MISSING BODIES:
A qualitative approach to understanding support care work
in acute care settings

by

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Bachelor of Arts, The University of British Columbia, 1990

A thesis submitted in partial fulfilment of
the requirements for the degree of
Master of Arts

in

The Faculty of Graduate Studies
(Department of Anthropology and Sociology)

We accept this thesis as conforming
to the required standard:

The University of British Columbia

January, 1994

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Abstract

This project works toward understanding the setting of an acute care hospital from the perspective of individuals who work there but who are not specifically trained to work in biomedical settings. Eight volunteers working as janitors in a large metropolitan hospital discuss what is, for them, significant about their work. We learn from their discussions, that for some respondents, the most significant aspects of their work are often not centred around janitorial tasks. Rather, these respondents are acutely attentive to the needs of the people around them for comfort, companionship, and assistance. Often, both what is most rewarding and what is most difficult about the working environment the respondents experience revolves around this orientation.

The thesis recognises that this aspect of the work these janitors are doing is different from much of the work done in the hospital in that it is removed from the realms of science and technology, and attends more to the "comfort needs" of people who are confined by illness and injury. Attending to these needs is not formally recognised as an aspect of their work duties and this is problematic for the janitors. We will see also that, while not all the respondents are oriented to their surroundings in the same way, none is able to ignore being surrounded by many people, including visitors, patients, and other staff members from many disparate departments. In other words, none of the respondents is able simply to perform his or her janitorial tasks oblivious to the fact that this work is in a hospital.
The respondents express an awareness of the low status of their work in the hospital. A few experience their status as oppressive. Linked to this, some respondents talk about the experience of being made "invisible" by their uniform — which is to say, by the nature of their work. These experiences are used to consider the idea that, while high status in the hospital is associated with proximity to science and its application, perhaps low status is not simply the reverse of this. Low status, it is argued, occurs as a result of proximity to the more invidious aspects of disease and injury, without the recognition attached to a formal healing role.

Anticipating that the readers' experience of acute care hospitals will usually be limited, this thesis works to achieve a rich reconstruction of the environment and presents the respondents as characters the reader meets in the setting. This approach, although not unique in sociology, is unusual. The aim of it is to provide detail and information sufficient to invite the reader into an informed and confident dialogue with the respondents and with the analysis.
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Acknowledgements

I would like to thank my committee, Professor Dawn Currie, Professor Nancy Waxler-Morrison, and Professor Roy Turner for their patience, direction, and confidence in this project. In addition, I thank my maternal grandparents (Henry and Christina Howard), my mother (Shirley Nevin), and my sisters (Carrie Davies and Christin Wodham) for their warm support and encouragement during my academic years. To George Payerle: Your editorial comments, your interest, and your conviction have come at the most opportune time. Thank you. My thanks also to Kate and Pat Taylor for their time and warm interest. Most importantly, I appreciate the many people at Saint Paul's Hospital who have assisted me by their patient indulgence while I persisted. Too many to mention individually have contributed in this way to my research. Finally, a special note of appreciation to the men and women who volunteered to be interviewed. Their candour, interest, their sense of fun, and their seriousness add to the richness of my thesis, as it does to the days I spend with them "dressed in blue."

Janice Tanche

December 31, 1993
Dedication

Christina M. Howard

and

Shirley-Anne Nevin
CHAPTER I

The Vestibule
Introduction

During ten years of employment with Saint Paul's Hospital, I have been puzzled by an apparent arrangement of various working groups in the facility into a status hierarchy. As an undergraduate, early attempts to "do" research in the area of health and illness were focused on the problem of this hierarchy. These early projects afforded me an opportunity to search volumes representing research in Anthropology, Medicine, Psychology, and Sociology for scholarly work examining the experiences of support service staff working in the institutional setting of the hospital. I was initially frustrated to discover the absence of this perspective in the literature. However, as my research interests matured, I came to be perplexed by the absence and began to see it as a kind of puzzle or mystery. It seemed less and less plausible that the missing perspective was simply an oversight. Only certain types of individuals were absent. Not only support staff, but often individuals who come to the hospital as patients, as visitors, or as clergy are conspicuously missing in health and illness research. These individuals have in common the fact that they are not present in the facility as biomedical professionals. I came to understand this absence as a reflection of a phenomenon of "missing bodies" that exists in biomedical institutions and in the representations of these institutions.

Missing bodies. Who are they? If they are not merely overlooked or malevolently excluded, why are they absent in the literature?
Over the years I have worked in the hospital, I have learned that it is not uncommon for individuals who carry out the janitorial work for the facility to refer to themselves as "invisible." Since this seemed to parallel my notion of "missing bodies," I wondered what they would say if someone finally asked them. I wondered how these people would answer a sociologist who asked them about their work. Would their responses help me to understand the absence of support care workers in health and illness research? This project — my thesis — attempts, with the assistance of a charitable and interested group of volunteers, to begin to understand "missing bodies."

The Setting and the People

Saint Paul’s Hospital was founded on its present site by the Sisters of Providence in 1894.¹ The Sisters own the property and physical plant that is Saint Paul's, and until the mid 1970s, they were sole managers of the facility. During the 1970s, because of their reduced numbers and their ages, the Sisters of Providence closed the School of Nursing and hired lay people (with respect to the Catholic Church) to work as administrators and managers. Today, four Sisters and a priest remain in residence. The Order also retains board positions and continues to have significant influence on the operation of the hospital. As well, the Sisters are an important resource for Saint Paul's staff who still turn to them for assistance.
Under the Sisters' administration, the hospital grew from a frontier infirmary to a significant biomedical centre recognised internationally for work especially in neurology, cardiology, and renal specialties. Saint Paul's is a teaching hospital associated with the University of British Columbia, and, until 1974, the Sisters of Providence sponsored and supported a residential School of Nursing at the facility. More recently, the hospital has enjoyed international recognition for research and treatment in the areas of pulmonary disease, Human ImmunoVirus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). Saint Paul's is now a metropolitan, medical treatment, and research facility with around five hundred beds. It will soon acquire another fifty to one hundred beds and two new outpatient clinics from another city hospital that will close in the coming months due to provincial health care budget constraints. Saint Paul's already serves a large outpatient population and operates several clinics such as the Diabetic Clinic, the Infectious Disease Clinic for people with AIDS and HIV, a Lung Disease Clinic, and a Haemodialysis Unit. The hospital is also Western Canada's adult renal transplant facility.

The physical plant is a collection of abundantly windowed, mahogany coloured brick buildings that are immediately recognisable as a hospital. Of the seven buildings that currently make up the facility, one is an original from the 1894 facility, one has been open for two years, and two have been open for ten years. Over the last ten years, as new structures were being erected, remaining buildings were renovated to accommodate wards and offices being
moved from place to place awaiting the opening of the new structures. The 1894 structure and two other buildings remain from the old plant. These are semi-occupied, and currently under extensive renovation in preparation for the arrival of new beds and clinics moving from the hospital previously mentioned. Two of these buildings were scheduled for imminent demolition in order to accommodate new structures planned some years ago for the sites they occupy. However, long term planning for the physical plant has recently been extensively revised due to a budget crisis in federal and provincial health care funding.

These changes have a dramatic impact on all aspects of the hospital, but the most obvious effect has temporarily given Saint Paul's an unusual look for a hospital. From the street, gaping holes that were once curtained windows of wards reveal the demolition of ancient plumbing and wiring. Walls are torn down, and marble staircases and floors are pounded into dust. The exterior currently sports construction waste chutes. Maintenance and security staff are experiencing the nightmares of ancient plumbing rupturing under the strain of construction, creating huge floods; wiring that mistakenly summons the fire department, and demolition dust that haunts every square inch of the hospital. Staff, patients, and visitors are faced with constantly changing access and detours as they try to negotiate their way about the buildings. Architects and construction planners have already had permanent offices at Saint Paul's for a
few years, and it seems to us now, that the buildings are under perpetual renovation.

Inside Saint Paul's, the buildings are fused by an arrangement of corridors and underground tunnels that mystify the uninitiated, and frighten the faint-hearted who periodically blunder into areas not meant for the public. Some corridors are longer than half a city block. Depending on one's job, it might be necessary to walk a couple of blocks, ascend ten floors by elevator, and return several times during a shift. The facility is large enough that travel time for breaks is built into the staff's working agreements. While travelling the corridors, staff exchange greetings and stop to chat with one another, or to help someone find their way. Patients' relatives wait in the corridors, and many scan passers-by for potential sources of information. Expectant parents pace near "Labour and Delivery," and small children shuffle along shyly on their way to meet new siblings. People stopping by on their way to work rush along the halls bringing containers of ethnic foods to feed confined kin. Twenty-four hours a day, patients, visitors, and staff move through the corridors between store rooms, Emergency, operating rooms, administration offices, Critical Care areas, the morgue, patient wards, and the cafeteria.

Few corridors are ever deserted, and one is seldom truly alone. Nevertheless, there are occasions when it is necessary to work alone in a section of the hospital. For many, this is an unnerving experience. A few employees simply refuse tasks that would require them to work in an area of
the hospital by themselves because they are nervous of vagrants who have, from time to time, been found sleeping or living in deserted or abandoned areas in and around the hospital. Employees are instructed in procedures to summon emergency assistance by using fire and security alarms, and some carry "personal alarm devices." Employees are uneasy with good reason as, on a few occasions, workers have been assaulted by individuals lurking in unattended areas of the buildings. Recently, the CNIB Tuck Shop was robbed when one of the hospital's "regulars" reached over the counter, grabbed a fistful of money from the cash register drawer, and ran. Members of the security staff sometimes wear bullet-proof vests and have agitated unsuccessfully for some years for permission to carry side-arms. Finally, more than a few employees are anxious due to various tales of ghosts that have been passed along by generations of staff, and an account of an exorcism that has circulated for several years.

Saint Paul's has a staff of approximately 3,000 people. The staff represents diverse socioeconomic, cultural, and ethnic groups. The hospital maintains a list of employees who are proficient in languages other than English. Every ward and department has a copy of this list. Wards and clinics routinely summon staff from all over the hospital to leave their immediate work assignment and come to another area to act as interpreters for patients or visitors.
All levels of skill and training are represented by the staff. For example, professionals are employed as social workers, accountants, and dietitians. Trades people work as respiratory therapists, profusionists, and mechanical engineers. Semi-skilled labourers are employed as Central Sterile Supply Technicians and Unit Coordinators. Unskilled labour is represented by dietary aides, housekeepers, and porters. Employees belong to four unions and various professional associations.

Theoretical Background

Sociologists have often addressed the characteristics of health care settings. Much of this work has been highly abstract. For example, Goffman's (1961) theory of "total institutions," Foucault's (1975) work on the "clinical perspective" or "medical gaze," and Navarro's (1985) critique of the structure of relations in medical institutions are excellent illustrations of varied theoretical works in health and illness. A few modern theorists draw on sociology's founders to generate theories related to health and illness. In this spirit, Garfinkel's problem of inter-subjectivity draws on Simmel's interpretive model, and Parsons' attempt to synthesize social structure and personality in the "sick role" (Parsons 1975) draws on Weber's generalised theory of social systems (Gerhardt 1989:180-4). Finally, a few researchers concentrate on explaining a particular and narrow range of empirical regularity appearing in a health care setting. For example, Leidermann and Grisso (1985) suggest a frightening
prognosis should we be identified by staff as "gomers" upon our admission to a hospital.⁵

Often, sociological research attempts to explain the organization of the community of individuals who are found in health care settings, while naively limiting the configurations studied to individuals who are health care professionals.⁶ Such research might pursue, for example, an explanation of the relations between health care professionals and other health care or administrative professionals. This was the task that Graham (1991) undertook in an ethnographic study of professional relations between two groups of obstetric practitioners — physicians and midwives. Another pattern of research examines the relations between health care professionals and technology. Barley's (1988) ethnographic research presented in the essay, "The Social Construction of the Machine," is an example of this type of research. The essay is an intriguing examination of the interaction between professionals and technology. Finally, the relations between health care professionals and patients have attracted interest. There are several examples of this aspect of health and illness research. For example, Armstrong (1984) provides an interesting addition to the sociology of patient/physician relations in his paper tracing the history of the patient interview, and May (1992) studies the interpersonal relations between nurses and patients. Also, Diamond's (1992) study of nursing assistants working in nursing homes is a sensitive and insightful look at the relations between health care workers and nursing home
residents. But, perhaps Mishler's (1984) analysis of patient/physician interviews is the best known (to sociology) of this type of work.

Conspicuously absent from most health and illness research is the presence and roles of non-professional people in this specialised community. For example, Stanton and Schwartz (1954) have provided us with extraordinarily detailed accounts of psychiatric hospitals. Both studies explore the relationships between hospital staff and psychiatric patients. One meets nurses, nursing aides, physicians, sociologists, patients, and psychiatrists, but never a janitor. Is this because the janitors have no interaction with the patients? More likely they are among the few staff who are regularly on the ward with the patients. Why then do they not appear in these otherwise thorough studies of psychiatric hospitals? Roles usually treated as peripheral or absent are those of health care support staff, the visitors, and even at times the people who are ill — who are in these cases re-interpreted as "diseases."

These absent roles and individuals are the focus of my research project. In particular, this present project concentrates on the role of support staff in the hospital.

It is useful now to speculate on possible explanations to account for the absence of non-professional support service staff in health and illness research. For example, professional closure in patient care disciplines might explain both the domination of professionals in health care research and the corresponding low profile of the non-professional. Other explanations would concentrate on
the influence of the workers' roots in differing social, ethnic, and economic groups. These socioeconomic explanations draw on arguments familiar to students of social inequality. Following are more detailed discussions regarding the influence of professional closure, socioeconomics, and gender on the visibility of professional versus non-professional workers in health and illness research. Also, an employee's length of service is important to a hospital, and this factor is considered in relation to worker status in the hospital.

Professionalisation and Professional Closure

Historically, nursing has been associated with domestic servitude. Thus, Chua and Clegg write,

British nursing at the start of the nineteenth century was no more than a specialised form of charring (1990:139).

The status of nursing, it is argued, has been raised to that of a profession by fixing the nurse's qualifications to specialised academic training and credentials, while abolishing any relation between nursing and domestic work. It is important to note that the change in the status of nursing work was not simply a result of the nurse's enhanced academic credentials with a consequential elevation of nursing to the status of a profession. Imperative to nursing understood as a profession is the requirement that the nurse abandon gender-specific domestic work and resist subservient compliance to physicians.8 Raising the nurse's professional status through requiring academic credentials
can suggest an explanation as to how she begins to appear more frequently in health and illness research in the 1970s and 1980s. However, while the argument may explain an increased visibility for the new professional, professionalisation and professional closure alone do not satisfactorily explain the comparative absence of support staff and others in health and illness research.

There are many ways to describe a clinic's hierarchy, but for the moment, to picture it as two aspects of a dualism will be useful. On the one side — the side that finds itself in the upper regions of a hospital's hierarchy — is work that is closely associated with science and technology, and its administration. Work at this end either manages and funds science and technology, or employs technology in the forms of imaging techniques, instrumentation, and treatment regimens used in the diagnosis and care of the diseased and injured. Hospital departments have a status associated with them that parallels an individual department's relationship with technology. On the low end are Long Term Care wards, Medical wards, and Psychiatric wards. Opposite these are Surgical departments and wards, Intensive Care wards, neurology, and cardiology. These higher status wards are the same ones employing the most advanced technology for diagnosis and treatment.

A head nurse will be promoted by being moved from a position as, for instance, the head nurse of a medical ward to a position as the head nurse of a surgical or critical care ward. A nursing administrator will be promoted from
Administrator of Medicine, to Administrator of Surgery, to Administrator of Critical Care although these positions require the same skills. High status extends to all aspects of a clinic that comes into contact with science and technology as it relates to medicine and health care. Thus, not only doctors and nurses who use the technology, but people and departments in the hospital whose business it is to find funding for this equipment and research, as well as individuals responsible for allocating its use, will have more status than people and departments who plan and budget dietary and plant service expenditures. The vice-president in charge of plant services would consider himself promoted should he be appointed to the position of vice-president in charge of medical planning, because he will (paradoxically) now understand himself to be closer to the "real" workings of the hospital where he will budget for acquisition of the newest technology. In this way, status in the hospital is influenced not only by professionalisation and professional closure, but also by proximity to science and technology.

From the point of view of sociology's literature examining health care environments, it is as though little of importance or interest to health and illness occurs in a hospital except what is directly related to technology or to the work of health care and administrative professionals who work with that technology. Perhaps this is because sociologists have discovered that they improve their access to the environments they study by aligning themselves with the professionals working in those settings. It was in the interest of this increased
access that Sudnow (1967) elected to wear the white lab coat of a physician while gathering field data from a hospital. An excerpt from my field note journal will illustrate the point.

I am cleaning a scrub sink outside one of the operating rooms. A patient is being prepared for surgery inside. I question the surgeon scrubbing next to me as to the procedure this patient will have in order to determine how long before I will be needed to clean the room. Thus, I calculate how long I might be absent for my break. The surgeon responds in lengthy, nearly incomprehensible, technical detail. I was puzzled by this until, after comparing my experience with other housekeepers', I realised the way I was dressed had made me privy to the patient's medical history. The housekeeping staff is required to wear operating room "greens" rather than the usual housekeeping uniform when working in the OR (operating rooms). This caused the surgeon to mistake me for someone who understood his monologue, and had a professional interest in the explanations he provided.9

It is heady stuff to be admitted to the higher echelons of a hospital's hierarchy. It is a stunning discovery that this can be accomplished, at least for the short term, simply by changing one's uniform. However, maintaining that
status depends on credentials, and dissociation from the lower levels of the order.

Another aspect of the professional may also assist to explain the relative absence of support service workers in health and illness research: In interviewing an employer and secretary regarding the secretary's duties, Game (1991) found that she aligned herself with the employer and was less comfortable in her interviews with the secretary. She explained her discomfort as,

symptomatic of a general unease about the power relations of research and the constitution of the other to the subject of research (Game 1991:127).

Academics who study health care institutions are professionals in Game's sense. Working in this mixed setting of professional and non-professional, researchers may be more comfortable exploring the work of other professionals. Further, the shared orientation of "professional" can, as Game discovered, make the other's work more comprehensible. In these ways, the professional becomes more visible to the researcher even though the researcher is oriented to a very different discipline.

Socioeconomics and Education

Employment organises social life and is the source of resources, enabling "the worker to meet his or her needs and expectations" (Navarro
If status in the hospital is taken to explain the differing visibility of professional and non-professional workers in health and illness research, then augmenting this explanation with evidence regarding workers' social and economic status is necessary. For example, the researcher would expect that relatively similar socioeconomic status would predict similar positions in the hospital's status hierarchy. While the following data are not detailed, they are sufficient to provide a few interesting comments about Saint Paul's Hospital.

A partial list of workers in descending social status order for Saint Paul's would read: Degree Nurse (DRN), Graduate Nurse (GRN), Licensed Practical Nurse (LPN), Housekeeping Lead Hand (LH), and Housekeeper (HSKP). Table I shows education and experience requirements for these positions.

Table I. Education, Experience, and Salary for Selected Positions

<table>
<thead>
<tr>
<th>EDUCATION*</th>
<th>EXPERIENCE</th>
<th>SALARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRN</td>
<td>4 years</td>
<td>5 years</td>
</tr>
<tr>
<td>GRN</td>
<td>2 years</td>
<td>5 years</td>
</tr>
<tr>
<td>DRN</td>
<td>4 years</td>
<td>none</td>
</tr>
<tr>
<td>GRN</td>
<td>2 years</td>
<td>none</td>
</tr>
<tr>
<td>LH</td>
<td>none</td>
<td>5 years''</td>
</tr>
<tr>
<td>LPN</td>
<td>1 year</td>
<td>2 years</td>
</tr>
<tr>
<td>LPN</td>
<td>1 year</td>
<td>none</td>
</tr>
<tr>
<td>HSKP</td>
<td>none</td>
<td>none</td>
</tr>
</tbody>
</table>

* Post secondary education.
'''' Approximate.
'''''' No length of service increases.

Degree Nurses have a four-year Bachelor of Science degree. Differing from Degree Nurses, senior Graduate Nurses were trained during three-year
residential nurse training programmes directly associated with hospitals. Since, most of these programmes are discontinued, recent Graduate Nurses are usually trained during two years in a college programme. This can later be augmented by two years in a university programme to qualify as a Degree Nurse. Licensed Practical Nurses have a one-year college course. This training can be extended by another year at a college should the LPN wish to qualify as a Graduate Nurse. Starting salaries correlate with the hospital status of the positions (eg. $36,600, $35,900, $29,900 per year). Education requirements correlate with the salaries of Degree RNs, Graduate RNs Licensed Practical Nurses, and Housekeepers.

If the Housekeeping Lead Hand at $32,000 per year is substituted for the Housekeeper, the Lead Hand earns a wage similar to that of the beginning Graduate Nurse and LPN. However, the Lead Hand is still lowest in the hospital hierarchy. A few other low status positions also pay at a higher rate than some higher status positions in the hospital setting. These low status positions are all positions that do not have a direct connection to the advanced science and technology employed in health care delivery.

Obviously education correlates with status in the hospital. The Graduate Nurse has more status than the LPN, but less than the Degree Nurse who in turn has less status than the Intern. However, Saint Paul's Housekeeping Department is surprisingly highly educated. Although the educational achievements represented are usually unrelated to health care, approximately
six percent of the department is more highly educated than Graduate and Practical Nurses.\textsuperscript{10} A few housekeepers are more highly educated than Degree Nurses. Undergraduate and graduate degrees represented in the Housekeeping Department are Art History, Anthropology, Political Science, Physiotherapy, and Sociology, among others. This information is generally known throughout the hospital. Also, a few employees in low status positions have prestigious health care qualifications from countries other than Canada. These employees are frequently unable to benefit from their foreign training while working in a Canadian hospital. If education is related to social status, then at Saint Paul's it seems this measure applies only to job related education that has resulted in Canadian health and illness credentials.

While there is a (job related) education/status correlation in the hospital, and a relationship between salary and status, anomalies in the correlation are interesting. They need to be taken seriously because they suggest that a socioeconomic analysis does not fully explain the differing visibility of professional and non-professional workers in the environment.

The Influence of Length of Service

Considering Table I, it is evident that the length of service at Saint Paul's counts toward the higher salary paid to some employees. In the case of Degree RNs, Graduate RNs, and Practical Nurses, salary increments occur automatically over time. In the case of Housekeeping staff, salary will only
increase if seniority is sufficient for an individual to win a position that pays at a higher rate; and then, only if such a vacancy exists. Nevertheless, a certain respect is given to long service employees, based on several pragmatic factors.

For example, as visitors to hospitals, we are aware that the physical plant is usually a conglomeration of buildings constructed over several generations. The buildings are joined by a bewildering maze of tunnels and corridors that are nearly impossible for the visitor and a new employee to negotiate. Simply learning to find one's way between a place of work, the cafeteria, and one's locker is a familiar initiation to work in a hospital. Wards, while containing clues to their whereabouts in their names, are still a challenge to find based on those clues. For instance, to find 3SW, one must know where south and west are. One floor's "Main" ward may run along the main corridor, while on another floor, the "Main" ward is in a wing off what appears to be the main corridor. "Main" is an historical reference to the time when this corridor was the main corridor. For these reasons, a new employee can neither be assigned to transfer a patient between wards and clinics, nor sent to collect supplies from other departments.

After the employee can find her way about, she still cannot be depended upon to do these basic errands without error. Just as the physical plant is built up over generations, so is procedure in a hospital. Each procedure has a set of bureaucratic chores attached, and these are accompanied by the personalities of several generations of administrators. The employee must
learn these. Which chart to take? Which form? What forms must be signed, and by whom? Who has signing authority? When and how is identification checked? Which type of gurney is used? Which route is appropriate? Who has authority to question her as she goes about the task? Each department has a set of intricate procedures, and as the employee moves from one department and job to another, she becomes skilled in their different procedures. Eventually, her co-workers will seek her advice as they anticipate an errand to a ward on which she has worked, or a shift on which she has experience. In this way, she becomes more valuable to her co-workers as time goes on, and a certain status begins to emerge, relating to her years of service.

Nevertheless, this status does not readily translate between job ranks in the hospital. For example, both Sudnow (1967) and Graham (1991) noticed a marked tension between long term nurses and new interns. However, in these cases where nurses used their years of service to the hospital to "break in" new interns with respect to nursing authority, length of service did not enhance the nurses' status beyond the point where the interns learned to assert their own professional status. Status related to length of service is primarily only active within the particular general work group to which the employee belongs. A twenty-year employee in the Housekeeping Department will retain her lesser status with a new nurse (and even with a nursing student) who is assigned to this housekeeper's ward.
Women's Work

I want to consider one other potential explanation for the relative absence of support staff in health and illness research. The largest groups of people who occupy support service positions do work traditionally associated with "women's work." These people are employed in dietary, linen, sterile supply, and housekeeping services. It may be that workers in these areas suffer the same invisibility associated with domestic work done by women in the home and in the paid labour force, in general (Vogel 1983:152-4). Alternatively, Code (1988) suggests that the lower status of women in health care professions results from persistent stereotypes regarding women's lesser cognitive powers. A cursory analysis makes these explanations appear to be potentially useful; however, one must consider the fact that the male/female work division has blurred at all levels in hospitals during recent years.

General medicine now enjoys a comparatively large ratio of female medical practitioners, and the general physician's status is variously argued to have been raised and lowered by this change. Some nurses are males and the status of nursing is argued by some to be raised by this. However, a competing argument is made that the male nurse's status as a male is lowered by his professional association (Chua and Clegg, 1990). Historically, support services have experienced a pronounced male/female division of labour. Dietary services employed males as cooks and supervisors, while females worked on tray lines, delivered meals, worked the sandwich and salad bars,
and in the dish rooms. In janitorial services, males maintained the public areas of the hospital. They did the work associated with the fact that the institution was a public building. For example, male janitors were responsible for the long gleaming corridors that greeted the public on entry to the facility. Female janitors worked in patient rooms performing functions more closely related to caring for the ill in the home. They cleaned the furniture and floors around the patients' beds, and kept the patients' bathrooms and utensils in sanitary condition. All of this has changed. Females are cooks. Males work on the tray line. Females operate large floor maintenance machines in the main corridors. Males work in the patient rooms.

There is a correlation between work that has historically been "women's work" and the lower status of people (male and female) doing that work in the hospital. However, this relationship does not fully explain the status hierarchy. Trade positions (e.g., engineers, electricians, painters, and instrument technicians) continue to be highly paid and exclusively occupied by males. Nevertheless, although the positions may enjoy more employment status than Housekeeping, Linen, or Dietary Department positions, tradesmen still experience the low visibility of other support service workers in the hospital.

In summary, I have considered four possible explanations for the low visibility of support staff in health and illness research: professionalisation and professional closure, a power relation inherent in the status of professionals and
its effect on the visibility of support service workers, socioeconomic status, and the potential relationship of "women's work" to support service work with a consequent low visibility for the workers in these positions. Although each of these possible explanations advances at least a partial rationalization for the high visibility of professionals in health and illness research, none satisfactorily addresses the low profile of non-professional workers, or the frequent absence of patients and visitors in health and illness research done in clinical settings.

The "Healthy Hospitals" Project

As we have seen, support care workers have, for the most part, been invisible to research done in health care settings. At best, support care work has been treated as peripheral. At worst, the significance of the support care worker has been intentionally ignored. These phenomena are reflections of the invisibility experienced by support care workers in the hospital setting on a day to day basis. Recently, Saint Paul's Hospital was confronted with the necessity to take support staff into account in an unexpected way.

In 1990, Saint Paul's responded to an acute nursing shortage by approving and implementing the "Healthy Hospitals Project." This Project is jointly funded by the Federal and Provincial Governments, by Saint Paul's, and by the Registered Nurses Association of British Columbia (RNABC). The Project's Mission Statement (called "Healthy Hospitals Vision") declares,
Healthy Hospitals aims to create a workplace where everyone is empowered to share control over decisions that effect [sic] them — where all levels are actively encouraged to work together, without fear of failure, to innovate, problem solve, and experiment in an atmosphere of mutual respect.

Initially, the Vision Statement was not read broadly with regard to all classes of staff in the hospital. Rather, its focus was on attainment of the comprehensive inclusion of nursing in patient care decisions. "Everyone" was meant to include nurses with doctors, interns, and hospital administration. Healthy Hospitals's goal was to understand what would make the facility an attractive work place for nurses. In this way, it was hoped that Saint Paul's would attract new nurses and the chronic nursing shortage would be overcome.11

While aimed at gaining sanction for more significant (and, thus, more satisfying) participation by nurses in patient treatment regimens, Healthy Hospitals encountered the same omission that is problematic in health and illness research. The project had been implemented without specific regard for support service staff.12 My own work finds this omission both curious and provocative. What caused the Healthy Hospitals Project to overlook support staff is, in part, the hierarchical structure of the hospital. What is absent from much health and illness research and from the initial implementation of Healthy Hospitals are the aspects of health care associated with being at the bottom of the hierarchy. These are the same aspects of patient care most distanced from
science and technology. As Healthy Hospitals attempted to get underway, its directors began to take support staff into the project. This occurred partially because support care workers began to express their interest in being included. As well, if the aims of creating a desirable workplace and of allowing more significant participation by nurses in patient care and treatment were to be accomplished, the project required the cooperation of support care workers. If this large group was not happy in the facility, Saint Paul's could not be a pleasant working environment.

Also, support care workers' jobs may be required to change in tandem with changes to nursing responsibilities. For example, if nurses were going to participate more completely in patient care, they would need more time. Thus, increased budgets would be necessary to pay for more nursing positions per patient. Alternatively, some of their responsibilities could be taken by non-professional staff. Since the provincial government, and, thus, hospital administrators, are adamant that there is no more money to pay for new nursing positions, the nurses will have to attempt to reduce their current workload in order to accommodate new duties. But they cannot simply abandon some of their work. All work currently done in patient care is considered essential. Nurses would require the cooperation of another group that is willing to accept extra duties. 

Once support service staff was added to the Healthy Hospitals Project, all hospital staff were surveyed in an attempt to identify the areas that could
benefit most from the Project's attention and support. Hospital Employees' Union staff was advised by the union not to participate in this survey.

Nevertheless, Healthy Hospitals, with the assistance of a consulting firm, concluded that the department where workers suffered the bleakest working environment at Saint Paul's was the Housekeeping Department. Consequently, the Project's directors focused particular attention on this department.

If Healthy Hospitals is successful in assisting nursing's aim of achieving more involvement for the nurse in the patient's treatment regimen and nursing downloads a portion of current responsibilities to accomplish this, the work most likely to be downloaded will be what I will refer to as "comfort work." The following section looks more closely at this concept

The Leib/Körper Distinction

Comfort Work

Certain hospital wards are removed from a significant connection to science and technology in their daily routines. For example, Long Term Care patients are not usually expected to recover from illness and return to living safely in their homes, and their treatment and care is not constructed around this goal. Long Term Care patients can be made more comfortable and sometimes more mobile by the use of medical technology; however, they will not recover their former health by its application. Consequently, the Long Term
Care ward functions chiefly to house elderly and disabled patients who are awaiting placement in less costly Long Term Care accommodation. Long Term Care is a low status service in the system; and, just as this ward has a lesser status than, for example, the Cardiac Care Unit, so too does the work of the people who staff the ward. This, at least in part, is because the ward is not associated with advanced technology. However, the Long Term Care ward's low status is also a function of its being home to patients whose bodies are deteriorating and in various stages of "out of control." In other words, the care required by these patients revolves for the most part around the facts of human embodiment: the inevitability of the body's deterioration and the consequent need for assistance to accommodate the fact of that deterioration.

All patients require some level of this kind of care. Patients need their beds changed, their meals prepared, and their living space kept clean. These tasks and other similar tasks are what I refer to as "comfort work." They are the chores of day to day life that a healthy individual would normally be capable of performing without assistance. For the patient, performance of some or all of these chores is temporarily relinquished to hospital staff. For most hospital patients, regaining the ability to perform these mundane, day to day chores is the heart's ambition.
Body as Machine

In a biomedical system, achieving the ability to regain control over one's day to day life is mostly thought to be the task of science and technology. In a hospital, science and technology are in the business of rescuing the injured and the diseased from suffering and death. Injury and disease are diagnosed with the assistance of sophisticated scientific equipment and testing. Once at least a preliminary diagnosis is reached, treatment will begin. The treatment regimen will be heavily dependent on science to inform technology in the form of surgery, pain management, and other medication. This aspect of the patients' care requires a different orientation to the body than the one we have so far discussed.

Postman writes,

[Technology] has . . . amplified beyond all reason the metaphor of machines as humans and humans as machines . . . Doctors and patients have come to believe that, like a machine, a human being is made up of parts which when defective can be replaced by mechanical parts that function as the original did without impairing or even affecting any other part of the machine (Postman 1993:117).

It is fair to say that Postman has overstated his case. Nevertheless, the "body as machine" metaphor is significant and serves to introduce two philosophical traditions that influence our understanding of human embodiment. The works
of Leder (1992) and Turner (1992) will provide a useful approach to furthering this distinction.14

Leib/Körper

The phenomenological term, "the lived body," is derived from the German, der Leib. For Leder, a philosopher, the heart of meaning for a concept of the "lived body" is that it is an "intending entity."

In saying that the lived body is an "intending" entity, I mean simply that it is bound up with, and directed toward, an experienced world. It is a being in relationship to that which is other: other people, other things, an environment . . . The lived body is not just one thing in the world, but a way in which the world comes to be (Leder 1992:25).

Leib, we might say, represents the social body, and is the aspect of human embodiment that requires "comfort work."

Opposite Leib, Körper is the "vision of embodiment that underlies our disease categories and diagnostic methods."

The epistemological primacy of the corpse has shaped not only medical technology, but diverse aspects of training and practice. Medical education still begins with the dissection of a cadaver, just as the clinical case ends in the pathologist's lab. In between, the living patient is often treated in a cadaverous or machine-like
fashion. The patient is asked to assume a corpse-like pose, flat, passive, naked, mute. The entire ritual and context serves to reduce the living body to something almost dead (Ibid., p. 22).

Leder notes that Foucault has described the shift during the eighteenth century of basing disease classifications on the expressed experiences of the patient to a "basis in the organic lesions found in the corpse" (Ibid., p. 21).

For Turner, *Leib* and *Körper* refer respectively to the subjective and objective body as with Leder. Turner credits Plessner's (1976) work with distinguishing the terms *Leib* and *Körper* as "representing two dimensions of the human body" important for Sociology. Turner writes,

- Whereas *Leib* refers to the animated living experiential body,
- *Körper* refers to the objective, exterior and institutionalised body.

This double nature of human beings expresses the ambiguity of human embodiment as both personal and impersonal, subjective and objective, social and natural (Turner 1992:41-2).

I will use the terms *Leib* and *Körper* as different orientations to human embodiment but, like Turner (and unlike Postman), I do not understand them to be mutually exclusive terms. Rather, an approach to embodiment will be influenced by being oriented more to *Leib*, or by being oriented more to *Körper*. Thus, for example, Turner continues,

- In trying to understand human perception, Merleau-Ponty argued that perception is always undertaken from a particular place or
perspective. It is not possible to talk about human perception of the world without a theory of embodiment as the perspective from which observation occurs (Ibid., p. 43).

Both perspectives, Leib and Körper, are active in the hospital. In other words, I am suggesting, with Leder and Turner, that biomedical training encourages medical professionals to use an approach to the human being that is dominated by a philosophical orientation to human embodiment represented by the term Körper. But this is not meant to suggest biomedical professionals have no awareness of, or interest in their patients' subjective experience of the condition that has hospitalised them. On the other hand, usually lacking formal biomedical training, most support care workers and patients understand illness and injury in ways similar to the ways other lay people (to medicine) understand illness and injury. Nevertheless, while support care workers may have little access to biomedical explanations for what they witness or experience during their working day, it would be naïve to suggest that support care workers have no awareness or understanding of biomedicine. However, the work support care workers do is "comfort work." Lacking sophisticated biomedical explanations, and being immersed in "comfort work," the support care worker is most likely to employ a philosophical orientation to embodiment that is represented by the term, Leib. Thus, we might expect that the support care worker will be more influenced by the subjective experience of illness.
I approached my research with the idea that these two philosophical approaches to understanding human embodiment might be used to understand the hospital's status hierarchy. High status in the hospital is associated with proximity to science and technology. Medical science and technology have a relation to a concept of human embodiment that is oriented to the body "as machine." Thus, in cases of illness and injury, we discover what is broken or worn, and fix or replace it. This orientation to human embodiment, Körper, attempts to gain control over human embodiment. However, low status is not simply the reverse of proximity to science and technology. It is not that support staff reject Körper as a theory of embodiment. Rather, the opposite aspect of the hierarchy is influenced by proximity to "the lived body."

I will argue that a workers' dominant approaches to embodiment significantly influence their experience of hospital work. I expect to show that support care workers are more often oriented to Leib, and that this orientation has a significant influence on the workers' experience of the hospital, and on their sense of status in the hospital. We will see that Leib has the positive influence of making many support care workers aware of, and empathetic to patients and visitors. However, the association with Leib also has a negative influence in that an incumbent in a support care position can perceive herself to be (or to become) a kind of "untouchable." For example, my field work finds that the closer the work in proximity to the more invidious aspects of the body, the more likely the workers in those positions are to understand themselves to
be "invisible" to other hospital workers. Occasionally, these workers will attempt to make themselves "invisible" while carrying out certain aspects of their work.\textsuperscript{15} This is because in our culture, "out of control" is a frightening or offensive aspect of life that we seek to hide from public perception.

Blum observes, "disease symbolizes the power of nature to do violence upon what men cultivate and care for, upon what we speak of as human culture" (Blum 1982:13). We seek to overcome disease and illness through medical (or other intervention) to bring the "machine" back into line. I expect to show that at least some individuals working in support care positions consciously attribute their low status to the proximity of their work to this aspect of our cultural beliefs. And, I expect to show that some support staff attribute their positive rapport with patients and visitors to their own Leib versus Körper-based concept of embodiment.

I now have an opportunity to mention a place where support care workers have appeared in health and illness research, and where these workers have been noticed by professional staff on wards. A brief extract from my field notes will serve to introduce this.

She has been assigned to work as the housekeeping aide in the psychiatric unit for the day because the regular aide is away. She is telling us with some amusement how she was startled first thing in the morning by a nurse who appeared behind her suddenly, inquiring in a friendly way as to who she was, how
she was, and where was [the regular aide]. It is rare that a nurse would notice the absence of a regular aide, let alone inquire after her by name and welcome her replacement. We all agree that this only happens on the "Psych Ward," and the consensus for an explanation seems to be that they notice us because they are sensitive to us being ignored and sometimes maligned due to the fact that the "Psych Ward" is ignored and maligned by the rest of the hospital.

Where health and illness research has notably taken support care workers into account has been in some studies where what is of interest to the researcher has been greatly influenced by an emphasis on the patients' experienced world: "other people, other things, an environment." Thus, support care workers do periodically appear in research that addresses, for example, Long Term Care. (See, for example, Diamond 1992.) Long Term Care and Psychiatry are the same wards in the hospital that are most distanced from science and technology.

In many ways, the theoretical aspect of this thesis will resist the idea of professionalism in a health care system where the physician has become the doctor, the nurse is now a health care professional, and the system is managed by administration professionals. The system has a dual nature, and this is not sufficiently addressed by the biomedical perspective. We have on one side health care and administration professionals, and on the other, health care
workers, patients, and people who encounter the hospital with patients or on their behalf. Of the people in the professional group, most are trained to view individuals using the health care system through a biomedical model.

Riessman writes, "the assumption is that medical practice is based on scientific knowledge," and "in the scientific mentality, complex, dynamic, and organic processes are reduced to cause-and-effect relationships" (Riessman 1983:5). Engel, in agreement with Riessman, describes this approach to health care in the following way.

The dominant model of disease today is biomedical, with molecular biology its basic scientific discipline. It assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables (George Engel cited in Lock 1982:286).

It is this disease model that has required medicine to align itself almost exclusively with natural sciences, and to look for solutions to disease and injury in the application of science.

Engel continues to say that, because a biomedical model always wants to bring disease explanations back to biological variables, it embraces both reductionism — the philosophic view that complex phenomena are ultimately derived from a single primary principle — and mind-body dualism — the doctrine that separates the mental from somatic (Ibid.). Thus, we might argue, viewed through the lens of biomedicine, that people requiring health care
services are constituted as patients only. Patients present diseases that will be overcome through biomedical technique. The health care professional is trained to seek resolution through the work of the mind (science) and its application (technology). The Leib/Körper distinction expresses itself in the fundamental difference in approach employed by the professional and the patient, the professional and people encountering the profession with the patient, and the professional and other health care workers. We will be wise to wonder with Blum if this approach is insufficient. He writes,

> Technical approaches to suffering cannot give the afflicted anything more than means to endure their affliction or to manage their affliction or to alleviate the distress of the affliction (Blum 1982:6).
CHAPTER II

The Library
Through chat which takes place during breaks and at other times during a shift, staff become generally aware of some aspects of one another's lives outside the hospital. We learn, for example, who works at a second job, who is married, who has children, and who is a student. More often than not, information about one another is collected indirectly when one staff member passes along something he knows about another: "She works full-time as a gardener," or "He is a full-time student." During the three-year period prior to writing this, I consulted with several co-workers, asking them if they would be comfortable talking with me about their work in an interview. Of those asked, all were enthusiastic. In turn, these co-workers passed along information about my research to other staff, and people began to ask me questions about my academic interests. In this way, individuals working in the Housekeeping Department at Saint Paul's became aware that I might one day be looking for people to interview about their work. As I was making final preparations to begin interviews, one co-worker offered himself as my first volunteer. The following day, I brought my questions, consent forms, extra tapes and batteries, a notebook, and a tape recorder to the hospital. Andrew met me at a coffee shop after work, and my interviews began.  

The vice-president of Plant Services had written a letter to be posted indicating my need of volunteers. However, a week after Andrew's interview, posting the letter became unnecessary when he reviewed his experience at a staff meeting. Andrew explained to our co-workers that he appreciated the
opportunity to "think seriously" about his work, and he suggested participation in
my project for this reason. His recommendation was generous and helpful.
Following the staff meeting, two or three housekeepers approached me for
more information, and others lingered to hear our conversations. More
volunteers stepped forward. The initial response was so positive that it seemed
as if interviews could easily continue well beyond what would benefit this
project, and there were time constraints to be considered.

The Work

Staff in the Housekeeping Department at Saint Paul's are divided into the
categories of "aides" and "cleaners." Until recent years, this has been a sex-
related division with females as aides, and males as cleaners.

Cleaner work is considered to be physically more demanding than aide
work because it requires the use of heavy equipment, such as floor scrubbers
and buffers. Cleaners generally work in the public areas of the hospital. For
example, they maintain the floors of corridors and walkways. As cleaners are
not usually working in occupied patient rooms, the cleaners' contact with
patients and visitors tends to be limited to the public areas of the hospital. This
means cleaners are more likely to be asked for directions than for personal
favours. For some, cleaner work is preferred because it does not have such
close proximity to patients and visitors as aide work does. Working in public
areas rather than in patient rooms, the cleaner is more able than the aide to
choose to limit interaction with the public. The cleaner, because the assignment might include several wards, is not missed by medical staff on one ward who assume he is working on the other. Cleaners enjoy less supervision in general by both the Housekeeping Department and hospital management. The size of the cleaners' work area makes it difficult for a cleaner to complete all duties assigned for each working day, and a cleaner may choose to work on a special project in lieu of completing routine work on a particular day. Consequently, it is anticipated that a cleaner may not have time to complete all of the assigned tasks every day. All in all, the cleaner has more freedom of movement than the aide because it is difficult for supervisors to discover when cleaners are away from their work area due to the size of the area a cleaner covers, and due to the somewhat self-directed nature of the work.

Aides work in closer proximity to patients for the most part. It is more like the work done in the home when someone is ill. Ideally, an aide is assigned to work in one ward where she is responsible for maintaining the immediate living space of approximately twenty-five patients, and is responsible for cleaning the staff and public areas of that ward. However, the aide may be responsible for two wards due to absent staff who have not been replaced. In this case, the aide will drop non-essential work (such as sweeping and washing patient room floors) and concentrate on fifty patient areas, the patient washrooms, and essential public and staff areas. The pace of aide work is more demanding than cleaner work. Due to the proximity both to nursing staff,
and to patients and visitors, an aide tends to experience scrutiny than a cleaner. Aide work is potentially monitored by medical staff, patients, and visitors, housekeeping supervisors, and hospital managers. Because she may frequently be sought out during a day to perform certain tasks and because the work area is fairly confined, the aide may be easily missed from her area by ward staff and by supervisors.

Historically, males were hired as cleaners and females were hired as aides. Ten years ago cleaners were paid about three percent more than aides. Because wage settlements were won as percentage hikes applied "across the board," eight years later, that gap had increased to about nine percent. Consequently, several women began applying for, fighting for, and winning cleaner positions on the grounds of entitlement by seniority. Many aides agree that cleaner work is heavier, and guess they would never be able to manage the cleaners' equipment. Some smaller women find that they are not physically able to do cleaner work at all, or not for more than a shift or two in a week. Nevertheless, many who have done both jobs prefer the cleaner work if they are physically able to do it because it is more varied, less supervised, and currently continues to pay a slightly higher hourly rate.

One often wins employment at Saint Paul's by knowing someone who already works there. The volunteers were all hired in this way. A few have been able to convince Human Resources to take their application on their own initiative; but none of the volunteers succeeded in securing an interview until
someone employed by the hospital made an effort to get the applicant's name put forward. The advocate might be a relative, spouse, or friend.

Once an individual is successful in being hired to work at the hospital, they will usually want to settle into a permanent full-time or permanent part-time position, rather than continuing to work on a casual basis. An employee wins some hospital positions based partially on skill and ability. However, for unskilled or semi-skilled work, the employee's seniority is the most significant consideration. There are very few positions for which the Hospital Employees' Union will allow experience to take precedence over seniority. Consequently, seniority hours become a focus for employees. One new employee will work more often than another based on having one hour of seniority more than the latter. Later, as the employee accumulates hours, winning full-time or part-time status with accompanying benefits is dependent on "having the hours." Thus, the least desirable positions fall to the most junior employees.¹⁹

At Saint Paul's, the Housekeeping Department is perceived as the least desirable department in which to work. In particular, work as a housekeeping aide is shunned. Consequently, many of the hospital's newest employees will be found working in these positions. Currently, these new employees are as likely to be men as to be women.
The Volunteers

At the time they were interviewed, the eight volunteers were distributed between cleaner and aide positions in the following way.

Table II. The Volunteers' Employment

<table>
<thead>
<tr>
<th></th>
<th>Cleaner</th>
<th>Aide</th>
<th>Cleaner/Aide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Females</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Table II shows in which classification (cleaner or aide) the volunteers were most likely to work. For example, two volunteers (one male and one female) work as often as cleaners as they do as aides.

There are three ways that status is classified by the Hospital Employees' Union: permanent full-time, permanent part-time, and casual. Permanent status employees have won a particular position, and work in that position according to a schedule. Casual employees are assigned by seniority on a day to day basis. These positions are temporary vacancies that exist due to illness, vacation, special leaves, or because the position is currently not assigned to a permanent employee. Thus, a casual employee might (and usually does) work in a different area on each assignment. Five of the volunteers are part-time employees. The other three are "casuals." Employees whose statuses are casual or part-time often work the equivalent of full-time hours. Five of the
volunteers depend on the hospital for full-time employment, one has full-time employment elsewhere, and two are full-time students. Also, two of the five part-time employees are committed to continuing full-time post-secondary studies in the coming fall.

If the group of volunteers is compared to the Housekeeping Department as a whole, the volunteer group would show some differences from the characteristics of the department's employees in general. Taken as a whole, the department's staff would show fewer students. However, the housekeeping staff is particularly ambitious. There is a surprising number of current students and individuals with post-secondary degrees in this department. The volunteers have been working in the hospital from one and a half to nine years, and on average, have less seniority than the department as a whole. This is reflected in the fact that the majority of the department's staff work as permanent full-time positions while the volunteers are mostly "weekenders" (part-time positions) who "pick up" extra shifts during the week on a casual basis. The average age for the volunteer group is probably less than average for the department. Volunteers were distributed between the ages of mid-twenties and mid-forties. Ages for the department taken as a whole will range from the early twenties up to the mandatory retirement age of sixty-five years. Finally, all but one volunteer worked either day-shift or graveyard shift every weekend. Permanent full-time employees work Monday to Friday.
Something the department staff in general and the volunteers share is their ambition. As mentioned, one volunteer has full-time work elsewhere, two are full-time students, and two others have firm plans to return to full-time studies in the coming fall. \(^{21}\) It is common in the department for individuals to be students or to have two jobs (one outside the hospital, and one of which will be full-time). In a few cases, the employee has two full-time jobs.

### Method

Throughout the research, I worked as a participant observer, and while I refrained from detailed discussions of my specific interest, I did not practise any deception in order to facilitate my observations. Thus, the research draws on my experience as a cleaner in the Housekeeping Department. This work cannot rightly be called cross-sectional. To be truly cross-sectional would require a more detailed examination of people working in other departments (especially in medicine), and of their perception of the place of Housekeeping and housekeepers within the hospital. Nevertheless, there are some cross-sectional data in the form of my own and the volunteers' recollections working in other departments. The ethnographic component of the work gives the research a longitudinal quality.

Interviews were conducted at a mutually convenient time and place chosen by volunteers. While space had been offered for us to use at the hospital, all of the volunteers declined this invitation. The alternatives that we
arranged made our surroundings more informal and comfortable. The first
interview (with Andrew) took place in a coffee shop. The tape from this
interview proved very difficult to work with due to background noise.
Consequently, subsequent interviews took place in quieter locations — usually
in my home, or in the home of the volunteer.

Interviews were semi-structured and open-ended. I began the interview
by having the volunteer read and sign a consent form, the text of which is
reproduced as Appendix I. Using the University of British Columbia letterhead,
the consent form contains some information about my research, reassurances
about confidentiality, and statements indicating the interview will not in any way
jeopardize the volunteer’s employment with the hospital. The consent form also
includes telephone numbers in case the volunteer wishes to contact me or my
thesis supervisor at a later date. The volunteer may decline the interview or
decline to have the interview taped at this time. None did. I next read aloud a
short introduction to my project. This is reproduced as Appendix II. After these
initial formalities, the volunteers knew that I was interested in hearing about
their work, including what they do beyond their assigned duties.

During the interview, I kept a list of sixteen questions before me along
with a piece of paper on which I could note comments to go back to as our
conversation proceeded. This list of questions is reproduced as Appendix III. I
read the questions one at a time and the volunteer responded to each question
in turn, with one or the other of us periodically asking for clarification.
Frequently, it was necessary for me to probe until the question seemed to be exhausted. We proceeded in this way to the last question which asked if the volunteer had any concerns regarding the interview or my thesis. Invariably, volunteers asked, "What is it about?" "What are you looking for?" I would respond to these queries, pointing out aspects of the volunteer's comments that I found particularly interesting or helpful. I was surprised when two or three volunteers expressed real relief on hearing that they had said something that I had found helpful. My explanations regarding the subject of my thesis would always lead the volunteers to telling me more stories about their experiences working in the hospital. We would continue with this exchange until after the one hour tape was finished.

I transcribed each tape word for word. This proved to be a tedious task. For the first three and a half hours of tape, I worked with a hand-held tape recorder, playing, pausing, and rewinding. Eventually, I arranged to borrow a transcription machine that considerably improved the mechanics of transcription. Having transcribed the tapes, I replayed each interview twice more, checking it against the transcript. In this way, I became very familiar with the interviews. I found, as I replayed and reread them, that there were links between the questions and between the interviews that I had not noticed before.
The Profiles

I have developed profiles\textsuperscript{22} from the transcripts, and these are found in Chapter III. The profiles were written by removing all of the questions and prompts from the interview transcripts and, guided by a copy of the complete transcript, reconstructing the interview as a monologue. Twenty to 30 percent of the original transcript remains intact in the profiles. Editorial notes added to the interview transcripts are contained in square brackets and appear in italicized print. Periodically, square brackets enclose text within the body of a comment by the volunteer. Here, the volunteer's comments have been paraphrased from the transcript to clarify the profile. The reader will also note curved parentheses. These enclose asides by the volunteer within quotations from their text, or by me when enclosed in the editorial comments.

In these documents, I have tried to conserve the flavour of the volunteer's personality and their approach to the work. Nevertheless, it is difficult to portray the fullness of our conversations adequately through the written word. The volunteers were often funny and often serious. All were animated. All were interested and curious.

Aspects of one interview transcript that are repeated in another are not repeated in the profiles. For example, all the volunteers described their work day in detail. These descriptions are not retained in full in the profiles. Rather, there is an example of an aide's work day, and an example of a cleaner's work day. However, the volunteers' work days varied according to their work area.
and their own dispositions. Thus, the routines described by one volunteer may
not adequately represent another’s work day. What is retained for the profiles
are aspects of the volunteers’ work that seemed particularly significant, unusual,
or poignant. These choices were made in concert with efforts to offer a portrait
of the individual and his or her experience working in the hospital, while
restricting the length of the profile so as not to overwhelm the reader.23

The profiles are a portion of the data for the thesis. I offer no analysis
within them. As the thesis continues, I will draw on the profiles. Relevant
quotes from them and from the transcripts are repeated in the analysis.
Consequently, the reader is free to treat the profiles according to their own
disposition. The profiles may be read in detail, browsed, or omitted. Familiarity
with the profiles, however, is recommended to allow the reader to become more
involved in the analysis of the interviews that follows the profiles in Chapter IV.

While I was editing the profiles, volunteers began to express interest in
reading the final document — the thesis. For this reason, it became important
to return to each volunteer with the profile, and ask for some response to it
because, although the volunteers are not recognisable to most readers, they
are recognisable to each other, to department supervisors, and to some
hospital administrators. Thus, it is important that they have the opportunity to
respond to my representation of their thoughts. This was my initial reason for
returning to the volunteers. However, once I had decided to do so, I
recognised the opportunity to "test" my data (see Stoddardt on “the member

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test of validity," 1991:8). To this end, I provided each volunteer with a copy of the individual profile. Also, at this time, I returned to them the tape recordings that we had made during the interviews. I retained the transcript.

My decision to have the volunteers read the profiles created some potential difficulties — especially since I had decided to do so before I had completed writing the profiles. Initially, I found it difficult to resist the temptation to pre-screen the profiles for comments that the volunteer might ask me to remove. Eventually, I decided I would continue assembling the profiles as I had begun, aiming to provide a sense of who the volunteer is, and an understanding of that individual's experience of working in the hospital. Since the thesis is a public document, and since the volunteers are identifiable from their profiles within the Saint Paul's community, I had already decided to exclude from any given profile what I had judged might compromise the volunteer. Such comments when quoted from the transcripts to the thesis, are not attributed to any particular volunteer if the comment might prove harmful or embarrassing to the volunteer who offered them.

Once completed, I gave the profiles to the volunteers. I explained that, while I hoped they would approve of the profile as it was, if there was something that they felt particularly strongly about, we would consider what to do. None of the volunteers had serious objections to any portion of the profiles. Fred and Edna were amused by the pseudonyms I had chosen for them. Gordon, ever the pragmatist, was quick to point out that there had already been
adequate opportunity to withdraw, and by this time the volunteers should be prepared to stand by their words. Harry, the actor, was entertained and a little perplexed by his character sketch. Barb, a chronic giggler, was surprised to see how often we laughed in spite of my having edited out several of the "[laughter]" notes.

Dot negotiated to have her name changed from "Dorothy" (which I had chosen for her). She also initiated an interesting discussion that was motivated by a certain uneasiness she felt at seeing her natural spoken language represented by the written word. The profiles have a conversational flow, and contain a number of important insights expressed in simple colloquialisms and analogies. For Dot, seeing these in her profile and imagining its presentation in an academic document created some embarrassment. Eventually, we concluded that the difficulty was a result of differing expectations for the quality of expression in the spoken versus the written word. Seeing the spoken word written creates some confusion regarding those expectations, and that confusion, Dot worried, might tend to encourage a reader to think the speaker ineloquent. Consequently, our discussion led to this caveat.

These are examples of the kinds of responses that were generated by the volunteers reading the profiles. None of them suggests serious objection by the volunteers. The fact that there were no serious objections raises the question, "Was there was anything controversial left in the profiles?" The volunteers discussed their difficulties with unmotivated co-workers, the
unpleasant working conditions they experience on particular wards, the general abuse and their own abuse of paid sick leave, the current and former Housekeeping Department management, the effect of peer pressure to do as little work as possible, and sometimes they questioned the union's approach to the management of the department. In other words, the volunteers broached sensitive topics that could create difficulty for them among their peers. However, none of the volunteers, having seen these comments in the profiles, requested that their comments be removed or altered.

A Question of Rapport

Rapport was an important aspect of the interviews. We sat over coffee or tea and snacks, and discussed what it was like for us to be lay people working in a hospital. We shared stories, some funny and some sad; and tried to forget the presence of a tape recorder. The candidness in the interviews is, in part, a result of the rapport that developed during our conversations. There are occasions in almost every interview when the volunteer cautions, "This is confidential." At that moment, the tape recorder is stopped. A fraction of a second passes on the tape until the recording resumes with some seemingly innocuous topic. In other words, the volunteers did on occasion speak "off the record" during the interviews, and at this time evidently spoke to me as a confidante. This fact, in part, demonstrates the volunteers' confidence regarding their participation in the interviews.
Volunteers also talked about aspects of their work day that one might judge imprudent to tell a supervisor, despite assurances regarding confidentiality and job security. From a supervisor's point of view, it might appear, for example, that the volunteer should not take so long with a certain task, or should not be spending time doing work that could be costed to a different department. A supervisor might argue that the volunteer should be able to "get along" on a particular ward, or should not be involved in activities that might compromise the hospital's insurance. There are many examples of comments which a guarded employee would have resisted making to a supervisor. While these aspects of the interviews are reflections of each employee's confidence in his or her work, the supervisory style they experience, and the protection their union contract affords them, they are also a result of the rapport that developed during the interviews.

It can be argued that familiarity tends to undermine what is "deemed to be an essential element of scientific procedure." Namely, that the social science interview be "an encounter between strangers" (Harkess and Warren 1993:317). Harkess and Warren note that, since the purpose of the qualitative interview is to "describe patterns rather than generalize results," snowball sampling is the most common way of locating volunteers. They write,

In our view, the key to understanding snowball sampling is the interview topic, in particular, its experience-nearness or experience-remoteness for the researcher's social circles, its
respectability or stigma, and its power to evoke emotion in the interview participants. The topic's affiliative power generates the sample and then shapes the situated context of the interview itself (Ibid., p. 321).

In this way, the authors begin to "challenge the assumption of strangeness" in qualitative social science interviews. They continue with an interactive analysis of the social relations operating in intensive interview situations, and note that volunteers are usually discovered in primary and secondary social groups. Harkess and Warren draw on the interactionist concept of the "generalized other." According to this concept, "the self" emerges as a composite role that is developed through the understanding of other particular roles (see Mead 1934). The authors go on to ask, if strangeness did obtain in the intensive interview sample, what effect might that strangeness have on the interviewer's understanding of the interview content? They write,

The generalized other emerges from primary and, in adulthood, increasingly secondary relationships . . . Consequently, the possibility arises that mutual strangeness may cloud rather than clarify communication . . . Topics that are stigmatizing and experience-remote for the interviewer predict differences in statuses, relevance, and shared meanings in the intensive interview (Ibid., p. 322 and 325).
While Harkess and Warren mount an effective challenge to both the validity of the "assumption of strangeness" and its consequences should it be found to be true, they must also consider the "consequences for validity" if rapport is enhanced.

They note Mishler "expects the 'natural' form of discourse in the intensive interview to foster storytelling" (Mishler 1986 cited in Harkess and Warren 1993:332) and that storytelling fosters rapport and friendship. However, Harkess and Warren observe with Mishler, that when interviews are conducted within a fabric of group familiarity,

The researcher must distinguish any features that may detract from validity — feelings of "stupidity," suppression of storytelling, betrayal of loyalty, and porous boundaries between interviewer self and respondent other — from those that enhance it — broadening and deepening the meaning of the interview in multiple encounters — and then decide whether the latter outweigh the former (Ibid., p. 334).

None of the volunteers was strange to me. They are all people whom I regularly encounter at work. Two of the volunteers are people I have "taken breaks with" on a semi-regular basis. The other volunteers are people I know strictly as co-workers. Of these volunteers, we did get to know one another during the interviews. Since the interviews, I have spent time with each volunteer, sometimes discussing the interviews, my research, and our work at
The profiles generated another opportunity for us to discuss the volunteers' orientation to work, and to the hospital. This informal chat is not, strictly speaking, what Mishler, and Harkess and Warren mean by "multiple encounters." Their use of this term refers to the practice of meeting the same volunteer more than once in a formal interview setting. Nevertheless, our informal encounters have afforded me the opportunity to broaden my understanding of each interview, and of each volunteer. I have asked for and been given clarification on particular points. These informal encounters convince me that the interview content is not threatened by the detractions to validity which Harkess and Warren mention ("feelings of 'stupidity,' suppression of storytelling, [or] betrayal of loyalty").

Harkess and Warren conclude by noting the necessity of, the process . . . of scrutinizing every study [for] the kind of personal knowledge interview participants have of one another in terms of effects on the conduct of the interview and the validity of the results (Ibid., p. 336).

At the time of the interviews, I worked for the Housekeeping Department as the weekend shift Lead Hand. This is a secondary supervisory position. In other words, all of the volunteers spend at least part of their work week under my supervision while I work under the direction of another supervisor. The volunteers have the benefit of the promises contained in the consent form. These reassure them of the confidentiality of the interviews and the security of
their jobs. Nevertheless, the fact that the interviews were conducted by a graduate student in sociology who is also their supervisor at work must be addressed as a potential difficulty.

The volunteers are particularly conscientious workers. They know their work is respected by their peers, and by their supervisors. As a result, they have a certain confidence in speaking candidly about their work. Even so, were this not true, as a supervisor my power is very limited by our union agreement which stipulates that one union member may not compromise another union member's employment by relating aspects of that member's work that could lead to the member being disciplined. Although the enforcement of this clause is not well defined, in my position as a supervisor, were any of the volunteers' employment status to be threatened as a result of participating in my project, I have no doubt I would be held accountable by this aspect of the union agreement. In other words, I fear at worst, I could lose my union card, and, therefore, my job. Thus, aside from the consent form, this union protection offers the volunteers further protection for their participation.

It is important to note that I also work as a cleaner (not only as a supervisor). As with some of the volunteers, I periodically experience a sense of stigma attached to my work. This mutual experience, as Harkess and Warren predicted, assisted to enhance the rapport in the interviews.
The Ethnographer

By now, the reader is aware that the thesis draws not only on a series of interviews, but also on ethnographic sources. I began work in the hospital in 1983 and was immediately struck by the strangeness of my work surroundings. To give a sense of what work in a hospital is like for a lay person, I include an edited excerpt from my journal.

I am called in the morning to work as the Operating Room aide. I have never done this before and were this not a statutory holiday, I would not do it now.

Entering the department, I see a man waiting in one of the offices. He is very pale. He jumps up to see who I am. He looks worried and afraid. I walk around the OR core looking for the room they are operating in. I find them just in time to watch a baby pulled from a woman's abdomen. This sight makes me swoon because it looks so unnatural. I often see the man over the next several months, walking the baby. He carries it in a Snugly with a blanket draped over it, so I have never seen the baby. One day, I approach the father on one of his walks telling him I was in the room when his baby was born. I tell him I would like to see the child. He pulls the blanket back and I chuckle because the laughing, big eyed, curly headed little boy is, without doubt, the cutest child I've ever seen.
We are advised of a male with a ruptured aortic aneurism waiting in emergency. I am sent to bring this patient, and naively go to get him. I find an ancient man hooked up to all manner of apparatus. Things beep, and puff, and buzz, and I say I cannot take him by myself. The Emerg staff rush him to the OR with me running uselessly behind. As the patient is pushed into the room, he begins to fight. He is yelling "No!" and other things I cannot understand. I'm not sure what is happening, but I imagine the old man is protesting being taken into the operating room for surgery because he knows it is his time to die.

It is hard to die in a hospital.

The surgeon is a man much admired for his skill. He looks at the patient, at the chart, and then curses. The man is over ninety. He has survived this long only because he was quickly retrieved by paramedics when he collapsed in his bathroom. The surgery must proceed now that the man is here. They are obligated by professional oaths to try to save him. And, if he dies on the operating room table, the room must be closed until the coroner prepares a report.

The man has received seventeen units of blood. The surgery shocks me. He is opened from his chest to his pelvis. His intestines are placed on his chest to be out of the way of the
aorta. Interns are dissecting near each hip to reach his femoral arteries in search of a graph. The aneurism is the size of a softball. It has been removed and lays discarded on a Mayo stand. The surgeon is trying to stitch in a silicone graph, but the old man's arteries are too fragile to hold it. The respirator is clicking and puffing, and the monitor beeps rhythmically. A blood bank runner arrives with more blood and tells me to relay the message that they cannot supply more for this patient. The old man is draining the reserves and this is a "long weekend."

Everyone is quiet.

Without warning, the surgeon throws down his instruments, turns to the monitor, and grasping the wires, rips out the plugs. He marches from the room.

The surgery is over.

I am stunned. An intern remarks to the scrub nurse that something is wrong with her aide. She looks at me closely and answers the intern, "She's okay. It's her first day." Others leave the room, and someone says to me, "Bag im!" This is an instruction to put the man's body into a "morgue pack." I refuse and flee the OR.

I've never seen someone die before today.

I've never seen someone born before today.
Later, I arrive with a woman who needs to have a fish bone removed from her throat. I am shocked to discover the old man’s body, covered as though he is sleeping, has been left in the patient holding area until the morgue orderly can remove it. He looks dead. The new patient asks with obvious trepidation, "What is wrong with him?" Fearing she will leap off her stretcher and run away if I tell the truth, I say, "Nothing. He’s just had some drugs to relax him in preparation for his surgery." She looks sceptical, but is willing to believe me.

Lay people working in a hospital are often bewildered, fascinated, and disturbed by their surroundings. I was all of these things, and also acutely curious and observant. The hospital seemed to me to be a place of unnatural and continuous calamity — until I began to study sociology. Then I was able to develop a more focused approach to my observations. This, and growing accustomed to the surroundings, helped me to find that working in the hospital seem less like a series of calamities and more like a series of controlled (though still sometimes unnatural) crises. Eventually, my experience lead to this thesis work, which began with an extended period of deliberate observation and notation. I began to keep field notes, and to search my journal for notes to include in my field notes. This thesis draws its ethnographic content from those notes, from my experience over ten years in the hospital, and from stories told
to me by co-workers and collected in my notes, particularly over the last two years.
CHAPTER III

The Portal
I want to suggest an alternative model, though I do not mean to banish the dispassionate stranger or the estranged native. They have their place in the critical story, but only alongside and in the shadow of someone quite different and more familiar: the local judge, the connected critic who earns his authority, or fails to do so, by arguing with his fellows — who, angrily and insistently, sometimes at considerable personal risk (he can be a hero too), objects, protests, and remonstrates. This critic is one of us . . . He tries to connect [new ideas] to the local culture, building on his own intimate knowledge; he is not intellectually detached. Nor is he emotionally detached; he does not wish the natives well, he seeks the success of their common enterprise (Walzer 1985:38-9).
Andrew

I do a lot of patient interaction. Actually, sometimes too much. Stand there and talk to them. Ask them who they are, and where they're from, and go on and on about their family. Bring them blankets if they need it, or if they want a towel. Pitch in and help them and the staff. [The nursing staff] is not there. So, instead of letting [the patients] wait for five minutes or ten minutes, it's just as easy to run out in the hall and grab something, and run back in. I don't think [the patients] really know the difference. Well, it's not nice to say. They know I'm in housekeeping. Yet, they don't know I'm not part of the actual team, so they just treat everybody the same.

On [my ward], you know [the patients] a little bit. You get to know their family, and why they are sick or how they've become sick. So, you go in and just see how they are. I feel I just go in and try to be bright and sunny, and hopefully this'll help them get better, and get out. I make special trips. There are a few patients that, we kind of connected. I wouldn't say family, but kind of like a little family. So, I always make a special point of going and spending a few extra minutes. "How was your night?" Sit down. Have a little chitchat. [On] regular wards, there's a quicker change over and you don't have longer periods to spend to get acquainted with them. You've got these set things to do, and you have to get it done by four o'clock. But, I think I usually approach everybody just the same. "Good morning," and, "How are you?" Start like that.
Andrew greets the patients in the morning as he makes his initial rounds picking up garbage. At this time he says, "Good morning." If he does not get a response, he knows the patient does not wish to talk, and so he carries on with his work quietly. Otherwise, he initiates conversation by asking if the patient had "a good night." To create conversation, he might ask if they will be in for a while longer. How does he respond to someone who tells him they are going home?] That just happened yesterday. There was a lady who just went home. I told her "Great! Freedom!" And she said "Yes. But, I go home to nobody." I kind of felt sorry for her. We had a little chitchat about it, and she kind of felt better about going home. We had a little giggle, and a laugh. I think by the time I left her room she was okay about going home. I think so.

Sometimes the nursing staff can be a little bitchy. Like when I worked on [ward]. I don't mind working on [that ward]. It's a good floor. It's just some of those nurses are a little different. Because I'm not part of their crew, I'm seen as an outsider, and I don't quite fit in with them. So, it kind of makes me feel uncomfortable. But, by the end of the day I just kind of put it off and I go and do my own thing. The nursing staff: I think they probably just kind of do their own thing and say, "Well, Housekeeping will get it." They're kind of in their own little world and you're just a peon. [Laughs.] "You'll do this and you'll enjoy it!" But, in most cases, I kind of feel like an equal. It depends on the nursing staff and what kind of mood they're in. They're not my supervisor, and
they're not the head nurse. I would consider them just to be my equal. Even though I'm doing a different job, my job is just as important as theirs.

I pretty much enjoy what I do. I really don't mind washing floors, or cleaning bathrooms, or making beds, and that kind of thing. Most important for me is the interaction with the patients, and, if I can tell them a little story that'll get them smiling. [He has worked in hospitals for about ten years. Usually, he has worked in Housekeeping or Dietary, although for a year and a half he worked as a nursing aide in a Long Term Care facility.] I really enjoyed working with the patients! But, because I didn't have that little piece of paper that said I was certified, or qualified, they said, "No." I'm probably in the pecking order kind of at the bottom, but not really at the bottom. These people have to be here, and we try to make them comfortable. Every little bit helps, I suppose.

[Although Andrew does not see himself as having a role in the patient's recovery, he is very definite about the importance of his participation in their day to day life while they are in the hospital. He sees his role as important because it is "non-threatening" for the patient.] They don't really know what's going to happen. The nurses and the doctors know what can happen, but they won't say. I'm not a nurse or a doctor. I don't know what's going to happen to them. So, we have some kind of common ground. I try to portray that. Just your "Average Joe." Do a little bit of housework. Try to make them feel okay. Have a little chat. Move on to the next one.
I've worked in nursing homes, and one thing that was really lacking in this nursing home is: You'd wash 'em, feed 'em, put 'em to bed. You did that through the whole ward. Then you'd go home. You never really had time to sit and find out about these people, where they come from, what they did. I think that's very important: At least be able to have some kind of knowledge or understanding of who these people are to make them feel comfortable, or make them feel more at ease. It's just like an assembly line. It was awful. I couldn't understand how people could do this day after day, and not know these people. You've got their chart. I don't think half the staff even bothered looking at their chart or who [the patients] were. I always managed to take a few minutes and sit down, have a little chat, ask about pictures in the room. If there is a picture on the wall one of the patient's family brought in, I usually comment on it. They're more than willing to talk about it: their relationship with this one or that one. They might even throw in a little story.

He's been on our ward for months and months. Before we went on strike I got a chance to meet his two sons. Of course, I knew his wife because she was in every weekend [when I work my regular shift on that ward]. He was just so happy that whenever his wife, or whenever the nurses weren't around and I was in his room, we could talk. He would tell me little things about his life, his family, and himself, and what he has done. He doesn't understand why he is so sick now. Now, he is to the point where he can't really have that
interaction. It's really kind of sad because I've watched him go from sick to healthy. He's back to sick, and now it's getting worse. I feel empathy for him and his family.

I've seen it all and it's just kind of second nature. You just go in, and whatever. Someone has passed away and you have to clean the room while they're still in there [so] you just kind of look past it. Get over it. I walked into 26, and I . . . Actually, it was quite funny. Both the guys names' were Eugene. The nurse walked in right behind me. I said, "Good morning, Eugene." Then they started yelling, "Eugene! Eugene!" The guy in the next bed had just passed away a few seconds before. It was quite funny because the other little old man was saying, "What do you want?" He didn't realise that his neighbour had expired. He was to go home that morning. Wow. He was well. They had him up walking and doing well. I didn't bother asking. Kind of figured cardiac arrest. They worked on him, but . . . it was kind of sad actually. He was a nice guy.

That little bell, it sure gets the shivers going. It's just kind of automatic. You know something big is happening.

My first year in a nursing home, we had twenty-five go. Fifteen of them happened to be on my shift over a period of a year. It was part of my duty to "wrap them." Wash them. Wrap them. Get them ready to go. The first time I was shaking like a leaf. Muriel, my best friend said, "Well, just think of it as
though you are getting them ready to go home. Washing them up." And so, we did. We were washing him up, and she started to laugh. She started to reminisce about this guy. All his little stunts he use to pull, or things that he used to do. He was quite a character.

I think the one that I was really very upset about was this gentleman, Andrew. He had known me since I was a little kid, and I'd known who he was. When I went to work in this nursing home, I went to work on his ward. I walked into his room, and he had just passed away. It was very devastating. I didn't know what to do. I stood there and looked at him, and watched him. Then I walked out and told them what I saw. I think his [death] stood out the most.

Barb

[Barb has worked in health care support services for about eleven years. She worked as a dietary aide in a senior's residence directly before applying at Saint Paul's and she began at Saint Paul's as a dietary aide "delivering trays and preparing desserts." Two years ago, she transferred from full-time housekeeping aide to part-time cleaner position in order to adapt to full-time studies in nursing.]

It's all the neutral areas. The aides would cover the direct patient areas. [Other than my assigned duties] I have assisted patients and visitors. Often, you have patients who can't get in and out of heavy doors, or are lost or confused. One day I found someone's stolen [sun]glasses and retrieved them.
All that is definitely not on my duty list. Occasionally they will out right ask, and other times I'll see patients struggling [and offer to help]. I'm not going to continue to let them struggle. I'm going to give them a hand. They're always very appreciative. Generally, they are in a wheel chair, or they have an IV pole. The patients: most of them don't ask. They just struggle.

Housekeepers are just social. That sort of breaks the monotony, doesn't it? I think some things I do for the patients in just listening to them are more than anyone else in the hospital does for them. To me, being an ear can do wonders. I've talked to a patient and they would just light up. I remember once in Haemodialysis, there was a patient who was very depressed and very suicidal. He needed someone to talk to him. He was making it very clear that he couldn't handle his haemodialysis. He'd had it! Nobody cared, it seemed. So, I went and talked to him for a while.

[Working as a cleaner in critical care areas, Barb has much less contact with patients and visitors than she experienced working as an aide.] Not nearly as much. It's very different because a lot of [the visitors] are grieving knowing that death is imminent. They're very distraught. They seem to have more nursing contact, and they're aware they have pastoral care. I'm not needed. The patients: most of them are comatose. [The visitors] look right past you. They seem to be just so stressed. They really don't notice you. [As for patients], everyone is brought in on a gurney, and brought out on a gurney.

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I don't enjoy being invisible. Point blank. [Laughs.] That would be my biggest gripe. Wearing this blue uniform surrounded by white uniforms, [other staff] walk right past you. The only time they would ever acknowledge I was alive was if they needed me to do something. In the end it [the invisibility] wasn't there. Initially [for the first four or five months on the ward], yes, I was invisible. "Where are you going, little housekeeper? We need this bed done."

Invisible. It was actually the patients warming up to me first. They started to know my name. (They actually know our job better than some of our casual employees. I mean they would tell [casual employees], "This is what you're suppose to do.") Then, the staffers took it upon themselves [to get to know me]. In one incident, I'd learned a staffer's name. I had learned her name because I make a point of learning names. That's important to me. I called her by name, and she was shocked.

For some reason they figure I am not capable of thought. I think it has a lot to do with the actual work you do. You are picking up garbage. You're like a garbage man. You're doing dirty things that most of them probably can afford to bring in help to do those things. Scrubbing dirty toilets. I guess it's just the work itself.

I don't think education has anything to do with it. It's a matter of people doing less appreciated work. Maybe it's the assumption that the nurses think that if you don't have the proverbial education — which isn't actually the case with housekeepers. I know housekeepers with TONS of education. So, that
isn't even relevant — I could see their thinking, "Oh well. They couldn't do anything else so they're washing floors. This is the best they can do. They're a janitor. Ho-hum. What a loser." I've actually heard the nurses at the hospital where I am doing my practical training snap at the housekeepers! You never see them talking to other nurses in the same tone, even if they had done something wrong or hadn't cleaned up a mess. I've never heard a nurse raise her voice to a nurse. They do to Housekeeping without even batting an eye.

Even the managers of Housekeeping treated us in the same demeaning manner other professionals do. That was a knife. But then again, the other managers would treat them like dirt because they were only Housekeeping managers. So, I guess it's just a whole hierarchy-thing going on. Housekeeping is at the bottom. Even when I was in the kitchen, I thought Housekeeping was at the bottom. [Laughs.] It was ridiculous, but everyone in the kitchen just sort of accepted that Housekeeping was at the bottom. It was just a known fact. So, when you go there, it's, "Yup. We're the scum sittin' at the bottom of the pond." [Laughs.]

I noticed the nurses are very task-oriented. And doctors: "I've got fifteen other patients to see today. You're just another task. I have to start this IV. I have to take this blood pressure. I have to change this dressing." As opposed to, "How are you? Are you okay today? Is there something I can do to help you?" It was very, "I have things to do. I have forms to fill out to do these
tasks to document what I've done." Whereas, with a housekeeper, if I didn't wash a floor one day, no one would ever notice. I could leave a housekeeping task and maybe spend that five minutes that no one else has with Joe Smith, Renal patient, who's had a really bad day.

To assess your patient for things other than his nursing or medical diagnosis takes a lot of time. Perhaps the profession doesn't allocate that amount of time. [The nurse has] eight patients and they all have to have their eight o'clock meds. They all have to have their ten o'clock vitals. They all have to have their eleven o'clock meds. In there you have to change them all, bathe them all, change their beds, and get them out doing their exercises. I think the workload is tremendous in the end.

Cameron

[Cameron is a full-time university student, and has a part-time position at Saint Paul's. He has trained as a Massage Practitioner, and worked in private practice. During the last few years he practised, nearly thirty of his clients who were suffering from AIDS related illness passed away. Eventually, Cameron found it necessary to give up his practice.]

I am a Registered Massage Practitioner. But I'm not trained to work in a hospital. There are no registered massage therapists trained to work in British Columbia hospitals. I practised for nine years. I didn't know it at the time, but near the end it started to get very emotional for me, very hard for me to get
through the day. I would get part way through the day and cancel everybody else. I would just get very, very sad and I knew I had to close my practice. I was very dedicated. Quite a perfectionist. I always over-treated. In the end, I felt like I wasn't able to give what people needed.

I was working at Videomatica. Videomatica was a cool place to work, but the money was ridiculous. Five-twenty-five. I got a raise to five-fifty. For the amount of work that I had to do and my age, I thought, "That's absurd!" A friend of mine was training to be a nurse. He said, "Just apply. Apply for Nutrition Services." [After working in a temporary part-time position for six months, Cameron became a "casual" in Nutrition Services.] They called me once in a two-month period. The day I was in there was a living hell. I was on the food line. Break the egg and you have to do it again. No way! I'm not a robot.

I probably get on my floor between eight-o-five and eight-ten depending on where I can find the mops. I do the garbage first. I tend not to want to spend time in patient rooms chatting. So, I take an empty, clean garbage can with the wrapper, and just exchange so I'm out and quick. When that's done, I'm on to bed-side [garbage] bags. That way I find I have more personal contact with each and every patient. "Good morning. How are you? I brought you a bed-side bag. You're going home today? Oh, good for you! Congratulations! Well done!" Dust checking usually comes before the first
break. Get it done. That way I know what needs my attention. What rooms have spills. What bathrooms have, say blood on the floor.

I tend not to want to spend any time with patients [in the mornings]. I think it's because I'm not warmed up to being in the hospital with people — with patients in bed. After I've done the garbage, I'm more comfortable with the fact that I have to relate to these people, or I can relate to these people. As opposed to first thing in the morning, I don't want to. That's why I do the garbage that way. Throughout the day? Yes. I will take the opportunity to clean a floor or a bathroom if there is nobody there. I will jump at the chance. It's easier to do, and I don't have to communicate with somebody I don't know [or don't] want to communicate with.

["Terminal Cleaning" (TC) refers to cleaning a room completely after a patient has been discharged or has expired.] My TC beds don't tend to show up until the early afternoon, so I don't get to those until after lunch. I prefer the "private" because I've done the entire room. I know that it's clean. I prefer to do "privates" because I don't have to communicate with people of authority, or other co-workers. I can spend the time cleaning, and know I've done a good job. By after lunch, I've probably done a third of the bathrooms completely. I've probably done half the floors, or the floors especially that need my immediate attention. Then, I finish in the bathrooms. [I do] some of them three
or four times depending on the patients — if there are blood problems or bowel problems.

Looking back on my massage therapy practice, I am sure that I didn't want to do that again. I would spend the least amount of time possible with patients. I am civil with patients and their guests, definitely. I joke with them. I don't know what people think. It may look like I don't want to talk to people. I'm doing my job. Even if another aide or another cleaner came up to me, or a nurse, and talks to me, I will continue to do my work. I don't stop and talk. It's not always true. But, generally that would be true. That's why I like my job: because there's often times where can I do my work, and do it well without having to deal with the people.

[Patients are] a grey area. I don't know what all that stuff is for, all the equipment. I have to walk in and see them looking like death [when] yesterday they looked okay. I can see that they are in worse shape or better shape. It can be quite disturbing to see somebody wired for sound. Open wounds. You do walk in on these things, and I would rather not. I didn't even apply for a year because I thought I wouldn't be able to do the work. I wouldn't even go to visit one of my aunts who was dying in the hospital. I could not go into the room. I've always been uncomfortable [in hospitals]. It's all foreign to me. And yet, people were very sick at my massage practice. But, that was different. That was hands on. You did help. I could help them, even though I couldn't
keep them alive. I was doing them a service. But cleaning somebody's
bathroom when they're pretty messed up? It doesn't make a lot of sense to me
even to clean it up [because they can't use it].

If somebody asks me for a housecoat, I might go [get] it. People would
ask me, "Can you help me sit up?" I just will not. "I'm just, I'm sorry." And I
will buzz, or push their ringer for them, and call a nurse. I just say, "I'm not
allowed to do that."

[The patients are] all tubed for days. Oxygen. There's always oxygen
water on the floor. It can be quite hard on me to be in a room where
somebody is in a serious condition, and tubed, and people are working, and I'm
trying to clean. Some of these people are there for weeks. [But] we have
kidney donors. They tend to be quite cool because they don't take long [and
because they feel good about what they are doing].

[When I asked Cameron if he was aware of an order in the hospital
which ranked employees in some way, he explained that he first became aware
of this by hearing other people talk about it.] Most people treat me as an
individual. As an equal. Especially when they know me. There are some
people (some nurses and some doctors) who have been on my floor the whole
time I been there [and] will not acknowledge me even if I've said, "Hello." I
think that is some kind of hierarchical thing. I think they think they are better —
that I'm some kind of peon. There is one nurse: she will say, "Hello." She will
say, "Good morning." But mostly, I get the sense that I am less than her. It's my experience that if they don't know me (if they've never seen me, if they're not aware of who I am, and that I do work), depending on who's on the floor and where I am, I will be treated like just another "person in blue." But, I find that when people recognize that I do my work, then that's not true for everybody. Some people seem to open up.

Some people do not do their job. I think that reflects on everybody else. [When someone does not do their work], I think that most people think that is true of everybody. We are very visible, but only at certain times. If you're in a "private" — terminal care in a "private" — you are out of sight for up to forty minutes. The nursing staff tends always to be within earshot of each other, or away for a few minutes at a time. With the "people in blue," that's not true. You don't go up to the desk and say, "Well, I'm going to be in here TC-ing for forty minutes and you won't see me, but I'm still working." I think that it might look to the people who aren't working in Housekeeping like housekeepers generally aren't working.

I would say that I have a very good standing with my staff. I have sense of community on my floor. I don't have that on [another ward I have worked on]. When I went to [the other ward], those people were miserable. I don't think they were miserable with me, especially. I was another "man in blue." A face they hadn't seen. I got the sense that they thought, "He's not going to do any more than the last people did." When I made it very clear that I was there
to work and do my job, people were responding to me by the end of the day. Saying they appreciated it, and I'd done a good job, and "I've never seen that done."

There was only one time. I went to one of the core bathrooms and there was some plastic and some blood. The odour was unbelievably bad and it physically made me ill. I was totally revolted and repulsed. I couldn't even cope with thinking about what I saw — what it was. I did clean it up. It took me a long time. I had to go in and out of the room a couple of times to get it to a place where I felt comfortable. It was beyond words. One other time: people tend not to lock bathroom doors. I always knock on a bathroom door, but, often they don't say anything, and I'm in there before I realise there is anyone in there. "Excuse me. I'll be back later. Don't worry about it." But, I walked in once and there was some kind of scar. I must have turned completely white.

[Do you see yourself making any contribution to the patient's life as a patient, or to the staff on your ward?] [As for the patients], I don't think that I have looked at it that way. I see myself as making a contribution, certainly, to the staff. I do my work. It looks good. I do a good job. For the most part. I know they appreciate it. [With the staff on the ward I work on we] seem to be a unit. We all work to some goal. To get things done. If I'm getting garbage on
the [ward] and there are Kleenexes on the floor — the nurses always throw plastic things on the floor — I always pick them up, because to me it doesn't look right.

Dot

The type of things I do during my work day? Do I do something during my work day? There are a lot of people who don't qualify for this interview! [Laughs.]

I feel as though with this job [collecting waste for compacting] I'm almost around staff more than I'm around patients. On the ward, I'm always around patients. You're actually right in there. You're a char-girl, really. On the wards, the patients are always asking you about stuff. "Can you raise my bed?" That's not my job. But, unless they appear to be like a nut and they're restrained, if they seem really with it, then I do it. Getting extra pillows. Getting them an extra blanket. Getting them towels. Getting them ice. Getting them water. Showing them where stuff is. Getting them soap for the shower. Helping their visitors get around. Getting vases, and helping them set up their flowers. Helping them set up their cards, and pin stuff on the bulletin boards. Most of the extra stuff I do on the wards is stuff that either the nurses would not have time to do, or the person would not bother to ask a nurse to do it.

I find I'm especially patient with the older patients. I mean, they're a little nuts because they're so bloody lonely. I don't think it's my job, but I have one
of these faces. I've had days where three or four patients grab my hand and start crying because they thought they were going to die, and never get out of there. A lot of them want reassurance, and a lot of them are lonely. I've been in hospital before. I was in for three days and I was bored out of my mind. It's crazy. You're sitting there in your pyjamas. You wouldn't even let half your friends see you in your pyjamas, and anybody prances in and sees you. It's kind of weird.

I would say one of the hardest parts about working in Housekeeping is dealing with nurses. There are a lot of lazy people in Housekeeping. And there are a lot of nurses that feel hard done by. So, you get those two together and you have a worst case scenario. You have people who think that they're just giving a hundred and fifty percent all the time, and you're doing nothing because you're in a blue uniform. What's the difference between two HEU people leaning on mops and having a chat for four minutes about something really strange they just saw (to keep their sanity), and three nurses sitting on chairs in the nursing station with charts in front of them? (I have a really hard time with liquid poop. If someone's just shit himself all over the floor, and I go in and clean it up, I might say to the aide on the next side, "Ugh! You wouldn't believe what I just had to clean up!" To just give myself a bit of time. That's my little bit of high drama for the day.) The nurses at the nursing station are not working. They're talking. It's the same thing. But, we're a bunch of lazy bums when we do that, and they're "Health Professionals" networking when
they do it. So, I find that the hardest. I find that they're really demanding. They're really rude about it. It's hurtful sometimes because I chip in. Then, to be treated like I'm some kind of lazy bum — especially stuff like cleaning up spills in a patient room and it turns out it's because the nurse did it. Sometimes I don't mind it, but it's this sort of [snaps fingers and points] "Go mop that up."

One of the nice things about the job is, I like the patients. I really feel that when I show up for a shift at the hospital, I'm going to be a little bright spot on at least one person's day. Patients, or staff even. I've met some really neat people at the hospital. It's nice to be human in such a sterile atmosphere. To bring a little bit of human contact to it. I like that.

Sometimes, depending on how your day as an aide is shaping up, I think we spend more time in the patient rooms than nursing ever will. If you're standing there mopping, it's just as easy to mop and talk — if someone wants to. Some people don't want to for whatever reason. They're tired. They're ashamed. They're embarrassed. They don't want anyone to know that they are whatever. [Patients are less inclined to chat with nurses] because [nurses] are authority figures. We're not. Which is a good thing sometimes, and sometimes it's a drag [because] sometimes [patients] think you're a valet.

If you don't like people, don't work in a hospital. There are days and there are shifts where, if you're not into it, you can avoid people. I can't do it as successfully. But I've talked to aides who, "Just totally don't make eye contact
with anybody and nobody ever talks to me!" They don't want to be bothered. They just want to do their work.

I guess this guy's liver had shut down. He was like nicotine stained, sort of. That's how his whole body looked. He was dying. I knew that because he was just really sick. He couldn't have been that old. He would have been about my age [mid-twenties]. There was this woman who looked to be in her mid-fifties who was probably his mom. She was sort of short, and sort of pudgy, and sort of round. She had a round perm, and she was just sitting there holding his hand. I knew that she knew that he was dying too. I didn't really know what to do. I just looked at her, and I smiled. I said, "Hi" and she just sort of, "Hi" back. She knew that she wasn't alone. I found that kind of hard. Not just because he was going to die. Just seeing her there too.

I was working in Emerg. Emerg is really weird because I'm pretty clean cut. It was a welfare weekend, and I saw a side of life . . . I never see people like that! Drug users, and a lot of native people who hadn't eaten since they got their cheque because they've been out bingeing on something. But you know something? They were some of the nicest people I've ever run into. You say "Hi" to them and they just about fall over dead. No one's treated them like a person in so long. As a housekeeper, that's how you feel. I saw this guy in Emerg vomiting blood. I had a really hard time cleaning that up. Like that's the
hardest thing I've ever had to do with the spills because if someone's really sick or really gross, I just don't look at them. Quite honestly.

I see the body bags go out down there. I've taken some rides down with some bodies. It's like TV. Everyone's seen a stretcher with a white sheet pulled all the way over. Everyone's seen that on TV. But, you've never seen someone sitting on this gurney wrapped in this white plastic that looks like kitchen stuff. That's real. I haven't been sort of numbed to that. I ID'd my mother's body in the morgue. If this is ever published, I would urge no one to ever volunteer to ID a body. I know on TV when they say, "Someone has to ID the body," some brave person says, "I'll do it!" Don't! I mean, if you can weasel out of it, do so by all means. It was sort of horrific.

Absolutely! At the very bottom. This is interesting, because of course I think Dietary people are at the bottom. [Laughs.] We're second from the bottom. I used to go through this when I worked on [ward]. They're such a bunch of []. Can you put that in the transcript? The women on [ward] are []! And I'm not talking about patients. They're really awful. I think that my patient contact is just as important as the nurses' or doctors'. I even think it's BETTER. I'm talking about just sort of talking to them so they're not bored stiff, or so they're not as sad, or so they're not as worried. There are a lot of people that are really scared in the hospital. I think that my human touch is important. I think that I've made some people's stays a little bit better in some ways. I think
that's just as valuable as what the nurses are doing. Especially the old people:
that's all they want. They just want an extra blanket, and somebody to listen to
them for a few minutes. I can do that just as well as anyone else. I can
probably do it better than some of those people. It's not like I'm not a nurse
because I'm stupid. I just don't have any desire to be a nurse. For all the
hassles, they don't make that much more than we do.

If I didn't do my job for four hours, there would be this huge mess. They
don't see you doing your job. They just see you not doing your job.

......

[For Dot, the hospital is a very political environment. She suggests the
public underestimates the experience of working in a hospital. She was
interested in the fact that, in spite of the size of the facility, the number of staff
working in it, and the volume of activity, the institution functions reasonably
smoothly. She followed these observations with comments regarding the
effectiveness of Saint Paul's staff "grapevine." Everyone should work at a
hospital. I've never experienced anything like it before. Ever! It's really
unique. If you haven't heard a rumour by ten, just start one. The hospital is
always busy. There's always gossip. Someone's always getting pregnant, or
going married. There are a lot of people. There is a lot of information there.

[However] within Housekeeping there's no accountability among peers to
do your work. There's a certain amount of it to not do your work. That's kind
of cool. With nursing, there are five of them. If someone disappears for two
hours, people notice. There's also the feeling if that [a housekeeper] doesn't do their job, it won't affect [another housekeeper] as long as I don't have to come up behind [the one who didn't do their work]. That's not true because then the nurse thinks everyone's lazy, and so you're dealing with that [nurse's] attitude.

You know what really gets me? People who feel like they're entitled to know what my wage is. That always gets me. If you don't tell them they assume you're making some outrageous amount of money. Thirty bucks an hour instead of thirteen-something to mop up something that no one would mop up. Which is why they sent their friggin' mother to the hospital. [Laughs.] That's the reality. If it was so great, half those people wouldn't be there. They'd be in home care, but nobody wants to clean up after them.

Edna

[This interview took place in Edna's home on her day off. Edna's husband also works at the hospital. He is the "Fred" to whom she refers. Directly before being employed by Saint Paul's, Edna worked as a mother's helper, and as a "Nanny." The "Nanny"-job ended drastically with [my employer] beating me up. Then I met Fred [who helped me get work at the hospital.]}

........
I find if I work as a cleaner during the week and then have to do my two graveyard shifts [also cleaner work], I just can't do it. I decided to work as an aide [during the week] because it's a heck of a lot easier. As a cleaner, you've got the machines if you're scrubbing, and you have to move furniture if you're doing carpets. It involves a lot more heavy [labour].

My permanent part-time job is as a cleaner on weekends. Friday night, I take care of the OR (Operating Rooms). Saturday night I do the kitchen. Then, I help the other cleaner with Emerg and garbage runs. I do the ORs even though it's not my job. But, he can't do the ORs because he'd have to change fifteen times between Emerg [and doing the ORs]. It's just too time consuming. ["Triage" refers to an initial sorting of emergency patients into categories of those requiring stitches, X-rays, cardiac monitoring, and so on.] Friday night, they triage seventy-two, seventy-four patients. So that's stretchers you have to do. [Friday night], I check my book to see which rooms haven't been terminally cleaned. There's usually three or four waiting. A terminal clean is everything in the room. From top to bottom. The beds, all the instruments, all the Mayo stands, and things. Everything has to be wiped down, and the floors have to be done. I pull everything into the middle, dust around all the things, like the lights and the tables, mop my floor all around the outside. As I push all the equipment back into where it belongs, I wipe it down, push it in, wipe it down, push it in. I go around the whole room like that. Then I concentrate on the bed, the anaesthetic table, and all the wires that have to be
done. I move the bed, and mop the middle of the floor, put the bed back, put
the belts across it, and it's done. I usually have four of those a night. If you're
not hustling, about twenty-five minutes for a room. A heart room can take you
forty-five minutes because it's bigger, and has more things in it. My shift on
Friday is not as busy as it used to be when they had a different cleaner on
afternoon shift who didn't do as many rooms. Sometimes I'd come in and there
would be eight rooms waiting, and eight rooms is a whole shift.

Saturday night I come in, grab my mop, head up to the kitchen, dust
check the outside, pull everything out to where I've dust checked, and then dust
check the middle. Then I go to the dish room and I spray it all. You clean out
the drains, and make it look presentable. I get it all dust checked and ready to
go, and then I take a break. Then I start mopping. When it's all dry, I push
everything back to where it was.

If [a ward] is out of linen for instance, it's not our job to go hunt it down,
but we will. If it's busy in the Case Room, we'll go looking for sheets so we can
make the beds so the women can have their babies. Fred does lots that isn't
on his duty list like scrubbing and buffing Emerg. Just about everything you do
is pretty well covered on your duty list [because it says], "Time permitting, do
this." People are really great. They don't ask you to do things that aren't on
your duty list. They seem to know what's required of you, and they don't ask
for more than that.

I like the pay.

We like the way people help out on graveyard shift. I think they're a little
more helpful on graveyard shift for cleaning up their own messes instead of
leaving them for Housekeeping. [laughs.] Before Fred was getting paid for his
breaks, he started to refuse to answer the page during his breaks. We went up
a couple of times, and there were nurses up to their knees in vomit and ka-ka
because Housekeeping wouldn't come between three-thirty and four. But no,
they're pretty helpful. [i don't like] how tired I get. I get too, too tired. [i have]
only that one day off [because the other is spent catching up on sleep from the
graveyard shifts]. You try and cram in your laundry, and your house cleaning,
and everything else. And you are back to work the next day. I find that
extremely hard sometimes.

The doctors are the bosses and the nurses get a little frustrated.
[laughs.] But, they don't take it out on the cleaning staff in any way that i've
ever seen. In fact, we had one incident when an intern from ICU had phoned
and said, "nobody made up my little bed and i'm tired." The other cleaner said,
"i'll be there in twenty minutes." Well, who stomps into the case room and
demands to see the head of Housekeeping but this little intern. "i want my bed
done and I want it done now!" [The head nurse] said, "Listen here! This cleaner's working in my area and you're not invited. Now you can wait your turn and don't you ever come in and bother my cleaners again!" It was hilarious. "What's your name? I'm going to report you!" "Well, I'm going to report you first!"

Emerg on graveyard shift: everyone gets along. They're so professional in the way they deal with things in there. There's no friction. I used to think that we were sort of pretty low down on the totem pole. I worked in Emerg for two years and then someone said to Fred and I, "I heard you guys are married!" I thought, "Gee whiz! After two and a half years, what an astute observation!"

We were known as the "A-team." Everyone really liked us because we get in and out and did our job really quick. But they don't get as chummy with Housekeeping as they do with their peers, of course. It was mostly in Emerg that I felt [the hierarchy]. "Oh, they're just Housekeeping." It's because the other people that work there during the week aren't as efficient, and consequently they lump you in. It just sort of carried over from during the week. "They don't do anything, so this weekend crew isn't going to do anything either." Once they realised [we do our work], I felt better. Now it's like "Oh good! It's the weekend. Housekeeping's here and they're going to work." [Now I fit into the hierarchy] where ever I want to be, actually. When you know how much you're appreciated for what you do, it really makes you feel better.
It's not like you have to work harder to prove that you're better. It's just that you just do your job and prove that you're sufficient. [Laughs.]

On Friday nights in the OR, they like it because I'm generally there when they need me. They always share their pizza, and their cake, and their cookies, and their popcorn. They're really good. But you will hear them complain about doctors. That's where I get my impression that there is an order in the hospital, and that doctors expect nurses to be there at their every beck and call. If they change their mind the nurses have to change their whole schedule because the doctor's changed his. [The doctors] don't seem to care that these nurses have other things to do. [The nurses] are supposed to drop everything and run because the doctor wants them "Now!"

[Like Dot, Edna finds the hospital a very political environment. She sometimes disagrees with the way the union assists problem employees.] If you're going to be a union of workers, be a union of good workers instead of a union of people just going in to get their money and doing as little as possible and the hospital looks like it hasn't been dusted for a year. That was the one thing we didn't talk about. The union. If you're going to be a strong union, be a strong union for something that's good. To me, a lot of those people that don't do their job and whine when someone says, "You're not doing a good enough job," I don't see why the union backs them. The union should say, "Look,
you're hired to do a job. Do it! Then we won't have any complaints about you."
That's the only thing that bugs me now, is the people who don't do their work.

... ...

Right now I'm happy in my job. Whereas, a year ago I was still pretty
ticked about the attitudes that some people had. I went to one of the Sisters,
and had a meeting. I said, "Everybody here is just about ready to quit!"
Everybody backed me up. I was so pleased. That was when they decided not
to renew [the contractor's] contract — after that meeting with Sister. With the
change to in-house a lot of people's problems were solved.

I found working afternoons during the week, that some people are still
complaining and grumbling about duty lists. I say, "Look. The Healthy Hospital
way is to take your duty list to your supervisor and straighten it out. Then you
can work and be comfortable." Sure there's little things that bug different
people, but once they realised that it's their problem and it's up to them to fix it,
not up to in-house Housekeeping to fix it. You can't fix something if you
don't know it's broken. Everyone that has a complaint should take their
complaint and get it sorted out for themselves. Any complaints I've ever had
that I've said, "I can't do this," or, "No. I'm not going to," I've never had any
problems. It's like, "Okay, I understand." It's really been different with
in-house. I think a lot of people have relaxed and lost that edge of, "God, I just
can't stand to do this." It was getting really bad.

... ...
I found when I did my training on day shift, I was too interested in the patients. More interested in what was going on with the patients than I was with what I was doing with my job. If a patient was talking with me, I would stay there and talk with them because they needed someone to talk to, instead of saying, "Oops, I don't have time to talk. I have to clean this toilet." I found out just how much of my energy I was over-extending to the point of making myself almost ill. Literally. Trying to help everybody do everything, and always be there. You can only do so much. Once you realise your limitations and your own physical energy, then you have to put yourself in a position to utilize that for yourself, not for other people.

[Edna seems quite happy in her work and I asked if she thought this had anything to do with her limited patient contact. She agreed with Fred that they felt happy in their work compared to other staff because they have some control over their jobs.] Our own bosses. We don't have bosses on our shift. Besides, they really depend on us. To really tick them off all you do is put an "Out of Order" sign on their bathroom or leave them out of toilet paper, and then they are really nice to you next time.
Fred

[This interview took place in Fred and Edna's home after he had listened to the last half of Edna's interview. Fred's responses were brief, but thoughtful.]

Previously, I was working as a musician, and in foundries, factories. I just put an application in. My mother happened to be working there. She said, "You put in an application." So, I went in and I was interviewed. Next thing, I was working.

Right now, my position is basically to take all the calls that come into Housekeeping and make sure they're done. Just general cleaning. Beds. Could be anything, actually. Floods. Body fluid spills. Snow removal. Anything and everything that has to be done that concerns Housekeeping, I'm pretty much responsible for getting it done. Basically, I just sign in and pick up the pager; go to the Emergency Department and see what has to be done there. That's where I base out of since it's the busiest. Then, just deal with the calls as they come up during the night. Every night is different. It's pretty hard too. The only thing that stays the same is the Emergency Department. The duties that I do there are stretchers, blood spills, vomit, and stuff like that. Once in a while I'll get something for a patient. Maybe get a bed pan or get a urinal — if [the nurses are] busy, and I just happen to be standing there and the patient wants something done. If I'm not busy, then I'll do it. I can't think of anything else that's not job related because pretty well everything is. The only
thing that isn't job related is if I do anything for the patients. Usually, I just get a nurse to do it and it's no big deal.

I enjoy the fact that I'm my own boss on my shift. The freedom that gives me, and the responsibility — rather than just being stuck in the same area day after day [and someone saying], "Do this." I enjoy the changes. [What can be difficult is] if it's getting really busy, or if a lot of stuff has been left and I don't know about it.

I'll get calls where people can be quite nasty sometimes. That's rare now. It used to be quite often. I'd get them just about every night. Now it's getting a lot better. I think more people know about us. Plus, I think the Healthy Hospital Programme that's going on now has helped quite a bit. People are starting to realise that they just can't keep doing that. I've complained about it before. The word has come up from downstairs [from the Housekeeping department supervisors], "You've just got to quit doing this. You just can't start screaming and yelling at somebody the minute they walk in the door when it's got nothing to do with their job duties."

\[\ldots\]

Obviously, if you're working in Housekeeping, you can't be a doctor or a nurse. You have to have qualifications to do your job. I think that's the only system that I really see. If you're qualified to do a job, I think you're allowed to do it. I think they are usually pretty accommodating. I mean, the doctors and nurses, without them you wouldn't have a hospital. So definitely, there has to
be a hierarchy that way. They have more education, more experience, and
greater responsibilities. So definitely, they're going to be at the top of the heap.
People that do the labour intensive things are generally lower down as far as
decision making goes and things like that. It's obvious.

[When housekeepers think nursing treats them badly,] I don't think it's so
much that they're treated differently. If you perceive yourself to be less than
somebody else, then obviously you're going to be treated that way. I think a lot
of it has to do with that. I don't really see too much of anybody thinking that
they're better because they're a doctor or a nurse. They have their certain
responsibilities. They know what they are; and then you have your
responsibilities and you know what they are. It's very seldom they mix, cross
over. Nurses don't mop floors and cleaners don't hand out drugs. I don't think
anybody really thinks more or less of someone as a person because of that. I
think it's pretty much cut and dry. Everybody knows. They know if something
has to be done that it is definitely something for Housekeeping, so I get called
to do it. I don't think they think any less of me for doing my job. If they do,
then that's their perception of what's going on.

Somebody has to be on the bottom. I don't think any work that's honest
work, especially in a large organization like a hospital . . . Everybody has their
niche to fill. If you take one part away, you're not going to have a whole
hospital. Who cares who's on the bottom? What's the bottom of a car? The
tires, right? You take the tires off, what good's the car?

Sometimes some of the ways some of the patients get treated [is difficult
to see]. Sometimes they tie people down. Things like that, I'm not too sure.
But then again, it's not my position to say. It's getting better. They can be
quite forceful sometimes and I didn't think it needed to be. And, I don't like to
see young people die. It's disturbing to see.

Gordon

I had a huge store. I was the youngest manager working for [Company
Name] in Western Canada. What a shock to go from being boss to working at
the hospital. In a union. I hated it. The first week, I hated it so bad. Clean up
shit. You're treated so badly. It's like a kick in the teeth. It isn't now for me.
Now, I'm quite satisfied with working there and being a student. I don't think I
could work there very much longer after I'm not a student. People get trapped.
When you start competing in your mind with "Joe Blow" who's one place ahead
of you on the seniority list, you have got to quit cleaning toilets.

I think it is part of my job to be nice to the patients. One of the things
that I think is important in my job is to go in and make eye contact with them.
Not necessarily talk with them or bug them. Just let them know that I'm not
embarrassed that they're there. Half the time, people that are really sick look
embarrassed that I even come into the room. I don't want them to think that I'm uncomfortable. I'm really glad they can see my face, my eyes. [Then they see] I'm not scared of touching anything in the room, or getting close to them. They know, I think. It never involves physical contact, and rarely verbal.

My ward is a medical ward and most of the patients have cancer or AIDS. They're not very happy. Usually they're in a state of shock, or denial, or bitter. When I first started at the hospital, I'd never met anyone that had AIDS. I'd never met anyone (I think) that had cancer even; where I knew they were going to die. It scared me at first because you used to have to wear masks and gowns. They never got to see me. The best thing that happened was when they took away the isolation. They use to have the pink signs, and you had to "gown up" no matter what — use bleach in the water. There were all these silly things that I wasn't educated on, but I got educated really fast because I was intrigued by it.

It bothers me that other staff members would work on my ward for the week because of their attitude. They might put on a gown unnecessarily, look terrorized, or look suspicious, or condescending maybe. Or, begrudging that they are a housekeeper. I just go in, and if someone has thrown up, "Well, if you didn't do that, I wouldn't have a job here." Somebody has to do that job. There's other unemployed people around, so it's not a big deal if they barf. I mean, they didn't do it on purpose.
I just want [the patients] to be as comfortable as they can be. They are already bitter and unhappy sometimes. If I can just go in unobtrusively and do my job and get it over with, that's good. But, if I can go in and make them feel comfortable, that's even better. If I was [a patient], I would want to feel like the [housekeeper] was being professional, and was competent. I try to relay to them that I'm not going to run out on the street and say, "You should have seen 'Joe Blow'. I recognized him. Oh my god!" That's probably one of their biggest fears. Especially if they're in there with AIDS. Especially if they're in a state where they haven't come to terms with their illness or their death.

I think part of my job is to be an active part of a ward that I'm on. An active participant. I've never thought that I've been working for the Housekeeping Department. In my mind, I'm working for the Head Nurse or the nurse in charge. I'm going to do whatever needs being done on the ward. It doesn't matter what the union tells me I can and cannot do. If the ward needs something done, that's where I'm working. It reflects on me. I'm not going to do the nurse's dressings, and I'm not going to do things that are going to put me in jeopardy with compensation. But I think part of my job is working with the team and getting to know them.

I really enjoy recognition, and it almost invariably comes from the nurses. I also enjoy the older people — elderly people that reach out and grab your hand. You sit there and talk to them for a minute, and let them hold your hand.
That makes me feel good. That's my best day when I have a sweet old lady that's having a good day and appreciates the work I'm doing and maybe thanks me for it. It means more coming from a patient, I think, than a nurse.

That was one of my hardest things to do working there: there is no recognition either way. No one has ever told me that I'm doing a bad job, or that I'm doing a good job. I resent the fact that we're not evaluated either way. "Joe Blow" doing nothing over there is making $12.36 an hour, and I'm making $12.36 an hour. Eventually you have to decide, "Okay, I'm working for me. I work for this ward." That's why I separate myself from the department a little bit. I'm not pretending I'm not in Housekeeping. It's just I have to have a focus. I have to have someone who I'm working for. I think it's a result of no feedback, but you watch people fall from being a good employee to being a regular employee. They come in great guns and they expect someone to come and at least give you — not do a white glove test, but — at least give them something. They don't get it, and then they just slip. As soon as you're bitter, you're guaranteed to find someone else who's bitter who's going to give you reinforcement. Once you've lost somebody who can go to a shift and not do a thing for seven hours, that becomes the standard that they work for.

It's discouraging that I'm falling for it. I was talking to another HEU member the other day about sick time. I use that as a benefit now on the job. I can get sick when I want and get paid for it. It's too bad because it's abusing the system, and, intellectually I know that is wrong. It's wrong to phone in sick
if you're not sick. But, it's there, and being used. There was Helga in Emerg.

Never sick a day in her life. She retired, and big deal. She ripped herself off of all this money which she could have made by not working so hard all of her life. It's unfortunate, but that's the way we start to think about it. It feels bad to be powerless against something that's destroying itself.

The hospital administration: how do they think we fit in? I don't know. I think that one on one, they value us. But I think when they are confronted with the whole global issue of running the hospital, then we become devalued. They have to prioritise as to what is most important. The same way as I prioritise on the ward about what I think is important. Then we get shuffled down. I don't think we are as important as we think we are. Housekeepers don't deserve to be paid as much as a doctor because they haven't put any time into it. They're not using their brain. Doctors have an investment, and they deserve to be compensated for their toil. If you choose to be a housekeeper, that's fine, and you're no less a person. But you can't expect to get remunerated the same way. There's a value to everything in the world, and I think nurses are more valuable.

Are there any aspects of my work I find particularly difficult or disturbing? Sometimes it's difficult for me to go into an area untrained and unaware. It's really hard to go in somewhere cold and feel like an outcast already. If the staff
in there are bad, they really can make you feel like the lowest thing on the
totem pole. That is disturbing for me.

I think that anyone who would agree to the interview is going to be a
type of person. There's a personality trait that is going to agree to do this.
They're maybe less jaded. Have you interviewed people that we both know
would be really negative about this sort of thing? Like have you been able to
interview people like [name]? There are some people that are going to give
you everything they think you want to hear, and [that person] would give you
everything you don't want to hear. Just out of principle.

Being able to say you goof off is part of that living-body thing, because
that's a natural thing to do, right? People that deny that they ever screw
around are pretending that they're not real. The person has to be comfortable
or else you say what the interviewer wants to hear. The whole time I was
sitting here, I was answering you and thinking. I'm so conscious that there's
always two answers in my head. I would have to choose what I want to say
and not the one that I think you want to hear. You evaluate the person you're
talking to as to whether you can trust them with your answer.
Harry

The idea of nursing has always been in my head, so the number one reason that I went to Saint Paul's was probably for the money, and the number two reason was to work in the environment — see if it was what I wanted.

I think that a big part of our job is (I find this very important), there's a lot of verbal work that goes on with the patients from just the basic, "Good morning. How are you doing?" It gets pretty boring and stuffy in a hospital room. Especially if they are bedridden. More importantly, especially on an AIDS ward when you get called to go in and clean up poop that's from a bed to a bathroom, I go in there with my number one objective to change the subject. To clean it as though I were doing nothing more than cleaning a smudge off a window — without any reaction — so as to try to salvage some of the person's pride. The last thing they want is for someone to go, "Yuck!" They feel bad enough as it is. I think you have to have a lot of compassion for their illness. Change the subject. I go to humour, and try to get them laughing as quickly as possible so they forget about it. I just clean it as though it was anything.

While you're scrubbing a tub and a toilet, you may as well be chatting. It makes the patient feel a lot more comfortable. It brings their day up. That's why we're there. We're there to make a healthy environment for the patient. I don't think that is just using [cleaning solutions]. I can't honestly say that I
enjoy the cleaning part of the work. But, I forget about it when I'm chatting with people.

I see [the things I do that are not on my duty list] are [part of my job]. I think that we get away from why we're there. I found when I was on [ward] I got to know the nurses very well; and, contrary to what the unions would like to hear, we used to help each other out a lot. I would help them out a lot, and they would even help me out if I was a little bit behind because of helping them. I even had nurses that would wipe out the sinks for me. I think that's one of the major problems of the health care system: it's not a team effort. I don't expect nurses to be running around cleaning everything. But there's been lots of opportunity where a nurse has needed a hand and I've helped them. Often, I find that patients are buzzing buzzers when all they want is a glass of water.

It's very rewarding to receive flowers and cards from patients along with the nurses. When they got their thanks-for-everything-stuff, there was always a mention for me, or a separate card for me, or flowers, or a bag of fruit, or something. "Thanks for keeping my room so clean, and brightening up my day each day." I think it makes it all much more tolerable because I can't see that anyone can honestly say that they enjoy wiping up shit.

I like working on patient wards. It comes back to being able to chat with them, and so on. I can tell you what I definitely don't like and that's cleaning administrative offices. It bores me to tears. Drives me crazy. I really enjoy working in Emerg a lot. I like the hurriedness of it. I like the whole geography
of it (for lack of a better word). I mean the nurses. I mean the people. I mean the drunks coming in. The beds: when there are eight beds to be done, and they all have to be done two minutes ago, I like that. It's always hopping. I've got very close with them down there too. So, they're very good about it . . . They don't treat me like a housekeeper. I hear a lot of housekeepers complain that they get treated like dirt by the nurses.

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Is there a difference between what [others in the hospital] perceive my position [in a hierarchy] to be and what I perceive it to be? I don't know. I can see where people have a problem with the nurses or even administrative staff leaving nasty notes and stuff. I really think there is a stigma. I do think that they think that we're all a bunch of brainless wonders. It's always been a big effort on my part to break that barrier. That's why I get along with other employees so well: because I break the barrier. Especially by doing a good job. When I got on [ward], [the supervisor] said the only reason I got on [that ward] was because nobody wanted to work there because the nurses had such a bad reputation. If you've noticed on my name tag there's a little pig hanging on it. They gave it to me when I left. They threw a little party for me, and they gave me a pig to remember them because they were all pigs.

It's difficult when you are working casual, to give an area your all when you spend a quarter of your shift trying to find your area. I think that gets difficult, and I don't think that they realise how often their area is covered by a
casual housekeeper. I think that we get labelled as lazy and no good. I think they definitely see us at the bottom, and I don't think that people realise how important our job is. You cannot practise medicine in an unclean environment. We're the spokes of the wheel. But I don't think that people place us very high in the hierarchy. I try to ignore that. I try to get rid of that. [On my regular ward], they were very good about it. Within a month, I think everyone on the staff was treating me as an equal. We were all there for one reason, and one reason only. That was to make somebody healthier, and get them out of there.

I happened to come in there right when they had been getting a lot of casuals. They were really down on the employees of the Housekeeping Department because they were getting some that just weren't doing anything. You're going to get people that just aren't doing their job. The fact that I was doing an extra good job just to break that, and also letting them know that they could count on me when there was a major spill or something [made a difference]. I would clean the nurses' bathroom maybe three times in a shift just to make their environment a little more comfortable. I think that they appreciate it because nurses work their butts off. And, to make myself part of a team instead of being the lowly housekeeper as they perceived the position to be.

I probably went further than I should have. It's because of my nursing interest that I did, and my love of people. I probably spent more time than I should have talking to patients, and perking them up a little while I was
cleaning. I got concerned a couple of times that maybe I was building up something that [the nurses] would expect from other housekeepers when I wasn't there. I was afraid that one of the nurses might say [to another housekeeper], "God! I'm going crazy. If you've got a couple of extra minutes could you just make that bed for me?" And the housekeeper going, "Sorry, that's not in my job description." Or, "Who the hell do you think you are?"

I sincerely do enjoy working with the patients. Quite often I would work evenings during the week and on my breaks I would go back up and visit with [the patients on my regular ward]. Go sit with Mrs. "So and So" who happened to be particularly lonely, and didn't have a family. I see it make a difference. There was one lady that was just really down. She was an ex-opera singer. I took her in my C. D. Walkman, and left it with her with all my classical opera music. She picked up a hundred percent. The nurses couldn't believe it. Just having someone young there talk about opera. Gordon is a very caring, compassionate person. I've seen him give up his breaks to take someone down for a cigarette, and wheel them back up. Then again, he has also created a trust and a team-thing on [his ward]. His nurses trust him enough to take a patient down. I don't think we're even allowed to do that. I think we can get into a lot of trouble for that. I know that it's not just Gordon and I. There are other housekeepers out there who do the same thing. But then, there's housekeepers that don't. So, there's a friction there.
I find it very ironic that none of that is ever brought up in the hiring. Maybe those people that worked in [the contracted company that was the previous Housekeeping Department management] didn't even know themselves. I was even told by [a supervisor] not to talk to the patients; not to interact with them in any way. I just simply go in there, do my job and get out of there as quickly as possible. I was afraid to cross that line because I was specifically told not to. I mean, I have fed patients by hand. I've dressed patients. God forbid any of the union people should find that out. I think they would have a fit because if I'm helping feed a patient, or if I help him put his pants on and he falls over and breaks his neck, do you think that the hospital is covered? Not a bloody chance!

I'm not bothered by anything. It doesn't bother me to be mopping and see somebody getting their head stitched up. None of that bothers me. If anything, it's the other way. It fascinates me. I know you said you had a problem with poop. I have no problems getting my hands right in the toilet and getting the sucker clean when somebody's had a really major accident. I can't think of one thing that bothers me except for toe nails in the bath tub. I think you need to have a sense of humour about it. It's the only way to survive. Once I had to empty a guy's spittoon. "Can you empty that?" He happened to
be blind, too. It was like a Dixie cup full of black spit. It was warm when I picked it up. I just went out and joked about it with the nurses.

I've met housekeepers that just hate people and just refuse to chat. Even if the patient is talking to them, they don't respond. They're just a robot going in there and doing their cleaning. I think that those people don't belong in that environment. I love the hospital. I especially love Saint Paul's. Once I get my nursing I'll be back in there like a dirty shirt. I think that Saint Paul's is a special place. Most people get in by knowing somebody. I think that's a great system because, personally I would never recommend anybody that I thought might reflect upon me in a bad light. You have people that you already trust recommending people that they trust. I think that builds a good environment.

When I was in theatre — just a short little analogy — I felt that I would be a much better performer and actor if I had "crewed" a show before. So, I made a special effort to work back stage for a period of time to make me a better performer. Likewise, [once I'm in nursing, having been] in Housekeeping will make me a better nurse because you learn to respect other people's jobs. You've been in their shoes. If you've filled the shoes of the people around you, that makes you treat them better, and respect them better, and understand where they are coming from. [As for the patients], I get to hear their complaints
about the nurses and, always I go out of my way to rectify that and to leave the room with them feeling better about their nurse. I would have that understanding of what the patients are feeling about the nurses. I've had the opportunity to see and hear the opinions of the patients.

For some reason, patients feel closer to their housekeeper than they do to their nurse. I really believe that. It's amazing what they will confide in you about where they won't even talk to their nurse. Maybe it's just because you're just in there briefly. Maybe it's because you're not poking them with a needle every time they turn around — sticking things in their ears and up their nose. You basically go in there, and you chat on a casual level. I would try to be more casual like the housekeeper is. And more honest.

I think that we're an important link in communication between the nurses and the patients because with us, it's another body going from room to room. Many is the time that a patient has not been able to ring his buzzer and I have run out and said, "So and So needs help with this," "So and So needs help with that," and, "It looks to me like Mr. Johnston's dead." The nurses went in and sure enough, he died while I was mopping under his bed.

I also try to treat every room like it's my first room of the day. I think that will be something that I will incorporate into my nursing. [If you think,] "Here comes another bloody patient," you don't even realise that you're missing out on probably one of the nicest ones. If you give everybody a fresh start when you walk in you get more in return.
Janice

This is a strange place — surreal. I was often in the old ICU. I've only been in the new one a few times. I must go into the rooms to get the garbage. It is late; around nine o'clock. The hospital is different at night. Most of the main lights remain on, but there is no light coming from outside through the unshaded windows, and the nurses have turned the overhead lights off in the patient rooms.

Each patient has his or her own nurse. The nurses sit in the rooms or outside the glass wall and watch. The nurse sits at a small table, the patient's "over the bed" table which the patient doesn't need. There is a very large chart on the table. The nurses jot short, almost imperceptible notations on the charts. They frequently get up and go to the patient and make some adjustment to dressings, tubing, or machinery.

I move around in these rooms almost unnoticed. As long as I don't stand still, no one appears to take note of me. I move very slowly because I am a little overwhelmed by what is around me. There is a bed, of course, and stainless steel cabinets, and bedside cabinets; but, there is a glut of tubing, machinery, beeps, air mattresses, wiring, monitors, respirators, IVacs, poles, lights, and more monitors. It takes several moments to take it in. Things are hissing, blinking, beeping, and puffing. Finally, I become aware of the patient. The patients are surrounded — embedded actually — in so much paraphernalia it is hard to notice them. In one room, two interns and a nurse hover over a
patient. They are doing a cut-down procedure on the patient's arm in search of a vein for yet another interveinous line. Their patient is oblivious to them and their procedure. They are working with just the light of a lamp they have pulled out from the wall over the patient's head. It is the lighting mostly which makes me remember *The Anatomy Lesson of Doctor Tulp*, a painting of medical students huddled over a cadaver, dissecting it.

These people are so sick, it is difficult to believe people could be so sick and yet live another few hours. I always feel badly for the families of these patients because the families are unaware of this ward's statistics. They don't know what it means to wait outside this ward to see their loved one.

There are very few sounds from the patients that aren't related to the machines (the respirators especially), but periodically a patient moans or whimper. The nurses don't seem to respond as easily to those sounds as they do to the alarms from the machines. In one room, a patient moans quietly and the nurses continue to talk to one another. On the other side of the room, another patient's monitor begins to sound its alarm. The nurses continue talking for a few seconds, then glance at the monitor. One goes over to reset it. I think the nurses respond to the machines rather than to the patients. I can understand why. It is as though the patients have somehow ceased to exist in all the paraphernalia.

Outside another room is a sign which instructs quiet because the patient is on the drug pavulon. The patient is a sixteen year old boy with leukaemia.
The drug is to induce full paralysis so the respirator can completely control his lung function. His natural breathing was resisting the respirator. The instruction for quiet is because although the boy appears to be unconscious and unaware, he may be awake and listening.

ICU is a strange, disorienting place. It has every piece of medical technology — all ticking, clicking, blinking — and all the medical technologists — nurses, residents, interns, doctors, and respirator therapists are sitting, standing, talking, and walking about — but it is also as though there are no patients in this place.

I am picking up the garbage in ICU again. A woman lies surrounded by all the usual machinery. She is on a water mattress in hopes she won't develop pressure sores. She is in a coma. This is an unusual patient in that there are two young people sitting with her, one in front of the other, like passengers on a bus. They each hold a book in their left hand and one holds the woman's hand with his right hand. The other strokes the woman's leg. While I am there, the woman shudders and shrugs her shoulders. Her children simultaneously lower their books and watch her breathlessly a moment. When they see she will not move again, they resume their reading.

The boy with leukaemia is the same. No. Much worse. He doesn't move at all. Even his eyelids don't flutter under the tape which holds them down to protect his eyes from drying. His face is puffy and discoloured. There
are four people with him. Two young women stand at the foot of his bed. One holds his foot. An older woman is at the head of his bed and leans down to speak into the boy's ear. A man stands behind the woman. I imagine these people are the boy's family — his sisters, and parents. Their faces are obscured by the masks they must wear to protect the boy, but I recognize the look in their eyes. It is a kind of impending grief look. They are shocked in anticipation of what is coming very soon. They know the boy will soon die and they are trying to steel themselves for the pain. There is another man with them. I think he is the boy's doctor or perhaps the father's father.

I really only glance through the glass wall. I have the sense this family time is very private and it is rude to look. Perhaps this has something to do with why the ICU staff tries to restrict visitors. Even the boy's nurse is trying not to look.

Late in the evening I see the father and the father/doctor leave together. The father is speaking earnestly. The father/doctor speaks quietly, as though reassuring him. It is not until I return to the unit the next night that I understand what I saw the night before: The boy's room is empty. All the paraphernalia is gone save for one IVac whose small red light is still on in the darkened room. I realise then the family was saying good-bye to the boy because they had come to turn off his respirator and allow him to die.

Outside the ICU I find more of the woman's family. I ask about her. She fell while hiking. A head injury. Surgery. Coma. She is fifty-two. Her children
are there. They are in their twenties. Her brother waits with them. Another sister has arrived from the East Coast. I have never seen a patient so well supported by her family. The family is getting some resistance from the ICU staff because the family insists on remaining with the woman at all times, and the ICU staff resists outsiders in the ward. The family is certain the woman knows they are there, and they are certain she needs them and is drawing on them for strength.

Even though I am evidently a janitor, I am always surprised by how much family suspect I will know because I work in a hospital. I can offer some reassurance because I know patients like this woman can suddenly improve very dramatically. I tell them this. The doctors have told them this too. My saying it makes it something other that just medical knowledge. Now it is a kind of folk wisdom, too.

Four nights later, I am back again. The woman is in a different room. She has been extubated. She is off the respirator and all the IVs have been removed. She opens one eye and labours it to follow me in the room. I smile at her because I am relieved to see her improvement. She moves restlessly in her bed and keeps trying to follow me with one eye. I tell her I am happy to see her getting better. She closes her eye, then opens it again. I think she has winked at me.
CHAPTER IV

The Gazebo
That little bell, it sure gets the shivers going.

It's just kind of automatic. You know something big is happening.

(Andrew)
In 1983, I was employed by Saint Paul's Hospital to work in the Central Supply Department (CSD). This is the area of the hospital where instruments are cleaned, sterilized, stored, and dispensed. When I began my employment with the hospital, I was made immediately aware of an intricate system of ranking operating both in the Central Sterile Supply Department, and in the hospital as a whole.

We have not been here long. Because the new department requires more staff than the old, there are many new aides in CSD. A certain status is attached to those of us who worked in the "old department." Even I have benefit of this status because I worked one shift there. Following that shift, I worked two weeks of "nights" helping to set up the new department before anyone else moved over. As a result of those weeks, I know where everything is here — even the obscure specialty items secreted away by the nurses. This has improved my standing in the department with some aides, but angered others. This special knowledge in a junior person has disturbed the ordering of the CSD aides.

Lois and Mary are at the top of the order due, in part, to their seniority. They are very different from one another. Mary is from the Caribbean. She speaks with a slow singsong delight, and moves about the most slowly of all the aides. This, she
claims to be "the way things are done" where she comes from. She knows where almost everything is and the work she does is admired by the others. So, in spite of her pace, she retains the high status that is attached to the number of years she has worked in the hospital. Lois is quicker. She is also extremely good at her work, but she is often very irritable for reasons that are never clear.

If an aide has questions about how to do something, she must first ask Mary or Lois if they are "on shift." To ask someone other than these two — even to ask a nurse — creates enormous tension. It is seen to be a slight to the senior aides. Choosing Mary or Lois must be done with great tact, making sure never to ask one more often than the other, and making sure never to let on you think one has made a mistake by asking the other for her opinion. It is best to do a thing the way they have instructed even if you think it is wrong. It is better to take reprimands uncomplaining from a nurse than ever to say, "But Mary (or Lois) said . . ." This results in being shunned.

The first long trek from my locker to CSD taught me that smiling and greeting people in certain outfits might be met with a frown since I wore the uniform of a CSD aide. Over the years, the separation of working groups has
become less pronounced. Nevertheless, it does persist, and I continue to be
fascinated, perplexed, and troubled by the phenomenon.

It is interesting to note that while support care workers experience
anonymity which they attribute to their uniforms, administrators also experience
a certain anonymity with support care staff. Some months ago, I attended the
hospital to be interviewed for a research position and part of that experience
illustrates how we are noticed or not in the hospital because of our style of
dress.

I am wearing a long skirt and pumps. My shoes make a
clop, clop sound as I hurry along. I pass a co-worker in the
corridor, but he seems to ignore me. After I stop, and turn, he
explains he did not "see" me because he had assumed by my
outfit I was "one of the managers." Later, I clop, clop along a
hundred and fifty feet behind some managers who are returning to
their offices from a break together. They stop and peer back
down the corridor trying to distinguish who I am. They wait,
politely intending to greet their peer. We are all a little
embarrassed when they see it is only me they have waited for.

As a consequence of my interest in the hospital's hierarchy, during my
first year of university studies, I attempted to understand what might explain
such a rigid hierarchy. While reviewing literature in preparation for that paper, I
learned that support care workers have largely been ignored in health and
illness research. This omission of support care workers and parallel concentration on health care professionals seems to correspond with the status ranking of hospital services at Saint Paul's. In other words, the higher the status of the service within the hospital, the more visibility the service has both in the hospital and in research done in health care settings. Still, my hospital employment taught me that support care workers are often a link between the institution and its professional staff, and the patients who are treated in the clinic. Simple examples of this are found in the profiles, for example, when volunteers mention taking messages about patients to nursing staff. ("I think Mrs. So and So needs assistance," or "I think Mr. Johnson has passed away.") Other examples come from Andrew and Barb's talk about helping patients and visitors learn to "get around" in the facility. Support staff liaises with patients and visitors in more complex ways as well. For example, Harry pointed out that housekeepers are sometimes asked by patients to explain the actions of nursing and other medical professionals. The patient, the volunteers say, might speak openly to his housekeeper regarding how he is feeling, but be less than communicative with his nurse. For these reasons, the frequent absence of support care workers in health and illness research is puzzling and provocative.

An interesting way of understanding why a patient may be more communicative with his housekeeper than with medical staff can be taken from Goffman's work, *Asylums* (1961). Using Goffman, we might claim that the differing communicativeness could be a result of the patient's desire to control
personal information and the interpretation of that information by others. For example, the patient might that fear an admission of discomfort due to pain will be interpreted unflatteringly as "complaining." The patient knows his behaviour and what he tells a nurse (if judged to be relevant by the nurse), and the nurse's observations, assessments, and interpretations of that information will become an aspect of a semi-permanent record by its inclusion in the "nurses' notes" and "patient chart." The chart, Goffman reminds us, is available to several people with whom the patient comes into contact. The information in it and in the nurses' notes is routinely exchanged with other staff during "report."

"Report" is a function of every shift change. At this time, the two shifts sit at a conference table and the shift going home reviews the patients' charts and other observations about the patients in their care for the benefit of the incoming shift. Sometimes this information is transmitted to the incoming shift by an audio tape. Observations commonly include information about the patient's apparent emotional state, guests that have visited, information about tests and medications, and progress reports.

"Report" is also given to nursing administrators, to social workers, and to doctors "on rounds." Although these exchanges usually take place in conference rooms and are considered confidential, interns and teaching physicians may exchange "report" while standing in the nursing station or in the corridor outside a patient's room. Here, their comments can be overheard by
other staff and other patients. Strauss (1984) addresses this in the following way.

In the hospital a patient's body becomes much more open to public scrutiny, shared territory for all kinds of personnel who lay claim to its examination and manipulation. When carrying out their various trajectory tasks, the nurses, physicians, technicians, and other health workers manipulate and expose the body, inserting instruments, needles and tubes into it. The status of the body is so openly discussed among the staff that even visitors and other patients may over-hear the talk (Strauss 1984:155).

The nursing chart understandably becomes an uncomfortable aspect of hospitalization for patients. The minimal control a patient can exercise regarding what appears in the chart and how he is discussed is available only through deliberate choices with regard to what he discloses to his medical professionals. Thus, the patient may choose to be guarded with professional staff recognizing that it is these individuals who create the assessments and prepare information that he is never able to see and respond to.

Another way to understand why patients might be more open with housekeepers comes to us through Parsons's "sick role." When a medical professional inquires of a patient, "How are you today?" the question is taken by the patient to be an inquiry about her medical condition in relation to the reason for her hospitalization. During her interview, Barb suggested that this is
an accurate interpretation of the medical professional's question. Barb also noted that these professionals often have the harried appearance of someone rushing about, intensely concentrated on completing the tasks required by their work. It is unlikely to her that the medical professional will have the time and inclination for more general chat. Returning to Strauss, we find support for Barb's observations.

The various technicians who move in and out of patients' rooms are very much focused on their technical tasks and very little trained in the niceties or the physiological technicalities of comfort care (Ibid., p. 153).

Thus, having correctly interpreted the question as one requiring an answer from the point of view of her "sick role," the patient responds appropriately with information and descriptions regarding her current medical condition. For example, she may say, "The pain is more intense than before and has moved to the back of my leg." Ian is paying his way through medical school partially by working as a janitor at the hospital. When I discussed this observation with Ian, he indicated that the detail the patient gives is significant. His diagnosis and treatment are influenced by information that the pain has intensified or moved. Thus, he will press for these details.

When a housekeeper asks the patient, "How are you?" the question is often responded to with the standard, "Fine, thank you." The question is not always interpreted by the patient as one requiring a response from her "sick
role." As Andrew reminds us, housekeepers avoid using the words, "How are you?" to initiate a conversation, preferring something less likely to be interpreted as a medical inquiry. This is done so as not to be intrusive, to avoid encouraging the few patients who take the opportunity to produce a litany of sorrows, and to give the patient an opportunity to talk about something other than her illness. For example, by commenting, "What beautiful flowers!" one might give the patient an opportunity to talk about her garden or her friend's garden, and the housekeeper creates the opportunity to enjoy a friendly exchange about flowers.

Housekeepers' initial conversations with patients and their guests are often general in nature, and not inclined to be directly related to the patient's medical condition. As the conversation evolves, however, patients sometimes begin to talk more about their current health and their concerns about their hospitalization and illness. In this way, the housekeeper may come to know something about questions the patient has regarding her health or her surgery, concerns she has about how her home is functioning in her absence, or discomforts she is experiencing as a patient. Housekeepers take these opportunities to pass along information to patients about how to get along in the hospital; for example, "Don't choose the beef stew if it's on your menu, but the soups are usually good," "You should ask your nurse about that," or "She's a good doctor."
The interview volunteers believe that they are the only people the patients talk to who are not immersed in the fact of the patient's confinement. Housekeepers do not play a role like that of the worried visitor. They are not the care giver "who knows something the patient doesn't," or is going to "stick him with a needle," or "stick something in his ear or up his nose." The patients' and housekeepers' exchanges do not take place within the context of the patient's "sick role." They are more like the friendly experiences of strangers or acquaintances. Consequently, some volunteers suggest they "know more about the patients than the nurses ever will."

The volunteers suggested another explanation for the quality of their relations with patients. As Andrew put it, "I'm just your 'Average Joe'." Just as most people are not professionals, neither are most patients.

Mortality rates among the adult working population parallel the progressive incidence of illness that occurs as one moves down the social hierarchy. In 1982, the death rate of adult professional and managerial employees was 23 percent below the overall average, while for unskilled workers the death rate was almost 40 percent above the average (Bilton, et al.1988:72)

Whether linked to the economic ability to afford nutritious food, occupational health and safety issues, or to education, illness and hospitalization occur at higher rates as socioeconomic status decreases. Thus, patients and their visitors are more often like support staff in socioeconomic status than they are
like the health care professional. Shared language, the volunteers suggest, is an important factor in understanding their interaction with patients. These volunteers believe, because they do not converse in elaborate medical jargon focused on illness and treatment, that they are less threatening for patients. This, in turn, encourages the patients' openness with the housekeepers. The non-threatening nature of the encounters reflects back to conversing with the patient in circumstances removed from the "sick role."

Most information shared between patients, visitors, and housekeepers will not be crucial to a patient's recovery, and it is, therefore, not considered important by the housekeeper that it should be passed on to the care givers. However, periodically, patients are observed by support care workers, "doing drugs," or a housekeeper might realise that a patient is not taking medication because a small tablet has been dropped onto the floor. Housekeepers do not keep this kind of information to themselves. They weigh it against what understanding they have of nursing and medicine. They may consult with one another or with nursing staff with whom they are friendly in order to understand the significance of the information. If it seems important or if there is doubt about its significance, the housekeeper will usually pass this information along to the patient's own nursing team. This report may be treated with interest by nursing, but at times the housekeeper senses her concern is judged to be bothersome or impertinent. An excerpt from my journal will illustrate how this is problematic for housekeepers.
An old woman rushes up to me looking earnest and afraid.

"Where is the bathroom, please? Oh, please, where is it? Hurry."

It is not far away — thirty feet only — but she has forgotten where it is. I look around for one of the nursing staff to take her to the bathroom because I am not allowed to, and I'm not sure what to do with her once I get her there. But, there is no one, and she is pleading with me to help her. I walk with her. She takes those tiny shuffled steps of the truly ancient, and we arrive too late. She is devastated and embarrassed. She cries, and I try to reassure her. I don't know what to do, but sit her down and go for help. I tell them at the nursing station that she is in the cubicle and in urgent need of their assistance.

Ten minutes pass and I check on the old woman. She is still sitting there weeping, and no one has come to help her. I go back to the nursing station where they tell me her nurse is still at lunch. Finally, I am able to persuade them that the old woman is in need of them and someone goes off to help.

During a discussion with the Healthy Hospitals Project coordinator, it came to light that there was some confusion about whether there was an admonishment that support care workers must not "touch" patients, and if there was, where it came from. Nevertheless, most housekeeper recall being told there are no circumstances under which they may assist patients and they should instead
"get a nurse." This is not usually an easy rule to follow. Some patient needs are particularly urgent and others are especially simple. As Andrew tells us,

[The nursing staff] is not there. So, instead of letting [the patients] wait for five minutes or ten minutes, it's just as easy to run out in the hall and grab something, and run back in (Andrew).

Because I had learned that support care workers can play an important role in communication between patients and visitors, and the institution and medical professionals, the general absence of support care workers from health and illness research struck me as naive, if not astonishing. In some health care systems, it is expected that support care workers will play a significant role in communications with the patient. For example, Doctor Helen Huston established a medical clinic and then a hospital in Nepal during the 1950s. She worked there and trained Nepalese to work there for the next forty years. Recently, we had the opportunity to discuss the absence of support care workers in western medicine's health and illness research at considerable length. She expressed disbelief concerning this absence. In Nepal, she said, people who do support care work are expected to have important opportunities to pass information to the patient and to collect information from the patient. For these reasons, support staff is routinely trained and prepared with a basic medical knowledge concerning the patients they meet. In other words, it is anticipated that the support care worker has opportunities to exchange
information with the patient that the professional staff may not have, and the support care worker is consequently prepared for that event.

It was my experience while working in a health care facility that was the reason for my dismay in discovering the absence of support care workers in social science research. But I imagine readers who are less familiar with a hospital's working environment, are a little surprised by the extent and quality of the interaction between the volunteers and the patients that they have discovered in the profiles. Frequent mention of this interaction in the interviews is not a result of the way the interviews were conducted. Rather, it is an accurate representation of the ways that patient needs figure into the work day of someone employed as a janitor in the hospital setting. As a graduate student, I was careful, when talking about my research project with people who might one day be my volunteers, not to betray my specific interest in the interactions between support staff and other people in the hospital in detail. Also, this specific interest is not mentioned in the consent form, or during the introduction or questions. The volunteers might have oriented their interview responses to janitorial tasks and omitted mention of other people altogether — especially mention of patients and visitors. Yet, to varying degrees, all of the volunteers took patients and visitors into account in their responses. In some cases, volunteers began to talk about the patients almost immediately, and these volunteers indicated that for them the patients were a very significant aspect of the work.
Harry only very briefly described his job duties and then said, "I think a big part of our job is, there's a lot of verbal work that goes on with the patients." Both Harry and Gordon spoke spontaneously and at length very early in their interviews about their commitment to the emotional comfort and general well-being of the patients. In other cases, volunteers simply mentioned helping patients get around, sit up, get dressed, or they talked about bringing water, housecoats, or towels to patients during the course of describing their duties. When I stated, "I notice you do things not required by your duty list," and that I wanted to hear more about those things, Andrew and Dot began to speak at length about what Andrew called "patient interaction." Otherwise, the question, "Do you do things that are not formally prescribed by your duty list?" was usually understood to be a question about where patients and visitors fit into the volunteer's work day. This was the point at which Barb began to tell stories about her encounters with patients. Nevertheless, this question was not always interpreted to be an invitation to mention encounters with patients or visitors. Edna, for example, did a mental inventory at this time of how often she is asked by nursing staff to do "extras" and concluded that other people are fairly well aware of what her job is. Consequently, she is not often asked to do things that are outside her assigned duties.

If the volunteers had not mentioned their interaction with patients before, it finally emerged when I asked, "Is there anything you find particularly disturbing about your job?" Fred then expressed his concern.
Sometimes some of the ways some of the patients get treated. I find, that, ah [pause]. Sometimes they tie people down. Things like that, I'm not too sure. But then again, it's not my position to say. It's getting better. When we got the new security system [a new security manager] in there. They can be quite forceful sometimes and I didn't think it needed to be quite that, that [pause]. That's about it. I see, I don't like to see young people die, too. It's disturbing to see. 

Edna was the only volunteer who said very little about patients or visitors until she knew that this was a key aspect of my research project. At this time, she confided she found it difficult to get her work done if she worked in patient care areas, because she believed she was too easily drawn into conversation with the patients. In these circumstances, she found her concern for individual patients to be very draining on her emotional energy. Edna said she was, "always trying to help everybody do everything and always be there." She overcame this by changing her shift and work area to times and places where she would have limited patient contact.

Cameron's response to patients and visitors was particularly interesting. On hearing the introduction to the interview, Cameron was concerned that because he was trained as a massage therapist, he was someone with professional health care training, and, therefore, might not "qualify" to volunteer for the interview. Based on the facts that massage therapists are not trained to
work in hospitals and Cameron did not work in a hospital before joining Saint Paul's as a support care worker, we continued with the interview. Prior to meeting with Cameron, I had interviewed Andrew and Barb who had each treated patients and visitors as a significant presence in their work routines. Both spoke at length about things they did with and for patients and visitors, and about their conversations with patients. Cameron responded to patients and visitors in a way that seemed very different from Andrew and Barb. He concentrated during the interview on how he went about doing his work. His talk about patients and visitors was usually incidental to a description of the coping strategies he used to get his work done in spite of the distractions and obstacles to his work that patients, visitors, and other staff represented for him.

Cameron's experience with people who are ill differed somewhat from the other volunteers'. The clients he had treated in his massage therapy practice were people with HIV and AIDS. In the course of treating his clients, Cameron came to know each of them on a more intimate basis than we, as support care workers, usually experience with patients. As support care workers, there are individual patients whom we come to know and who become particularly significant for us. But for Cameron, each of his clients was an individual with whom he had a personal, though professional, relationship. Cameron developed a rapport with each of his clients and, on an individual basis, he worked very hard in helping them to overcome the discomfort, emotional strain, and pain associated with living with HIV and AIDS.
Cameron's clients were also people with an illness that resulted in their death. There was no way that Cameron's efforts to assist his clients to find comfort and well-being would overcome the reality of their terminal illness. During the last "three or four years" of his practice twenty-seven of his clients died. This experience was very disturbing for him and he said of it, "In retrospect, I knew that it was very hard, but I didn't know it then."

Later in the interview, we spoke again about his practice, and I asked him if he felt that his experience as a massage therapist influenced how he dealt with working in the hospital today, because Cameron finds it difficult to be in the hospital environment.

I've always been uncomfortable there [pause]. It's all foreign to me. The people that are very sick [pause]. It's not something maybe that I understand.

Cameron never really fully addressed my question. He agreed that the experience in his practice had been very difficult for him. He is acutely aware of the emotional risk of involvement with people who are sick, and he knew that he never wanted to "do that again." Nevertheless, Cameron also stressed the importance for him of "doing a good job" and the fact that he does not want to be distracted when he doing his work.

Initially, Cameron's response to patients and visitors seems different from the other volunteers' responses. But as I continued the interviews, I found Fred and Edna's responses to be more like Cameron's than like the other
volunteers'. Like Cameron, Fred and Edna concentrated on the work they did as janitors while other people in the environment remained in the periphery of their comments. Interestingly, these three also shared an understanding of their status in the hospital that was less troubled. In other words, their sense of being treated as though they were unimportant by other staff was less acute than for other volunteers. Although these three were not alone in this, their sense that the "good job" they do was noticed and appreciated seemed stronger than in the others. These three described themselves more easily as part of the "health care team," while other volunteers put more energy into trying to be recognised as "part of the team" or saw themselves as excluded from "the team."

Although some people are content in their employment as janitors in the hospital, no one imagines that someone aspires to the work. One does not grow up dreaming of becoming a janitor; not even of being the best janitor. It is work we fall into by accident. No matter how good a janitor you are, you will never be recognised in prestigious circles for your good work in the way that a good teacher or a good physician might be recognised for excellence. A janitor's excellent abilities as a janitor will never command a parallel ability to demand an extravagant fee for stripping a floor of dirty, aged wax and restoring it to some former lustre. The work is simply and obviously not work that is rewarding in any of these significant ways. Nevertheless, there are two main ways the volunteers find their work rewarding.
The first requires an objective orientation to the actual janitorial work. The volunteer looks at the cleaning work that has just been completed and sees a job well done. These volunteers have a sense of accomplishment in fixing something so that the environment is more healthy and more pleasant for co-workers, for patients, and for the public. When Cameron, Edna, and Fred experienced satisfaction in their work, it was for these reasons. Their reward was in doing a good job of accomplishing the chores necessary to address the needs of the people around them for a clean and tidy environment. Cameron, Edna, and Fred use objective criteria to measure this accomplishment. "It looks better." It was messy or dirty, they cleaned it, and now it "looks better."

The second way volunteers looked for rewards in their work was subjective. For example, in speaking about what she found rewarding about her work, Dot said,

That's one of the nice things about the job is I like the patients. Because I really feel like a lot of the time, (I'm so egocentric, but) I really think that when I show up for a shift at the hospital that I'm going to be a little bright spot on at least one person's day.

Barb suggested most "housekeepers are just social. That sort of breaks the monotony, doesn't it?" Whether to pass the time or otherwise, Andrew, Barb, Dot, Gordon, and Harry focus on the comfort needs of the people around them in their working environment. They watch for opportunities to help the patients, to offer encouragement, to keep them company; for ways to help relieve
patients' boredom or fearfulness; and for ways to reassure the patients and visitors, or to put them more at ease. What is rewarding for these volunteers is the belief that through these tasks, taken on voluntarily, they "make a difference."29

These volunteers feel rewarded in the belief that they have addressed the subjective needs of the people around them in a positive way. Thus, for example, when a small group of housekeepers learned an old woman was restrained in a chair for several hours a day, they began to take turns stopping by to hold her hand for a moment. Although she would spend many hours turning the pages of a magazine and studying the photographs in it, the nursing staff would routinely remove the magazine to give the woman her meal tray and not replace it when they took the meal tray away. Consequently, housekeepers began to take turns ensuring that the woman had a magazine put back on her table after each mealtime.30 Another janitor often spends a few minutes during the day in the Long Term Care patients' dining room playing their piano for them.

This, however, is not the assigned work of a janitor in a hospital.

Support staff's interaction with patients is a difficult issue because in a worst case scenario, support staff assisting patients can compromise the hospital's insurance and the worker's compensation. It can also create problems between unions. Yet, as individuals, many who work as support staff are concerned for, and interested in the patients in the areas in which they

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work. Also, housekeepers are frequently asked by patients and visitors for assistance. Thus, because of the prohibition conflicting with the apparent needs of the patients, comfort work is often done covertly.

No part of a housekeeper's work is assessed on the basis of interaction with the patients. Whether her work is satisfactory or not, is judged by her supervisors and most of her co-workers based on the cleanliness of her work area, her knowledge of the equipment, supplies, and solutions she employs, her punctuality, and her good working relations with other staff. Perhaps it will not be noticed that a particular cleaning task is not done on a certain day. But, if it is noticed and she is asked to explain it, the fact that the task was not completed will be the problem, and the explanation by the housekeeper that she was kept busy by several patients asking for favours or for company will not suffice. As a result, for some housekeepers, how they believe they make a contribution and what they find rewarding about working in a hospital environment conflicts with the expectations of their employers and other hospital staff.

Housekeepers are not generally recognised by other hospital staff as having the amount of interaction with patients that they do, or the amount of insight into patient care that they do. We are not generally understood to be an aspect of the patient care team. Bernstein will assist our understanding of the reasons for this. He writes,
There are deep cultural reasons and causes — as Gadamer, Arendt, and Habermas have argued — why in the modern world the only concept of reason that seems to make sense is one in which we think of reason as an instrument for determining the most efficient means to a determinate end, and why the only concept of activity that seems viable is one of technical application, manipulation and control. . . . Knowledge must be objective — or else it is only pseudo-knowledge. When values enter, they must be treated as noncognitive emotional responses or private subjective preferences. From this perspective, especially in its positivist variants, talk of practical or political wisdom or phronēsis as a special type of rational activity may have a certain charm but fails to live up to the promise of serious scientific knowledge (Bernstein 1985:46-7).

As a consequence of this, the very aspect of their work that is most rewarding for some housekeepers is not recognised by their supervisors, other staff, or their employers as a legitimate contribution to health care. It will not be surprising then, that among the people I interviewed, I found that the more the volunteer seemed focused on the patients and visitors, the more inclined that volunteer was to experience his or her work status as a burden. Conversely, the more inclined the volunteer was to judge his work by how well he performed
janitorial tasks, the less he was inclined to experience his status in the hospital as offensive, oppressive, or troubled.

I had an opportunity to test this finding after I had completed my interviews. Georgie is usually an articulate and enthusiastic woman. However, for several weekends, she seemed unhappy at work. I asked her why. She was very animated in explaining to me that she experienced working as a "housekeeper" as a stigma, both at work and in her private life. She described community work in which she is involved and explained she believes people do not take her seriously in that work because, after all, she is "only a housekeeper." She said, she is embarrassed that anyone would know that is her work, and consequently, sometimes resorts to sophisticated nomenclature to disguise the true nature of her employment. Since she was troubled by this and was interested in my thesis work, I explained at some length that I had found housekeepers whose focus at work was the well-being of the patients were more troubled by being "just housekeepers" than housekeepers whose focus at work was on their janitorial duties. I explained that I understood this to be so because the work that they did which was the most important aspect of their presence in the hospital (for them) was unrecognised and even expressly prohibited in the facility. My explanation failed the test with Georgie. She seemed to me to be obviously sceptical, and I was suddenly aware of how much my explanation must have sounded to her like a justification by a supervisor for an expectation that janitors should ignore the people around
them in favour of concentrating on their cleaning work. I hurried on to my second explanation.

For this we must return to chapter one and the distinction between Leib and Körper. I explained these two terms, making the distinction between a perspective that employees a concept of embodiment centred on the experience of the "lived body," and a concept of embodiment centred on the "body as machine." While biomedicine does not want to ignore the comfort needs of the individual who is sick, the dominant concept of embodiment in a biomedical system is based on an understanding of the human body as "body as machine." The body's needs for nutrition and hydration, for example, might be overcome with feeding tubes and intravenous lines. When the body breaks down, it might be catheterized, drugged, x-rayed, tested, and connected to monitors. But, as Strauss tells us,

In addition to the changes in technology, medical interventions, and the chronic illness trajectories themselves, the characteristic organization of today's hospital also contributes to making comfort work a complex issue. The institution is organised principally around the giving of acute care, meaning an intensive focus by the personnel around strictly medical aspects of diagnosis and therapy (Strauss 1984:153).

An excerpt from Blum will suggest a way of deepening our understanding of this concentration on medical technique.
Disease, then, is the price members of society pay for the societal indifference to nature as anything more than a source of abundance or scarcity. Society in this state only relates to nature instrumentally in terms of its capacity to supply or withhold. There is no genuine interest in conserving or caring for the things of nature as worldly things, as culture, which includes among the many things, the bodies and souls of men (Blum 1982:14).

While the hospital's focus is on disease and illness, there is still the patient to consider. The patient may be confined to bed by her illness, confined to the ward by monitors, or restricted from eating by illness, tests, or surgery. Often, she must be dressed in hospital gowns to allow for convenient access to her body. Drugs may blur her vision or make it difficult to concentrate so that she cannot read or follow a television programme.

During confinement, her medical team is focused on her treatment. They ensure that she receives her medication on time. She must have appropriate exercise and physical therapy. Is her diet right? Are there signs of infection? Are there effects from the treatment that might forestall her recovery? Is she resting properly?

Nurses are sometimes still educated at schools that emphasize comfort care, but the organization of the ward work tends to pull both the [nurses and various technicians] toward the multitude of
mundane activities that help keep the ward functioning as an organization (Ibid., p. 153).

In other words, to address the requirements of all of the patients' medical regimens successfully, the ward must follow detailed routines.

The treatment will take time. During this time, the patient waits. She waits for her medication, waits for her doctor, waits for visitors, waits for meals, and waits to recover. If she is well enough, she might pass the time exercising by "doing laps" around the ward, visiting with other patients in the lounges or on the roof garden, or perhaps chatting with staff who come into her room or that she finds in "the link" waiting for an elevator. While she waits, there are comfort needs that must be addressed. Her meals are prepared for her. Her accommodations are cleaned for her. Her visitors are given directions to find her. These needs for companionship, meals, a clean environment, and relief from boredom correspond with a concept of embodiment that parallels Leib, and as Blum and Strauss suggest, they are not well provided for by biomedical techniques.

Jobs closely associated with "the lived body" (as ours are) have a status that parallels the problem of the "lived body" for biomedicine. The "lived body" is not ignored by biomedicine, but that it is not well provided for is evidenced by some patients' chronic boredom and loneliness.

Perhaps this is because medicine would say, under the auspices of its compassionate and technical gaze — we will take care of
the affliction and everything else should fall into place. But this "everything else" is nothing other than the being or life of the person when he is seen from the perspective of needing to be more than a patient (Blum 1982:21).

The "lived body" has a status in biomedicine that is like that of the support care worker. In other words, it is nearly invisible. It is left to "fall into place."

This explanation, much to my gratification, intrigued Georgie. She responded to it with enthusiastic interest.

Later that day, in conversation with the supervisor with whom I work, I recounted my conversation with Georgie. I began with the Leib/Körper explanation. She regarded me with scepticism. A little embarrassed, I fell back on my observation that a differing source of reward for janitors in janitorial work versus patient interaction seemed to influence the worker's sense of status in the hospital. The more reward the worker found in a cleaning job well done, the less troubled the worker seemed to be with regard to status. The more the worker focused on the patients' needs, the more troubling those workers found the experience of status in the hospital; and the more likely the worker was to express his or her working status in terms of stigma. She thought for several minutes about this. She mentally tallied the housekeeping staff she knew and judged the focus of their work. She guessed the correlation between her co-workers' focus and their talk about their status in the hospital. Then, she smiled and agreed enthusiastically.
There has been a serious morale problem in the Housekeeping Department at Saint Paul's for some years. The difficulty is costly because it affects productivity and expresses itself in a rate of paid sick leave twice that of the other departments in the hospital. Discontent expresses itself visibly in workers' attitudes. As the volunteers said, "Some people just do not do their work." "I would be embarrassed to come and pick up my cheque." Although morale has improved in the last year, it remains a costly problem in productive hours lost both on the job and through paid leaves.

From my findings, the simple solution may seem to be to insist that cleaners and aides concentrate on their janitorial tasks and ignore the patients and visitors around them. Housekeeping supervision, it might seem, should concentrate on achieving this orientation to work from housekeeping staff. This approach, however, does not adequately address the real need in the hospital environment for people who can "take a moment and run for a towel," or fetch a vase, or a nurse. It does not address the real need of some patients for companionship to relieve their boredom and their loneliness. Neither does it address the fact that it is simply not possible to ignore the fear and loneliness expressed by some patients. Nor the joy, pride, and hope expressed by others. Nor the satisfaction which many staff experience in patient interaction. Further, it is not possible to screen applicants from janitorial positions based on the measure of their empathy. Neither, we might argue, do we want it to be possible. Also, to limit cleaners and aides to janitorial work ignores the fact that
for some, the work is simply excruciatingly boring. Imagine a work day spent doing nothing but "housework." Then imagine five of them strung together in a work week. "Visiting" provides a diversion. It is, for some, a way to "pass the time" while one goes about the task of earning a living.

While an institutional definition for patient care remains the dominant tradition in the facility, there is a growing recognition at Saint Paul's that the origin of relevant contribution to patient care is not limited to medical professions. Although he has used it in a different context, I borrow from Chambliss (1989) to say, "What I have called 'levels' are better described as 'worlds' or 'spheres'" (p. 76). I have described working groups at Saint Paul's as a series of levels best understood as a hierarchical structure. From the profiles and from the ethnographic work, the reader will not now be likely to allow the possibility of denying the persistent sense of a hierarchical structure. Nevertheless, Saint Paul's is working toward understanding our working community as overlapping and intersecting spheres which share the common goal of excellence focused on the multifaceted needs of patients, their families, the hospital's staff, and the community. We might say that we have come to recognize that, "the society which treats its sufferers as clients and nothing else treats them as a population in need of equality without quality" (Blum 1982:24). We are striving to overcome this approach to patient care. It is fair to say that this is the underlying intent of the Healthy Hospitals Project. It is also important
to note that this intent is stated explicitly in the hospital's Mission Statement which reads in part,

Saint Paul's Hospital seeks to heighten trust and increase mutual participation among its staff by encouraging open lines of communication between departments and all health care providers. It attempts to meet the spiritual, physical, psychosocial, emotional and cultural needs, not only of the patients but of each staff member, as well as reaching out to families and friends in a supportive manner.32

Saint Paul's has long enjoyed a reputation for excellence in treatment and care from the perspective of biomedicine, and the hospital receives many letters from former patients expressing warm satisfaction with regard to their care. Nevertheless, recently the community that is Saint Paul's Hospital has begun to refocus on excellence in patient care from a broader perspective. It is reasonable to hope that because of this, comfort work done by support care staff might soon be better recognised for its contribution to patient care. It can be expected that such recognition will do much to improve the working conditions of support care staff for whom working with people is the most rewarding aspect of their work. For example, clarifying the question of whether interaction with patients is prohibited, and if it is, acknowledging the difficulty such a prohibition imposes on some workers is a necessary first step. Allowing that some interaction with patients and visitors is a necessity in almost every...
job in the hospital will apportion support staff a sense of legitimacy for this aspect of their work. Resolving this question alone will expunge confusion and frustration from the working life of some of the department's staff. This improvement, in turn, will enhance the working environment of the Housekeeping Department as a whole.
Epilogue

People who work at Saint Paul's as support care staff provide comfort, information, humour, and diversion in what might otherwise seem a sterile, frightening, and even hostile environment. They provide a youngster an opportunity to gloat about a new sibling, new cardiac post-op patients a chance to brag, and give a neglected elder a hand to hold for a moment. Certainly, this is not to say that others in the facility lack such kindness. It is only to acknowledge there is much to be done for someone who is confined and the professional's work too often takes her away from what brought her to health care.

I am a clerk in the office where she must sign out. She is weeping. It is early morning — at the end of the night shift — so I guess it must be a patient who has died.

She only knew him as her patient. All night she tried to get to his bedside to sit with him. She did not want him to die alone. But she was so busy. Too busy. All night her other patients were awake and calling for her. All night she went about her duties, comforting them and trying to settle them, and she was unable to spend those few moments with the man who was dying.

He died this morning.

The nuns tell us: if we can, we must open the window and leave the body for an hour. This is to give the spirit time to leave.
Her shift was over then. Other nurses relieved her, but she stayed with him, to keep his body company while he "passed."

This morning, for her, there is no relevance to the question, "Does the spirit pass?" She has no need to know. Her patient, hers, he died alone this morning.

And so she weeps . . .
Endnotes

1. Thanks to Sister Jeanne for her assistance with the historical details regarding the Sisters of Providence and Saint Paul's.

2. Saint Paul's has a number of "regular" patients who are known to staff because they drop into Emergency for treatment of injuries, substance abuse, and psychiatric disorders. They are seldom admitted except to Emergency. Often these patients are simply looking for a meal and a safe place to rest. They are fed, sometimes given a bed in which to rest, periodically de-loused, and then sent back to the street. They return in a few hours, or days, or months. In a few cases, staff have worried about what happened when someone did not arrive according to his usual routine.

3. Saint Paul's staff is of varied ethnic origins. Tales of ghosts and exorcisms are particularly upsetting for some employees of Asian and West Indies ethnicity.

4. This, of course, is not an exhaustive list of the positions people with these various skills work in.

5. "Gomer" is an acronym for "get out of my emergency room" and is described as a patient's attitude and character which draws on features of the television character, Gomer Pyle. This patient is thought by hospital staff to be mentally dull, or difficult and uncooperative due to stubbornness, mental illness, or alcoholism. The label may be applied to the patient based on dress, whether
they present themselves at the hospital with family members or other support people, or whether they have the smell of alcohol on their breath. For further discussion of the moral evaluation of patients in health care settings, see also Roth (1972).

6. The term "health care professional" will be taken to mean an individual with specialised training to work with patients in the health care setting. This training will be a formally organised programme and result in accreditation by a professional association. Nurses, doctors, laboratory and imaging technologists, physical therapists, social workers, practical nurses, nursing orderlies, and some nursing aides are examples of health care professionals. Excluded from this category (e.g., non-professionals) are a hospital's support staff who work as store keepers, operating room aides, plumbers, janitors, nursing aides, sterile supply aides, and morgue attendants (to name some of the support care roles).

7. Diamond (1992) and Sudnow (1967) are notable exceptions to this claim.

8. An example of nurses' resistance to compliance to physicians will be discussed later when Saint Paul's Hospital's Healthy Hospitals Project is considered.

9. Notice that I assume the man was the surgeon and not the OR Aide or a scrub nurse.
10. This figure is offered by Fred Muzin, president of the Hospital Employees Union (HEU) and former chair of Saint Paul's HEU local.

11. This nursing shortage is not limited to Saint Paul's. Rather, since the mid-1980s, most Canadian facilities have been facing the same very difficult problem.

12. This should not be thought of as a malicious exclusion. Rather, as Jeanne Carne (Project Coordinator) explains, support care workers represent a large, diverse group, with less in common than nurses as a group share. As the Project was developed, it may have been thought that such a group would make it unwieldy. For this reason, and since the focus was on attracting nurses to the facility, support care workers were not initially included.

13. Note the difference between Long Term Care and Rehab patients where the aim is to improve their current capacity, and involve them in a more independent style of living than they experience in the acute care setting.


15. For example, see Sudnow's (1967) account of the morgue attendant.

16. All of the housekeepers that the reader will meet in the thesis are identified by pseudonyms. Roughly, I chose these names according to the order in which I needed names and the order of the letters of the alphabet. Thus, for example, I chose a name beginning with the letter "a" for my first interview. The sex of the volunteers can be accurately assumed from the names.
17. This happens because no replacement worker is available and because certain absences are routinely not replaced. The practice is referred to as "doubling up" or being "doubled."

18. During the 1991 contract negotiations, union and management agreed on a wage parity package that partially closed the gap in cleaner/aide wages. The remainder of this agreement is meant to close the gap completely.

19. Having "enough" hours was made even more significant during recent negotiations with HLRA when winning full-time or part-time work was made virtually impossible before 1996 for casual employees with less than a certain number of hours.

20. At the time I was conducting interviews, I was only in the hospital on weekends, and the people who volunteered were those who could find me on the weekend.

21. One of the two returning students took a second job instead of returning to studies.

22. I have modelled these profiles after Carol Howard's excellent example which I found in her 1993 thesis written for the University of British Columbia, Department of Anthropology and Sociology.

23. While I enjoyed writing the profiles, for the edification of researchers who might consider the same process for their own work, I would add that I found writing them to be a challenging and time consuming process, crowded with
many difficult choices regarding what to leave in, to clarify, to move, and what to remove. Nevertheless, the result has been very satisfying, and the response by the volunteers to the profiles has been rewarding.

24. The reader should note that I am a weekend lead hand which is a supervisory position at the hospital. This fact will be dealt with in the following pages of this chapter.

25. I join a group of housekeeping staff who take an afternoon break on the roof garden during the summer months. In the fall, we move to the shelter of the Gazebo. Some of these staff are people who volunteered for these interviews.

26. During the mid-eighties, I worked in the "Nursing Office" with the Administration Supervisors. Although I don't remember who it was, one of them helped me to make the distinction between "calamity" and "controlled crisis." I mention the supervisors here by way of taking an opportunity to thank them. I am indebted to the patient indulgence of these men and women who helped me to deepen my understanding of the environment in which we work.

27. I was surprised when Cameron referred to patients' visitors as their guests during his interview. Since that interview, however, I notice a few housekeeping staff refer to visitors as patients' guests. Cameron explains this as an effort to allow patients' to have some control over the space in which they are temporarily living. For Cameron, "the room belongs to the patient and the
visitors are the patient's guests."
Thus, not only is it difficult to clean a room when there are extra people in the room, but, "It is awkward to interrupt a conversation and say, 'Excuse me. I just need to sweep your floor.'"

28. The reader will notice a syntactic variation between this quotation and Fred's profile (see page 98). This is because the quotation cited here is taken directly from the transcript of Fred's interview.

29. Although I have separated the volunteers into these two categories for the moment, the categories should be understood to be an "ideal type." No volunteer was completely committed to the objective cleanliness of his or her surroundings and oblivious to the subjective needs of the people around them, and none ignored their formal job duties in favour of being company for patients and their guests.

30. Some staff wish for the ability which housekeepers have to move easily about among the patients. For example, John works as a social worker for the hospital. One evening we were discussing a patient who was particularly unruly. He had been on the ward that day and heard her calling, "Nurse! Nurse!" with tremendous volume. She had done this all day the previous day while I scrubbed the main corridor of her ward. I recounted for John how, when the housekeeping aide had finally told the woman, "I am not the nurse!" the woman had yelled at her, "Okay! PERSON!!!" John immediately realised that I had access to her room and asked, "What was going on in that room?" He
followed this by saying he envies housekeepers their ability to move around the whole hospital, in and out of rooms, and "really see" what is going on.

31. Waiting for elevators is a notoriously chronic activity at Saint Paul's.

32. The Mission Statement is reproduced in its entirety as Appendix IV.
Bibliography


Appendix I

ON BEING A HEALTH CARE WORKER
Janice Tanche
Graduate Student, Sociology
University of British Columbia
Phone: 222-9239

I am willing to participate in a research project which studies the experience of working in a hospital as a non-professional health care worker. I understand that I will be interviewed, and that the interview will require about 1½ hours of my time which I give on a voluntary, unpaid basis. During this time I will be asked questions about the kinds of things I do during my work day. I understand that during the interview, there will be an opportunity for my questions, and that there will be time following the interview to discuss this study if I wish.

My participation in this project in no way reflects on my work, nor will it in any way effect my employment at Saint Paul's Hospital. My participation is confidential. My name will not be recorded with my responses, and nothing which might identify me will occur in final presentations. I understand I am free to refuse to participate or may withdraw my consent at any time. Such refusal will in no way reflect on my employment with the hospital.

I have received a copy of this form.

Signature: Date:

I agree to the interview being tape recorded.

Signature: Date:

(If you have any questions or concerns about this research or your participation in it, please contact me or my supervisor at the above telephone numbers.)
[Please note that my thesis supervisor's phone number has been omitted from this document for the purposes of this printing.]
Appendix II

As I explained I am doing research for my graduate thesis. My thesis is trying to understand the experience of working in health care from the point of view of people who are not specifically trained in health care settings as professional health care workers. I want to ask you some questions about how you came to be working in the hospital, about the nature of your work, your job duties, the things you do which are not specifically recognized as part of your job, and about what working in the hospital is like for you. By way of introduction, how did you come to be working at Saint Paul's and what kind of things did you do before you came here?
Appendix III

Interview Questions

1. What did you do before coming to work at Saint Paul's?
2. How did you come to be working here?
3. What other work have you done in the hospital?
4. What work do you do in the hospital now?
5. What are your job duties?
6. Please describe a typical shift of work.
7. Are there (there seem to be) things that you do on a shift which are not formally part of your duties? I would like to hear more about those things.
8. Are there aspects of your work you particularly enjoy?
9. Are there aspects you don't enjoy?
10. Do you think there is some sort of system of ranking people working in the hospital?
11. Where do you think you fit into that?
12. Is there a difference between the place the hospital and other staff working there see you fitting into Health Care and what you actually do?
13. Are there any aspects of your work you find particularly difficult or disturbing?
14. Is there something we have not talked about which you think might be important to discuss?
15. Is there someone you think I should ask if they would be interested in doing an interview for this project?
16. Do you have any questions about the interview or my study?
Appendix IV

Mission Statement
Saint Paul's Hospital

Saint Paul's Hospital was founded in 1894 by the Sisters of Providence, a Catholic religious community of women. Drawing their inspiration from Emilie Gamelin, their foundress, they served the poor and those in need with compassionate loving care. Through St. Paul's Hospital they continue their work by encouraging and fostering the development of new and varied programs of health care to meet the needs of the community which the hospital serves.

Saint Paul's Hospital is committed as a Catholic Christian institution to continue the healing mission of Jesus Christ. Thus, we strive to create an atmosphere that respects the dignity and worth of every person. Compassionate concern for every individual, as well as concern for social justice, directs the way service is rendered and assures that no person shall be discriminated against for whatever reason.

Saint Paul's Hospital seeks to heighten trust and increase mutual participation among its staff by encouraging open lines of communication between departments and all health care providers. It attempts to meet the spiritual, physical, psychosocial, emotional and cultural needs, not only of the patients but of each staff member, as well as reaching out to families and friends in a supportive manner.

Saint Paul's Hospital is a major teaching hospital affiliated with the University of British Columbia and numerous colleges, and accepts its responsibility to provide educational opportunities for students of many health care disciplines. The hospital is also a major diagnostic, treatment and research centre providing a unique contribution to the provision of health care in the Province of British Columbia.
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