs in acute care. This may be perceived by care aides as attitudes of superiority.

The issue of status or stigma associated with segregated jobs is germane to the situations of all nurses, and one which needs to be addressed. Following is a discussion of social values concerning the PCA job which contribute to the stigma and low status of that job.

Social Values About Attributes of the Job

The findings of this study concerning the many positive aspects of the PCA job are significant in terms of revealing certain social values and beliefs about work with the elderly, about nursing which involves direct care to patients
and clients, about "lower echelon" jobs in Canada, and about what constitutes desirable attributes of a job. That is, one does not expect to find desirable attributes in a job which is characterized as lower echelon, and involving direct care to the elderly.

Social Values About Direct Physical Care

Why is work in the health care system which involves direct physical care considered lower echelon? This is a social value held in other milieu besides the health care system in Canada (eg the participant who did not discuss this aspect of her job even with her family). It is a question that merits further attention, since it is through direct care activities that the caring role is primarily enacted. As pointed out by some participants, it was through their work of helping residents with activities of daily living that the residents were able to regain a sense of dignity and ability to face the world (to "become representing again").

Social Values About Working With the Elderly

The narratives of the participants vividly supported the fact that the dominant culture in Canada does not value elderly people as much as they are valued in other cultures. Correspondingly, working with the elderly is also not as valued or given as much prestige as working in other areas of health care. Two study participants pointed out that acute care RNs had different attitudes toward them than longterm care RNs. As previously mentioned, the
observations of the participants may have been related to the disparity between value or prestige of work in acute care and the value or prestige of work in longterm care.

Another part of the explanation of why work with the elderly is not valued may lie with the phenomenon of status composition as explicated by Tomaskovic-Devey (1993):

> When a job becomes socially associated with women or a minority group, status composition processes may further disadvantage that job relative to other positions with similar skill requirements (p.13).

That is, women are consigned to occupations which are considered less desirable and of lower status, such as nursing the elderly (with immigrant women of Colour being assigned to lower status jobs within that occupation). At the same time, the job of nursing the elderly becomes even more devalued or accrues even less status, since it is socially associated with women (especially immigrant women of Colour).

Social values toward the elderly and toward nursing the elderly need to be challenged further, as do the social values ascribed to the women who do that work. In order to do this effectively, certain premises underlying the ascription of lower social value to those who work with the elderly must be exposed and challenged. One such premise is the notion that immigrants work in lower echelon jobs because other Canadians won't. That premise is now examined.
Is This a Job Which Other Canadians Won't Do?

The finding of the study that there are many positive aspects of the care aide job calls into question the common sense notion or underlying premise that there are certain jobs which (white) Canadians "won't do", but which immigrants (especially immigrants from Third World countries) are willing to do. This common sense notion contributes to the social devaluation of PCA work.

This notion influences one to think that the job of care aide or nursing assistant must be quite awful and we should sympathize with those who must do it. We fail to see the true value of the job. Although the job is characterized in literature sources as a "lower" echelon job (i.e. a job with lower social status and income attached to it) in terms of its social importance it has great social value, as many of the participants have pointed out. The job of care aide has, on the other hand, many negative attributes. These negative attributes, however, are for the most part the result of job segregation rather than being intrinsic to the job itself. The fact that most (white) Canadians do not work in care aide jobs is due to the phenomenon of job segregation, which in turn is a function of racism and gender segregation as organizing principles (Carty & Brand, 1993; Ng, 1988; Tomaskovic-Devey, 1993). According to the conceptual framework of Tomaskovic-Devey, this in turn perpetuates itself, since the fact that it is a job mostly occupied by immigrant women of Colour further decreases its status and negative attributes such as closeness of supervision, etc. These
supervision, etc. These negative attributes, however, are not intrinsic to the job, but are ascribed. There are many rewarding aspects to the job, as the study has shown, and it is a socially valuable job, as the study participants have pointed out. The strategies adopted by the participants to underscore the value of their work is similar to strategies of people in the feminist movement to emphasize the value of "women's work" in the face of societal devaluation.

**Strengths and Strategies**

**Importance of Combatting of Racism**

The narratives of the women bear out the statement by Bannerji (1993b) that racist attitudes cause an "incredible cost in terms of emotional energy". Bannerji notes that silent racism in the form of the "singling-out and reducing cold look" takes as much emotional energy to combat as incidents of harassment on the street. Statements of participants that they felt as though they did not "belong in the environment", or that racist attitudes are often "sneaky" support the observation of Bannerji and other authors that such attitudes are pervasive and are an unspoken part of the social environment. It is significant that one participant stated that she preferred racist attitudes to be open rather than covert. These points have implications for education in "multicultural nursing" and "cultural sensitivity".

Henry, Tator, Mattis and Rees (1995) state that there is a growing body of evidence which indicates that racist ideologies and practices affect the
administration and operation of human-service organizations. The authors cite manifestations of racism in human services such as lack of access to appropriate programs and services, ethnocentric values and counselling practices, devaluing of the skills and credentials of minority practitioners, inadequate funding for ethno-racial community based agencies, lack of minority representation in social agencies, and a "monocultural or ad hoc multicultural" model of service delivery. Some of these points are well illustrated in the longterm care facilities: i.e. devaluing of skills and credentials of minority practitioners (many of the participants had been professionals in their countries of origin); and lack of proportionate representation in occupations other than PCA. As well, participants found access to health care services for themselves to be inappropriate (i.e. not addressing their problems effectively); and most participants were unable to access desired educational programs.

Part of the problem in combatting racism, according to the above authors (Henry et al., 1995), is the persistent notion that it does not exist due to officially stated claims that this is a society where everybody has equal opportunities. The authors put forth the idea that Canada as a state promulgates "democratic racism", or an ideology which promotes institutional racism, while claiming to abhor racism. An example of this point may be seen in the wording of the Closer to Home Report (Province of British Columbia, 1991) where the authors claim to be against racism, while stating that
There are growing staff-to-staff and staff-to-client problems, as the workforce and society become increasingly racially mixed (p. C-37).

The wording of this Report promulgates the myth that racism is the result of immigration, and racial conflict occurs because races mix; this is one of the myths which, as Henry, Tator, Mattis and Rees (1995) point out, form the basis of "democratic racism".

The ideology of "democratic racism" as described by the above authors, (i.e. the covert and ubiquitous nature of racism) has implications for planning strategies to combat racism, and has implications for rethinking our use of terms like multicultural nursing and "cultural sensitivity". Some American nurse researchers (Fahy, 1994) consider that using the terms "transcultural nursing" and "cultural sensitivity" is like winking and speaking in code in an effort to avoid talking about and resolving "very real racial divisions in society". This is also applicable to the situation in Canada.

Social Groups as Agency

The participants in this study demonstrated many strengths and strategies during work, which suggest agency in resolving the numerous problems facing them as individuals and as a group of working women. An example has been given of strategies used by participants to combat societal devaluation of their work. In addition, social groups at work which provided social support, feelings of strength, and mutual support with difficulties of the
job might well provide some bases in the present and in the future from which
to address the source of these difficulties which derive from the contextual
social factors of racism and hierarchy, and segregation of jobs.

Summary of Chapter

The method of institutional ethnography which guided this study allowed
a preliminary understanding of the largely hidden social relationships which
informed the daily experiences of the PCA participants. The narratives of the
women in the study revealed that their experiences were multilayered or
multifaceted and that these experiences were situated in and informed by the
specific social contexts of a hierarchical health care system, economic
uncertainty, and racism in Canadian society. Additionally, the context of the
immigration experience formed an integral background to the consignment of
women to the job of PCA, and helped to inform many of their coping strategies
on the job.

The connections between these social contexts and the everyday
experiences of the women were not immediately obvious either to the
participants or to the researcher: i.e. the "problematic" of their lives began to
emerge from the narratives of the women and took comprehensible form during
the process of analysis of the narratives. During this process, ideas belonging
to various sociological schools of thought were drawn upon (such as
phenomenology and symbolic interactionism) while the whole was guided by the method of institutional ethnography and the writings of Black and other antiracist feminists, which kept it grounded in a partisan perspective.

It was demonstrated in the second section of this chapter that the job of PCA does have health hazards (in quality, the same as in other hospital jobs, though comparative prevalence has not been explored). In later sections of the chapter it was demonstrated that the job is indeed segregated on the basis of race, class and gender, and that there are health implications arising from negative aspects of the job which are attributable to its being a segregated job. Three negative attributes of the job were examined more closely, specifically those of social closure, closeness of supervision, and low social status. Prevalent social values related to stigma or low status of the job were examined, and some underlying premises of these social values were challenged. The ideology of "democratic racism" was discussed in relation to its perpetuation of the segregated nature of jobs and resulting inequalities.

It was seen that the narratives brought to the fore issues which are relevant not only to the situations of PCAs but to all nurses. The implications of these issues for the practice, education, administration, and research areas of nursing are discussed in the following chapter, following a summary of the study and its conclusions.
CHAPTER SIX: SUMMARY; CONCLUSIONS; IMPLICATIONS FOR NURSING

Summary of the Study

The problem this study has approached was the paucity of information about the experiences and health concerns of immigrant women who work in the lower echelons of a labour market which is segregated by race, class and gender. The occupation of patient care aide (nursing assistant) is primarily occupied by immigrant women of Colour. Narratives of ten female patient care aides who are immigrants from various "third world" countries, and whose job is considered to be in the lower echelon of the labour force, have been analyzed and themes delineated, guided by the research method of institutional ethnography and antiracist feminist writings. The following questions have been posed in this study: "How does this occupation affect the health of its members? Does the fact that it is a segregated occupation have a bearing on the health of its members?"

A review of pertinent literature revealed that there is a paucity of information about the health needs and concerns of working immigrant women of Colour. In particular, there is little information about the experiences of patient care aides. Guided by the method of institutional ethnography as used by Dorothy Smith and Roxana Ng, ten patient care aides from a number of
medium to large extended care facilities were interviewed over a period of two months. Open ended questions were asked during the first interviews with the women, and then as analysis of the data commenced, more focussed questions were asked as common themes and subthemes began to emerge. A surprising finding was the high level of commitment to and satisfaction from working with the elderly on the part of the study participants. A central theme of commitment to the elderly was identified, and a process of using strengths and strategies to maintain health of the caregivers was conceptualized. Difficulties of the job, which absorbed a lot of energy, were demarcated into physical and mental stress, attitudes of others, and social closure (i.e. not being able to choose another job). These were countered by strengths and strategies which the participants brought to the job. This process took place in the contexts of the immigration experience, racism in Canadian society, the hierarchical health care system, and general economic uncertainty; these were seen as contextual themes which informed the work experiences and strategies of the participants.

The central theme of commitment to the elderly contained within it the essence of the nursing role, which is the caring or helping relationship. Thus the participants were enacting an aspect of the nursing role which has been devalued but which nursing theorists are currently giving legitimacy.

It was seen that the immigration experience, while representing a continuum of losses and gains to the participants, imparted to these women a
unique perspective on their caregiving work. This perspective imparted strengths such as ability to empathize to an unusual degree with the elderly, ability to form close relationships with people at work, and the ability to use numerous strategies to get through the difficulties of the job.

Narratives supported literature findings that the patient care aide (nursing assistant) job was indeed segregated on the basis of race, class and gender; the educational system appeared to be an accessory means of relegating immigrant women of Colour into lower echelon jobs such as the PCA job. Job segregation appeared to have negative health implications for women working as PCAs. These negative health implications derived in part from working conditions or attributes of the job which were in many ways similar to attributes of other low echelon jobs. The negative health implications also appeared to derive, however, from the fact of social closure itself, i.e. the perception in women that they had no other choice in occupations.

Physical difficulties of the job were seen to be mainly related to time pressures originating with a rigid working schedule to which PCAs must adhere. Attitudinal difficulties from others appeared to be related to the hierarchical health care system, racism, and social closure. Most of the participants had past, present, or incipient health problems related to their work, and participants who perceived the most social closure were experiencing more health problems. The health care system did not appear to be optimally responsive to
the needs of the participants: eg one participant stated that she did not feel that she could receive appropriate help for an emotional problem, and some participants had repeated treatments for injuries, that seemed ineffective. This supports the idea that the workplace and organization of work are potentially strategic focal points for preventative health intervention.

The job attributes of social closure, closeness of supervision, and stigma or low social status were examined more closely, as these attributes, according to current literature in the field and according to the narratives of the women, had the most implications for health. Social closure caused feelings of entrapment or powerlessness, and engendered controlling behaviour on the part of some PCAs toward newer and casual PCAs. This translated into closeness of supervision by some PCAs over other PCAs, and by some RNs over PCAs, which caused distress in participants. Low status of the job, according to the literature, is a negative health determinant. Some social values and premises underlying ascription of low status to this occupation were examined and challenged. The ideology of racism which perpetuates the segregation of jobs was examined and premises underlying this ideology were exposed also. Implications for nursing in the areas of practice, education, administration, and research are explicated after the conclusions.
Conclusions

It is concluded that the job of patient care aide has implications for health which derive from its status as a lower echelon job in the Canadian labour market, and that the workplace and organization of work are potentially strategic foci for preventative health measures. This job, along with other lower echelon jobs, is segregated on the basis of race, class and gender. That is, it is primarily occupied by immigrant women of Colour, who are consigned to it through various social mechanisms such as discriminatory employment practices and de facto exclusionary educational institutions. Since women occupying lower echelon jobs such as patient care aide cannot move to other jobs, employers do not feel the necessity to improve working environments in those jobs, thus conditions such as fast-paced work schedules, closeness of supervision, and lack of opportunity for decision-making persist. In addition to having to endure unpleasant working environments, most women working as PCAs feel constricted by lack of choice in occupations, and this has negative health implications also. It is through racism and genderism as organizing principles that immigrant women are consigned to these jobs. The contexts of racism, gender discrimination and the hierarchical health care system inform the working experiences of both PCAs and RNs, and it is advantageous to both groups to combine efforts against the negative effects of these social contexts. Strengths and strategies of the women participants in the study suggest agency
in addressing and solving these problems.

**Implications for Nursing**

The themes and subthemes arising from the narratives of the participants have many implications for nursing in the areas of practice, education, administration, and research. Implications for administration and research are discussed under separate subheadings, while implications for practice and education are discussed together as they are intertwined and it would be repetitive to treat them separately.

**Practice and Education**

**The Working Environment as Focus of Health Promotion**

For the last decade or so recognition has been growing that the focus of health care delivery must change from a tertiary and technological focus (which is expensive and ineffective in terms of improving the health status of the population) to a more preventative and health promotion focus (Siler-Wells, 1988). Siler-Wells advocates a shift to non-traditional strategies for health care delivery. Similarly, the *Policy Framework on Designated Populations* (Province of British Columbia, 1995) stresses the importance of placing the health care system in a broader context of health determination, and also suggests that people whose needs are not being recognized by the health care system must be represented on decision-making bodies where the fundamental planning for health care occurs. RNs and PCAs should seek representation on such
decision-making bodies, and advocate for the working environment as a focus of health promotion. To advocate the working environment as a focus of health promotion implies not only to advocate for on-site activities such as exercise programs, assertiveness training, etc. (i.e. the lifestyle modification model of health promotion) but more importantly to advocate that working conditions within health care facilities are themselves very important health determinants which must be placed on the agenda as foci for changes in health care policy. As this and other studies have shown, to address the working conditions of PCAs and RNs necessitates that occupational segregation by race, class and gender must be challenged and deconstructed (i.e. the structural change model of health promotion). Both PCAs and RNs should ensure that their professional bodies and/or organizations such as unions are advancing the position of "emancipation as the alternative legitimating ideology to equity" (Glazer, 1992). That is, RNs and PCAs should urge their unions to begin to think not only about issues of pay equity, but also about the advantages of uniting with and supporting those in different strata (classes) of the nursing profession with the aim of challenging the debilitating and demeaning practice of occupational segregation on the bases of race, class, and gender. In preparation for and concomitant with advancing this position to unions, professional bodies, and decision-making bodies in health care, RNs and PCAs should form study groups or committees at the places of work in order to develop their
consciousness about this issue and learn to articulate their position on it.

**Developing Consciousness Re: Ideology of Racism**

Racism and its manifestations in social institutions such as the healthcare system and educational system must be exposed and challenged. Racism must be challenged not only because it is an injustice and indignity toward certain designated members of the population (eg "visible minorities"), but because it is an organizing tool (along with gender discrimination) for keeping everyone "in their place". In order to combat racism, and in order to challenge and deconstruct racial and gender segregation of jobs, PCAs and RNs must be able to counteract myths underlying the "ideology of democratic racism" whereby institutions promulgate racism while officially claiming that racism does not exist (Henry et al., 1995).

Since discrimination and racism are systemic- that is, deeply rooted in institutional policies and practices, they cannot be addressed merely by educating individuals about attitudes (Henry et al. 1995). Classes in "cultural sensitivity" and anti-racism offered within some institutions, rather than eradicating racist attitudes, may merely have the effect of causing people to hide racist attitudes, or "at least being more careful of what they say" (Fahy, 1994). Therefore, it would seem more appropriate and effective to challenge racism by counteracting myths that support the ideology of racism, and to examine how racism is intricately tied in with gender and class discrimination
which together oppress almost all women, as anti-racist feminists have pointed out (Chater, 1994; Glenn, 1992; hooks, 1989). In this way, racism could be seen as a force affecting (in different degrees) not just some designated "others", but ultimately affecting most health care workers; i.e. the immediate affront of racism is directed toward designated "others", but the long-range effect is to constrict everyone.

Some of the underlying myths of the ideology of democratic racism which PCAs and RNs must counteract include the following (Henry et al., 1995; p.307): this is a democratic society, therefore racism does not exist; discrimination is a problem faced by everyone from time to time; racism is a result of immigration, i.e. racial conflict occurs because races mix; minority groups refuse to fit in and adapt to Canadian society; people of colour have cultural problems, race is not the issue; non-whites lack the skills and motivation to succeed; racism comes from ignorance, therefore education about other people will eradicate it.

In addition to myths underlying the ideology of democratic racism, social categories created by the state, such as "visible minorities" must also be deconstructed (Bannerji, 1993a). This could be done partly through examining other examples of the social construction of "otherness", such as in the Report on Designated Populations (Province of British Columbia, 1995). While the authors of this document recognize the important effects of social determinants
such as employment, income, education, social status, etc. on the health of women, they portray the main problem faced by immigrant men and women of Colour as lack of access to health care services.

Hospitals and longterm care facilities provide striking examples of the institutionalization of racism: while mission statements claim multicultural tolerance and non-racism, jobs within these institutions are clearly demarcated along racial lines. "End Job Segregation" should become a position and a slogan within the health care system. As a contribution toward this position, PCAs and RNs should support the removal of educational barriers to immigrant women of Colour which would include removing existing barriers to credentialling, and facilitating the credentialling, of foreign-trained RNs. Subsidized educational programs, both on and off-site, should be made available to health care workers wishing to upgrade or move into other human service occupations.

Other Measures to Improve the Working Environment

The findings of this study suggest that patient care aides and registered nurses would do well to consider the effects of negative attributes of segregated jobs, such as closeness of supervision, lack of autonomy, interpersonal subordination, and social closure on their own health, and on the health of their coworkers. Supportive relationships to counteract these negative attributes should be sought from and offered to coworkers. The helping or caring aspect
of the nursing role should be extended to coworkers by being sensitive and empathetic to one another’s working experiences, and by respecting each other’s valuable contributions to health care delivery. Registered nurses who are in a position of "supervision" over other nurses or nursing assistants need to consider how the structuring of the workday may affect both caregivers and residents, and how their own attitudes and actions help to construct the working environment of these caregivers.

**Promoting the PCA Role**

As pointed out in the narratives, we are constantly reminded that the health care system is being affected by uncertain economic conditions. It is vital, therefore that the importance of the relational aspects of the PCA role be made known, as part of a strategy to safeguard and expand this role. The relational aspects of caring work with the elderly and the value of this work need to be articulated and promoted more widely. It could be useful for members from both groups of caregivers (PCAs and RNs) to prepare descriptions of and underline the importance of their relational work with the elderly and distribute this in the form of reports to nursing practice groups, administrators and policy-makers, and community groups including families of elderly residents.

**Assessing Immigration Experience and "Culture"**

Some study participants described very difficult experiences for the first
few years after arrival in Canada. Therefore it is appropriate to consider, in relation to the health of patient care aides, guides for assessment of the immigration experience. It was mentioned in the chapters on findings and discussion of the findings that the study participants had experienced losses and gains through the immigration experience, and each participant could be seen to be situated on a continuum between losses and gains. In assessing clients who have immigrated recently, the concept of a critical period encompassing loss and gain (adapted from Campbell, 1987) is a useful tool. In contrast to conceptual frameworks which visualize the client as proceeding rather passively through various stages of adaptation to a host environment (Biocchi & Radcliffe, 1983), the conceptual framework of loss and gain within a critical period may allow the clients to visualize for themselves the impact of the immigration experience on their lives, and may suggest a self-directed progression for those who are perceiving mostly losses.

Additionally, the point about urban or rural (or non-traditional and traditional) origins of people who have immigrated may be more relevant to the understanding of "cultural" differences in prevalent social values among people, than is country of origin. For instance, values such as importance of social interdependence may be more important to people from rural backgrounds in China or South America than to people from urban backgrounds in China or South America (Vancouver Health Department, Greater Vancouver Mental
Health Services Society, and United Chinese Community Services Society, 1990). Similarly, as suggested in some of the narratives, prevalent social values in an unindustrialized country may be similar to social values in a small community in Canada, while both may be disparate from predominant social values in an urban centre in Canada. These findings suggest that nurses should avoid simplistic explanations of cultural differences but instead should strive to understand the complexities and multifaceted aspects of culture (Fahy, 1994).

Nursing school courses in "multicultural" or "transcultural" nursing should include in depth analyses of the complexities of culture, rather than "snapshot" pictures of various cultures. Students should be cautioned that it is not possible to know other cultures through one course. Nurses could begin to see "multicultural nursing" not just in terms of hospital or community patients who speak another language and have different health beliefs, but in terms of coworkers whose difficult working conditions are different in degree though not in quality from those of RNs themselves.

Administration

Numerous issues relating to hospital or health administration arose from the narratives of the study participants. These included the issues of racism, physical and verbal abuse, closeness of supervision, lack of opportunity for independent decision-making or autonomy, atmosphere of blaming or finding fault, interpersonal subordination and humiliation, dismissive attitudes, and
favouritism. On reviewing some recent literature in the area of health administration (eg Gardner & Cummings, 1994; Perley & Raab, 1994; Sabiston & Laschinger, 1995; Tebbitt, 1993; Wilson & Laschinger, 1994) it appears that management in the facilities where the participants work need to adopt and enact the philosophy of empowerment for the employees. In contrast with classical types of hospital management wherein it is assumed that individuals need close supervision to carry out their tasks properly, in the more current philosophy of hospital management - Total Quality Management (TQM) - it is assumed that individuals will do excellent work if they have the proper resources. Status, controls and discipline are deemphasized in the empowered organization, in favour of collaboration and the facilitation of self-managed teams. Integrity and respect for employees is fostered at all levels and input is sought from staff which can then influence the organization. As one participant suggested, people in administrative positions may benefit from experiences of partaking themselves in direct care of residents from time to time.

Discouraging "informers" would improve the atmosphere of "blaming" and factionalization, as would the practice of impartiality or fairness. In addition, other measures such as increasing the numbers of full time staff rather than maintaining large numbers of staff on a casual basis would ameliorate the disadvantaged status of many PCAs who are now only casual.

The problem of physical and sexual assault by residents against
caregivers also needs to be addressed more vigorously. While inservices have been given on the topic of managing aggressive behaviour, some participants considered that such inservices were not specific enough to the case of aggression by demented elderly residents. It may be advantageous to train PCAs to prepare and deliver inservices on that topic.

More options for upgrading need to be made available to women working as PCAs. Possibly a cost-sharing plan could be negotiated with federal and provincial job-training programs to institute subsidized on-the-job training for various human service occupations, including RN preparation. Although in an era of budgetary restraint this might not appear to be a likely prospect, it would probably be cost effective in the long run in terms of less sick time, and more positive health outcomes for women now being constricted to segregated jobs.

Racism within health care facilities needs to be addressed more vigorously and effectively. In the previous sections it has been suggested that inservices on "multiculturalism" and anti-racism should be directed not only toward changing racist attitudes, but toward examining the sources and effects of racism, such as job segregation. Administrators should support the position of "End Job Segregation" in their facilities.

Research

The findings of this study are consistent with the few other studies found about the health effects of race, class, and gender segregation of jobs, and
suggest that this topic is a useful direction for further research investigation. Such research is congruent with, and would expand the contemporary recognition of social determinants of health such as employment, status, and working conditions. Racism is also a very important determinant of health, and needs to be recognized as such. Recognition of racism as a determinant of health must be accompanied by planning and implementation of measures to counteract it. A participatory action research project on implementing the position of "End Job Segregation" in the health care system, as described in preceding sections, would be a very timely and useful study.

Also within the topic of working conditions, the relation between self esteem, autonomy and independent decision-making ability are areas which need further investigation. Analysis of discourses between managers, RNs, and PCAs could also be a useful area of study which could illuminate aspects of hierarchical relations. Projects to implement organizational philosophies of employee empowerment could be organized as research studies, and the results of such studies disseminated in administrative and other nursing journals.

Another area needing further research is the importance of the central role of caring in nursing, and the contribution of PCAs to this area. According to one theorist (Jacques, 1993) the project of theorizing caring work, or making "caring work visible within scientific/managerial discourse", has barely begun.
The findings of this study support the need for continuing work in this area, and the need to recognize and make known that direct-care activities are a vital part of the caring role.

Premises underlying certain social values such as ageism, and how ageism impacts on the caregivers of the elderly are likely topics for nursing research also. Related to this is the need for more information about managing dementia and aggressive behaviour in elderly clients. For instance, comparing prevalence of aggressive behaviour in more unstructured work environments versus prevalence during the usual structured work schedules would be an interesting and useful study. It would be appropriate and fruitful to involve PCAs as research assistants in such a study.

Summary

Implications for nursing in the areas of practice, education, administration, and research have been explicated. It is suggested that the working environment of health care facilities as a target for health promotion would be a strategic and appropriate focus for all four areas of the nursing profession. This would necessarily imply a challenge to and deconstruction of racist ideology and job segregation. Such a direction would help to place Nursing in the forefront of innovating approaches to health care delivery and policy.
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APPENDIX C

Study Title: Perspectives of nursing assistants on their work and health
Interview Guide - Sample of open-ended questions to be used in initial interviews

How did you decide to become a personal care attendant?
What were things like for you before you took this job (in Canada? back home?)
What are things like for you now that you're in the job?
How do you view other people who work in this facility? (eg Are people here easy to work with? What are the other people like that work here?)
How do you view the residents? (eg Is it very hard caring for residents? What are they like?)
How do you view the work you are doing? (eg What's the work like? Are there any bad moments? good moments?)
How does your work relate to other things in your life?
How does your work relate to your health?
How do you see your role in B.C.'s health care system?

(Prompts: And then? You're saying that...? What was his/her reaction when you said/did that? How did you feel when he/she did/said that?)