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The Subjective Work Experiences of Hospital Patient Attendants

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ABSTRACT

The Subjective Work Experiences of Hospital Patient Attendants

Julia P. Vickers

This descriptive exploratory study is based on in-depth interviews with patient attendants drawn from three Montreal-area hospitals. The sample reflects the age and gender proportions of the patient attendant populations in these institutions. The issues addressed include: the reasons for doing this type of work, which aspects of the work the patient attendants like and dislike, the actions taken to improve the work environment, and abuse suffered by patient attendants in the workplace. Although the literature clearly shows that hospital staff are subject to considerable abuse, most research deals with nurses' work experiences with very little focus on the patient attendants' experiences. Patient attendants are not immune to this phenomena, and physical and verbal abuse are almost an accepted part of their daily work life. Faced with repeated acts of abuse, the majority of patient attendants, males and females alike, tend to ignore these incidents or take evasive action. Verbal reports of abuse are rarely made and nobody files a written complaint. Despite high levels of abuse, the majority of patient attendants enjoy their work, especially the contact with the patients and most of them would choose to do the same type of work again. Recommendations are made concerning the need for further research to identify the extent of abuse in Quebec hospitals.

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1. INTRODUCTION

The health care system is a vital and continually changing sector of the service industry. It is a hierarchical, multi-faceted sector. Those who directly care for the patients/clients (doctors, nurses, nurses' aides, patient attendants) have very different statuses (Aguirre et al. 1989); the services provided take place in a number of different settings (hospitals, nursing homes, clinics and patients' own homes), and care can be given for varying lengths of time (emergency, acute-care, chronic-care, extended-care). In spite of this diversity, the research in the field of health care workers has tended to concentrate on the role and experiences of nurses in the hospital setting (Decker, 1985; Parasuraman & Hansen, 1987; Pekrul, 1992; Blegen et al., 1992). Very little research has been conducted on the work experiences of non-professional care-givers such as patient attendants. This latter group represents an important sector of the health care team—it makes up approximately one quarter to one third of a hospital's nursing staff during the day, and approximately one eighth to one sixth during the night (Dewar & Macleod Clark, 1992)—and yet very little is known about the work experiences of the women and men involved in this aspect of the health care industry. My overall objective is to correct this deficiency.

I have worked in the health care system, as a registered nurse, for the last twenty-three years, both in Quebec and in Great Britain. I did my nurse training in a regional hospital, and then moved on to community health care—visiting clients in their homes. Later, I returned to work in hospital as the shift system was more easily adapted to meet the demands of my family life at that time. I have worked in many hospitals and different communities, in both rural and urban settings. Although the structure of the British and Quebec health care systems are very different, the role of the non-professional caregiver is similar. The fact of having worked in close liaison with patient attendants for many years influenced my decision to undertake this study.

The research on non-professional health care workers falls into two categories. The major category comprises research conducted in nursing homes (Roth, 1990; Waxman et al. 1984; Monahan & McCarthy, 1992; Tellis-Nayak & Tellis-Nayak, 1989; Helmer et al., 1993; Brannon et al., 1990). The ancillary staff interviewed described a specific job description and set of work activities that suggested their responsibilities were separate and distinct from those of other health care workers. Their chief complaints were the lack of autonomy and no input in the decision-making process. *"[I] see so many things happening and I have no control over them"* is typical of the negative feelings expressed (Monahan & McCarthy, 1992).

The second category includes a small volume of research on patient attendants in a hospital setting. These studies, however, tend to confine the work of the nursing ancillary staff to the role of "nurse extender." In this context, the work of patient attendants is not regarded as a job in and of itself, but simply as a way to

permit the registered nursing staff to complete their own jobs (Crockett & Gibbs, 1993; Blegen et al. 1992). A number of patient attendants with whom I have spoken during the course of my work as a hospital nurse have confirmed this demeaning, low-status view of their work. *"The nurses push the work that they don't want onto me"* and *"It's only the orderly"* are examples of comments which reflect the lack of importance attributed to the work of the patient attendant.

By focusing on patient attendants as part of the health care team, I hope to bring to light information about the experiences of this group of health care ancillary workers in a hospital setting. At the same time, I will comment, where appropriate, on how the work experiences of hospital patient attendants differ from those of their counterparts in nursing homes. The specific objectives of this research are

- to investigate the relative importance of gender and job on the entry patterns, subjective work experience, mobility patterns and job satisfaction of women and men involved in one area of the health care industry (patient attendants);
- to encourage recognition of the valuable work this group performs; and
- to promote the use of these workers to their full potential.

1.1 Contribution to knowledge

As mentioned above, there is a dearth of research on the work experiences of ancillary hospital workers. This study will address the problem by adding to the limited volume of available information. Such research is also timely, especially in Quebec, where major health service reform is under way. Quebec's department of health and

social services (MSSS) has undertaken a major restructuring of Quebec's health care delivery system, the main thrust of which is a change from inpatient care to ambulatory care. This entails a reduction in the number of hospital beds, an increase in day surgery and a shortening of the length of stay for patients admitted to hospital. Many individuals will need some care following day surgery or early discharge from hospital and this will be provided in their own homes or at clinics in the Centres Locaux des Services Communautaires (CLSCs). The aim of this reorganization is improved patient care and a more cost-effective health service. With increased use of the CLSCs, day surgery and ambulatory care, the hospitalized population will comprise more acutely ill patients, who are more dependent on the provision of basic hygiene care. In addition, with the aging of the population, it is more likely that there will be increased demand for gerontological nursing facilities. Both of these areas are labour intensive and ancillary staff could play an important role. Given these considerations, it is of paramount importance that reorganization take place with a full understanding of the roles of all participants in the health care team.

1.2 Theoretical orientation

Two different theoretical perspectives—the gender model and the structural model—have been applied when studying the situation of women and men in the workplace. Both models have been used to explain variations in job satisfaction and differences in subjective and objective work experiences. The GENDER model argues that personal characteristics and sex-role socialization account for variations in work

experiences that are often in evidence in the wcrkplace. Women and men, it is argued, bring different perspectives into the workplace. The STRUCTURAL model argues that the workplace shapes the employees' work experiences. Accordingly, women and men working in the same environment are expected to report similar experiences (Decker, 1985).

Northcott and Lowe (1987) examined the relative importance of both models in a conventional workplace (the postal service) and found little support for the gender model. Their results supported the structural model; women and men doing the same job—regardless of whether it was as a mail carrier or as an inside postal worker—described their work in similar terms and reported similar levels of job satisfaction. For a number of reasons, I do not necessarily expect to replicate these results when examining the work experiences of hospital workers. "Caring" has traditionally been described as "women's work." Furthermore, in spite of the increasing number of male nurses and patient attendants, women still predominate in the health care work force and the work is still thought of as "women's work." How do these men fit into a female-dominated workplace? I expect to find that they have different subjective work experiences than the female workers. These differences may be due to gender interaction, whereby nurses, who are mainly women, are more appreciative of the male attendants' work contribution, especially in the more traditional aspects of the job (lifting heavy patients, for example). Alternatively, the males could have more negative experiences from being in a subordinate stereotypical female role. Either of these findings would support the gender model.

1.3 Aggression and abuse

Aggression and abuse are widespread in our society and hospitals are not immune to these phenomena. Pekrul (1992) found that nurses in Saskatchewan were subjected to aggression and abuse from patients, patients' relatives and doctors, but that little action was taken to formally report these incidents: it was considered to be "part of the job." Given the lower status that appears to accrue to the ancillary care-giver, I expect these findings not only to be replicated in this study, but to be strengthened.

2. The Nature of Work

Labour, whether paid or unpaid, is an integral part of human life. Labour can be physical, mental, emotional or any combination of all three. Salaman (1987) defines work as "what a man (sic) does in his job; it refers to the activities involved in holding a particular job," and he defines "a job" as referring to "an actual employment situation and therefore includes such things as conditions of work, management, workers relations, levels of pay etc." (p.65). For most individuals, an income is derived as recompense for work done whereas for others it may be interest on money invested. For the unemployed, sick or retired, social security benefits may be their only source of income.

Work does not take place in a vacuum, even when the person works alone. The physical surroundings, the social interactions and the written or unwritten rules determine how and when work is done, and all of which contribute to the perception of the work environment. A fit between work and worker generally results in job satisfaction (Mars, 1982:35; Caston & Braito, 1985). The worker is in a continual interactive relationship with the work environment such that if a worker is not satisfied with the work environment s/he can initiate changes to improve the situation. These attempts at change may or may not have the desired effect; if a situation becomes untenable, the worker usually looks for another employment.

Work socialization entails the acquisition of knowledge and skills and the internalization of job values. It is not only the objective nature of the work, such as

control and tasks, but the subjective interpretations of the job that contribute to job satisfaction. From personal experience, Roth (1990) found that the initial formal education he received as a patient attendant was much less important than the unofficial training he received from his colleagues. They showed him how to cut corners and which tasks it was important to do thoroughly and which ones could be skimped on or not done at all. If an attendant persists in doing work that colleagues have said is unnecessary, the latter may retaliate by giving the attendant more work to do and not confiding inside information about patients or staff members. In so doing, they make the "uncooperative" attendant an outsider (Roth, 1990: 44HC). Nurses' expectations of the patient attendant will vary between nurses and between units, and this variance can only be learned from experience or from co-workers. The new attendant learns from the nurses who are his/her immediate superiors, his/her co-workers and from the patients. Other health care workers have little or no effect on the patient attendant's role. Thomas (1992) found that the sub-culture of a nursing unit, generated by different nursing philosophies, influenced the attitudes of all grades of nursing staff. Patient attendants who were involved in decision-making on primary nursing care units showed the same increased involvement as the trained nurses on these units. Trained staff and patient attendants both complained of a lack of autonomy and increased work pressure in team and functional nursing care units.

The majority of work is performed in conjunction with other workers who share a common interest or goal. It is possible to develop a sense of belonging to both the smaller work unit and to the larger organization (Symons, 1988). The individual is

affected on a day-to-day basis by the interactions which take place in the specific work area, but also by decisions made at the management level, over which the worker has little or no control. When there is no sense of belonging, there is frequently a sense of lack of control which can lead to a feeling of helplessness and dissatisfaction (Symons, 1988; Esland, 1980). On the other hand, a feeling of belonging and participation in an organization can increase job satisfaction. In Konner's words, "being able to make changes can make a person feel an integral part of the team" (1987:209). This approach increases teamwork and enhances productivity. In some hospitals, the current management approach of "shared governance" reflects this philosophy.

Individuals very often see themselves in terms of their occupational role, that is as people with specific qualities, interest or abilities which are normally associated with that role (Salaman, 1974:1). The individual can identify with other members of his/her occupational community. According to Salaman (1974), "members of occupational communities are emotionally involved in their work skills and tasks; they value their work not only for the intrinsic rewards it brings but also for the satisfaction they derive from actually doing it and the opportunities it offers them to use their work skills" (p.27). Group membership can reinforce the meaning of work. Giving meaning to one's work enables people to cope with what others see as a dirty or disagreeable job. In Mars' illustration of a refuse collection crew, the sorting of garbage and the rewards which that occasioned enabled the workers to negate the dirty label which others attach to their work (Mars, 1982:93-98). In similar ways, patient attendants may well

negate the so-called dirty aspects of their job, such as cleaning human excrement, by interpreting their job as helping other individuals in need. Union membership can also enhance this feeling of occupational community and give members a forum, not only for expressing their concerns, but also for making more formal complaints about work-related issues. The patient attendants' union at Hôpital Saint-Luc (one of the hospitals from which the sample was drawn) is extremely active in protecting the rights of its members. In order to keep everyone informed on a variety of work, union and social topics, it produces a monthly magazine entitled Le Porte-Panier du S.S.H.S.L (Syndicat des Salariés(ées) Hôpital Saint-Luc). The grievances undergoing arbitration are included in Le Porte-Panier and cover areas such as suspension, disciplinary letters, choice of vacation and, very occasionally, harassment. It should be noted, that in Quebec, hospitals are closed shops: union membership is obligatory, even for availability staff.

2.1 Shift work

In many public service sectors, it is necessary to provide services 24 hours a day, which means that the organization must work on a shift system, necessitating that some employees work evenings and/or night shifts. The health service is one such sector. Shift work can be socially isolating, putting the workers out of step with the rest of society; this may result in them having fewer friends, as they have reduced participation in the usual social interactions. Shift work can also cause an increased rate of absenteeism among evening- and night-shift workers because of a disturbance

to the normal diurnal physiological changes (Shires, 1993). Circadian rhythms indicate that bodily functions are at their highest during the day and lowest at night. It has been shown that shift work disrupts normal circadian rhythms (Coffey et al., 1988; Harvey, 1993). Nurses working rotating shifts were found to have the lowest levels of job performance, possibly because their bodies never have a chance to adjust to a changing circadian rhythm (Coffey et al., 1988:250). Rotating-shift nurses also experienced the highest levels of job-related stress, followed, in order, by the afternoon-, day- and night-shift workers (Coffey et al., 1988:251). Night-shift workers probably experience fewer interpersonal conflicts because they have less contact with other personnel and patients.

3. The Patient Attendant

Over the years, paid non-professional nursing ancillary staff have had a variety of titles. In 1936, they were called "Ward Helpers"; they were almost exclusively women and performed numerous tasks related directly and indirectly to patient care.

> "Hospital routine requires an unlimited number of steps, repeated non-nursing duties, such as arranging flowers, making beds, preparation of materials for sterilization, running innumerable errands, and so forth: as well as simple nursing duties, such as passing wash water, making up patients' beds, feeding helpless patients (...)" (Excerpt from The Subsidiary Worker by Louise Kieninger, American Journal of Nursing, October 1936: 984-986 cited in Roth, 1990: 44HD).

The situation has not changed much in the last sixty years; there is still a need for personnel to perform these tasks and today they are performed by patient attendants.

The job description of the Patient/Beneficiary Attendant at Montreal General Hospital (1993: Appendix II) defines the patient attendant as a person, whose function is

> "the surveillance, occupation, hygiene and well-being of beneficiaries"; who "sees to the comfort and general needs of the beneficiaries and assists them in moving about; if necessary, provides basic care to beneficiaries and can be called upon to set up certain devices; and who upon request, informs those in charge and other members of the nursing team of the behaviour and changes in behaviour of the beneficiaries."

The major responsibilities of the patient attendant are

> "(to) perform duties related to the general needs, basic care, comfort, surveillance, occupation, hygiene and well-being of beneficiaries. (To) actively participate in unit activities related to quality of care and unit management issues, including informing those in charge of behaviour or changes in behaviour of the beneficiaries, (and to) participate in the implementation of the therapeutic plan including setting up certain devices" (MGH, ibid.).

It is expected that the duties related to the care of the patient will occupy 80% of work time. The job description is basically the same for all hospitals.

The tasks most frequently performed by patient attendants include: hygiene care (washing, shaving and combing hair); answering call lights; passing meal trays, preparing patients for meals and feeding patients; transferring patients from bed to chair or stretcher or wheelchair and back to bed; emptying urinals and bedpans and recording output; assisting patients to ambulate; distributing water jugs, ice, juices and between-meal snacks; pre-operative baths and shaves; listening, communicating and comforting patients and families; turning and positioning patients; changing laundry bags; transporting urgent specimens to the laboratories and collecting emergency supplies from the central sterile supply; and reporting information to the nurses (MGH, 1994, Appendix IV). This list, which is not exhaustive, shows that the work of the patient attendant is varied and demanding of both physical and emotional energy.

Health care workers involved in direct patient care are called upon to conceal their own feelings when they have to deal with difficult situations, cleaning offensive smelling excreta, vomit etc., as well as dealing with extremely emotional situations, such as coping with patients who are newly diagnosed with a fatal condition or accompanying patients during their final days. This is not unique to health care workers; Hochschild (1983) described it as emotional labour which often goes unrecognized when discussing the work of flight attendants. From her research with hospital nurses, Stelling (1987-88) concluded that the nurse's daily work includes

much of what she terms "invisible work"—aspects which are not defined in any job description but which are an essential part of the nurse's role. This "invisible work" includes physical, cognitive and emotional aspects, as well as intangible elements. Again, there have been no similar studies conducted into these undervalued components which are probably also part of a patient attendant's daily work.

Bryant and Perkins (1982) defined "dirty work" as "work that is culturally defined as esthetically distasteful, physically uncomfortable or psychologically repugnant" (p.204). In their study of poultry workers, they found that the working conditions in which the "killing, cleaning, dismembering and packing of poultry" are indeed malodourous, distasteful and in some instances repugnant. Nevertheless, men and women choose to work there, and 75% of the workers had no plans to change their job. Indeed, 60% of them said that they were satisfied with their job and 63% said that they would choose the same job again. Many of the workers had other family members working at the plant and this had a positive influence on their reported job satisfaction. The main attitude appeared to be that the inevitable can be made more pleasant "through meaningful social interaction" (Bryant and Perkins, 1982:207).

Unpleasant or offensive substances are to be found in everyday life. In their study of university students, Clark and Davis (1989) found that all bodily emissions except tears were considered dirty and defiling. Vomit and feces rated as the most offensive of the bodily substances, closely followed by urine, nasal discharge, and semen. "It appears that very little can be more devastating to our identity than the public display or suggestion that one's body has been bespattered by sexual fluids or

excrement" (Clark and Davis, 1989:655). They pointed out that bodily elimination functions are normally performed in private and individuals feel violated if another person performs these functions in public (ibid: 658).

Patient attendants are called upon to assist patients in the performance of these excretory functions, by giving and removing bedpans and urinals, by helping patients to and from the bathroom, including cleaning the patient when the patient is unable, giving enemas and, when necessary, disempacting, i.e. manually removing feces from the rectum. They also have to empty vomit bowls and suction bottles containing gastric contents or lung secretions which are all unpleasant substances not normally encountered outside of caring for the sick. Some attendants in the nursing home studies engaged in punitive actions against the residents when they considered that the resident had been deliberately incontinent or had defecated in an inappropriate place (Stannard, 1973:334).

Service workers frequently have a role overlap between their work and family activities. This is especially true for female health service workers, as they are the traditional family care-givers. Since they already possess some of these care-giving skills, it might be generally assumed that they are better prepared for this type of work. Nevertheless, Marks et al. (1993) concluded from their review of the literature on nursing home aides that those nursing home aides who had family care-giving responsibilities performed less well in their paid care-giving activities than those without these other demands on their nurturing skills. They interpreted this negative correlation as a sign of role-overload and suggested that employers could improve job

performance by addressing care-givers family concerns by introducing "flexible work schedules, on-site daycare, and training directed at incorporating work and non-work processes through relating job care-giving skills to family care-giving skills" (Marks et al. 1993:33).

In Quebec, in 1992, there were 8,559 full-time and 10,384 part-time patient attendant positions making a total of 18,943 positions. There was a 3.3% vacancy rate overall: 2.6% full-time and 3.8% part-time (MSSS, 1993: Table 1: p. 39). In the Montreal Centre region, the figures reported were 3,408 full-time positions and 3,881 part-time positions, totaling 7,289, with a vacancy rate of 2.4% full-time and 4.4% part-time for a total of 3.5% (MSSS, 1993: Table 4: p. 48). Most of the vacant positions, full-time and part-time, were in acute-care hospitals (MSSS, 1993: Table 8.1 p. 94/95). The main reasons given for the difficulties encountered in filling these positions were:

1) the shift being offered: there was greatest difficulty in filling night-shift positions, and
2) temporary assignments. Patient attendants make up 16.7% (5,948/35,858) of the nursing personnel in acute-care hospitals (MSSS, 1993:11).

The Quebec health service is in a process of change, partly to serve the needs of the population better, and partly to meet strict budgetary constraints imposed on it by the government. Several Montreal-area hospitals have been closed and others have had their mandates changed, thereby leading to a feeling of insecurity and anxiety among hospital staff.

3.1 The patient attendant as 'Nurse Extender'

Most of the literature on patient attendants working in hospitals is concerned with the efficacy of using this type of worker. It deals with patient attendants as "nurse extenders" and concentrates on how these ancillary staff can free up time for the nurse. By performing nurse-delegated acts, such as bathing patients, the patient attendants enable nurses to perform more complex tasks, like assessing the patient, planning care and patient teaching. All of the articles reviewed looked at the nurses' increased job satisfaction, but none of them examined the level of job satisfaction experienced by the patient attendant.

When Blegen et al. (1992) asked registered nurses for their opinions of patient attendants (called nurses' aides in that study), their responses ranged from full acceptance to outright rejection: "*A good nurse's aide is worth her weight in gold*" to "*Don't use them, don't want them*" (p.26). They found that nurses working in acute-care units are less likely to delegate tasks than are their counterparts who work in long-term care settings. Blegen et al. (1992) also found that nurses delegated more work to assistants when RN vacancies were high and when work-load was at its heaviest, and that during these same periods nurse job satisfaction was at its lowest (p.28). Nevertheless, most of the respondents agreed that there is a place in the health care team for a "thoroughly orientated, carefully supervised, and appropriately used" patient attendant (Blegen et al., 1992:31). Renz (1995) suggests that non-professional care-givers are frequently taken for granted by their professional colleagues. In a series of vignettes, she illustrates the vital role that these employees

can fulfill, and admonishes the hospital hierarchy for its failure to recognize the patient attendants' compassionate contribution to patient care.

The three hospitals from which the patient attendant sample was drawn use a system (albeit different ones) for measuring the nursing workload on each unit. One such system "GRASP" measures the workload objectively. The time taken to complete certain repeated tasks, e.g. changing a dressing or taking vital signs three times a day, is evaluated and, after agreement, the time allocation is assigned (Thibault, 1990:79). The amount of time varies depending on the complexity of the task and the condition of the patient. Included in this time allocation is a fixed amount of time for non-nursing work related to direct or indirect patient care, such as transferring a patient from bed to stretcher and bed making. The majority of these non-nursing tasks are completed by unqualified ancillary workers—patient attendants. Nevertheless, it is the nurse who calculates these figures for her group of patients; this is often referred to by the nurse as his/her GRASP figure for the day and is used as an indication of the day's workload. For example, a GRASP figure of 26 indicates that the given group of patients require 26 hours of nursing care in a twenty-four hour period, therefore the nurses caring for this group of patients will be fully occupied if they are to complete all the work necessary in this period. It can be seen that as the figure rises, the feeling of being overworked will mount as well, and a nurse with a GRASP of 30+ will be able to prove objectively, how busy s/he is. GRASP measures the total amount of nursing care, predictable or not, direct care, indirect care, teaching and emotional support, as well as any interventions which occur during the delivery of care (Thibault, 1990:179).

There is no such system for measuring the workload of the patient attendant, although care-hours allocated to complete patient care include the hours worked by the patient attendants. The patient attendants' work becomes subsumed in the general workload.

3.2 The nursing home patient attendant

There have been numerous studies of patient attendants working in public and private nursing homes in the United States. Helmer et al.'s (1993) national descriptive study of nurses' aides was based on a mailed survey and covered 40 nursing homes across the United States. Of the 600 surveys mailed, 41% were returned. Of the 246 respondents, only 15 (6%) were men. The demographics of the respondents were

Age range—16 to 58 years, with a mean of 34:

Years of education—7 to 15, with a mean of 12:

Years worked as a nurses' aide—2 months to 21 years, with a mean of 8.8 years:

Years working in present employment—2 months to 21 years, with a mean of 3.9 years:

Salary—mean hourly rate was US $4.65 (p.11).

These findings would indicate that the respondents have at least high school education and are more likely to stay with their current employer longer than were the respondents in Waxman et al's (1984) similar study nine years earlier. The results of this study may be skewed because the majority of facilities surveyed were non-profit

organizations located in communities of less than 25,000, where job opportunities may well be limited, although the findings are similar to the demographics Cohn et al. (1990) reported for their study of three western Pennsylvania nursing homes.

The job attitude scale part of Helmer et al's (1993) survey showed that the nurses' aides were satisfied with all components related to job satisfaction except pay. Almost three-quarters of the respondents (71%) were dissatisfied with their pay, which is not surprising seeing that they earned approximately half of that earned by the nurses' aides in Grau et al's study (1991). Although the nurses' aides complained about increased workload caused by staff shortages and high turnover rates, 53% of respondents said that they had enough time for direct patient care. Nearly all (91%) said that their job was important; this corresponds with the 93% of nurses' aides in Bye and Lannone's study (1987). In contrast, the nurses' aides felt that they were not appreciated by management (71%) and that there was little or no room for advancement (52%). Helmer et al. (1993) point out that only 24% felt that they were unduly supervised, a small majority of respondents felt that they had a high level of autonomy and 52% said that they had sufficient input into the care programs of the residents. These latter findings support the theory that involving staff in decision-making increases staff commitment to the establishment, thereby increasing satisfaction and probably reducing turnover.

Even those workers who are dissatisfied with their jobs may stay because of a lack of other opportunities. Grau et al. (1991) studied two New York City nursing homes with 527 and 242 beds; both establishments were unionized and offered

competitive employee contracts. As unionization of non-professional health care workers is rare in U.S. nursing homes, these results cannot be generalized. The study covered all nurses' aides working in one 24-hour period, so all shifts were included. There was a response rate of 85% for a total of 219 aides. Part of Grau et al.'s analysis involved the use of a "job tasks scale." It included 12 items tapping into the degree of enjoyment workers derived from performing certain tasks, such as bathing, toileting, feeding, dressing, transporting residents, and talking with the clients and their families. Grau et al. (1991) hypothesize that those workers who are older and have less education and lower overall family incomes may have lower expectations of their job and are, therefore, more readily satisfied than are their younger counterparts. The respondents' attitudes to their work were unaffected by the length of time they had been doing the work. Grau et al. suspect that a lack of job opportunities may be the major factor behind this finding. The respondents earned $9.16 an hour, comparable with the local hospitals at that time, and almost twice that of homecare workers doing similar work. The knowledge that they were earning more than they might in a similar sector of their service industry may account for their levels of job satisfaction (Grau et al., 1991:61).

The nurses' aides' main reason for continuing to do this type of work was "their relationship with residents"; they derive most of their job satisfaction from caring for the residents (Wagner and Colling, 1993:28). Another reason given for their remaining in this type of work was related to their family's and friends' attitudes to their work. If

these people "believe their work is worthwhile and meritorious employment, the workers' self-images are enhanced" (Ibid, p. 28-29).

Monahan and McCarthy (1992) studied seven different rural nursing homes ranging in size from 32 to 85 beds, all but one of which were non-unionized. There were 76 respondents, 95% of whom were white, 91% women. Their ages ranged from 16 to 71. They were employed for 30 or more hours per week. (42% married, 21% single, 18% separated or divorced.) Length of time working at the present establishment ranged from one day to 14 years, with a mean of 2.1 years. Educational levels varied: 79% had at least high school and 87% had had formal classroom training to be an aide. Sixty-four percent had additional household income. Forty-two percent were unsure as to how long they would continue with their present employer, and the same percentage wanted to stay for at least one more year; 16% wanted to find another job as soon as possible.

By means of an interview content analysis, Monahan and McCarthy (1992) arrived at five major themes which they believe are factors contributing to an individual choosing to do this type of work, their level of job satisfaction and job longevity. These themes fall into two groups, one positive, the other negative. The positive themes are

- Attachment to others—subjects wanted to help others, and were interested in working with people. They continue to do the work because of the residents and resent working short-staffed and not being able to give the care they feel is necessary. Their main reason for continuing to do the work was interpersonal relationships, with residents and co-workers alike.

- Gratification—they find the work personally rewarding. Respondents reported that their families were proud of the work that they do, and that this support boosted their self-esteem.

The negative themes are:

- Demands—subjects and their families disliked the work schedules. The nurses' aides found the work physically and emotionally draining and felt that their work was not respected by management.
- Monetary needs—many of the respondents started doing this type of work because they needed the money, and continue to do it because that need still exists, but they are dissatisfied with the remuneration.
- Decision-making by others—most respondents felt a lack of control over their work, and they would prefer those in authority to be more flexible and allow them more input.

The responses showed that financial concerns and a desire to help others were the main reasons for doing this sort of work. The major dislike, for respondents and their families, was work schedules. Other dislikes included stress, lack of staff and equipment, tiredness and emotional involvement.

Another study of nursing home patient attendants painted a grim picture of personal care without commitment, not actual neglect but, "*soulless service (...) cheerless attitude (...) coldness in the touch*" (Tellis-Nayak & Tellis-Nayak, 1989:311). One patient attendant described her work as to "*serve her 12 heavy-care charges*," working hour after hour doing menial body-and-bed tasks (Ibid). From my personal

experience, working with patient attendants in hospitals, I do not expect the respondents in this study to demonstrate this lack of commitment to either the patients or the establishment.

3.3 Gender Model versus Job Model

Northcott and Lowe (1987) used the "differential sex role socialization position" (p.117) or "gender model," which argues that men and women bring different perspectives to the workplace, based on their socialization to the female/male role and their life experiences based on these respective roles, and the "structural model," which argues that the workplace engenders common attitudes among the workers, regardless of their gender. They found little support for the gender model.

Their respondents, male and female, expressed similar levels of job satisfaction in each of the job situations. One situation, letter sorting, was highly routinized and repetitive, whereas the other, letter carrier, was less structured and had more scope for personal decision-making (Northcott and Lowe, 1987;120). Northcott and Lowe (1987: 118) claim that job satisfaction has an overall effect on the psychological well-being of the individual as well as affecting employment turnover, absenteeism and commitment to the employer in general. Employees "derive satisfaction from the same task dimensions" (Northcott and Lowe, 1987:128).

Northcott and Lowe (1987:121) used the following six questions to evaluate the workers' attitudes to their job;

1. All in all, how satisfied would you say you are with your job? Responses were requested in terms of a Likert scale of 1 to 7. 1 = very dissatisfied, 7 = very satisfied.

2. How likely is it that you will make a genuine effort to find a new job with another employer within the next year? Likert scale of 1 to 7. 1 = very unlikely, 7 = very likely.
3. I could get a better job if I quit working for the post office. Likert scale of 1 to 7. 1 = strongly disagree, 7 = strongly agree.
4. If you had to make the choice again, would you choose the same type of work as you do now? No/yes.
5. If you had an opportunity to take a similar job at the same pay in another organization would you take it or stay in your current job? Take it/ stay.
6. Have you looked for another job with an employer other than the post office in the last year? No/yes.

The responses to these questions were combined with objective information such as job title, shift, amount of overtime worked and other subjective measures of working conditions—for example, perceived possibility for advancement—to measure the level of job satisfaction.

Northcott and Lowe (1987) found that "males and females with the same job perceive it in similar terms" (p.122). They went on to examine if different factors underlie the same perceptions of work and reported similar levels of satisfaction. They found that working the day shift had a positive influence on the male letter sorters' reported levels of job satisfaction. They state that "there is little evidence that gender interacts with either working conditions or perceptions of working conditions to produce significantly different levels of job satisfaction for men or women" (Northcott and Lowe, 1987:124).

In 1981, a Finnish survey stated that the most important aspects of work for both men and women were being able to make decisions, having input in work routines and having a pleasant atmosphere at work. Women also "wanted their work to be socially meaningful to others, while men cared more about autonomy and good

salaries" (Kauppinen-Toropainen et al., 1983:193). Kauppinen-Toropainen et al. found that in Finland, nursing and medical jobs were "low strain" occupations with a low rate of emotional strain; they suggested that nurses' aides fall into the high-strain category, because they have "low-ranking positions with a more restricted work situation" (p.204).

Given that male and female patient attendants perform the same type of work in the same work environment, I would expect that they would experience similar levels of work-related stress engendered by a lack of autonomy and low occupational status, although this may be counterbalanced by socially meaningful interaction with their patients.

3.4 Aggression and abuse in the health care system

Aggression and abuse that are prevalent in the community can and do spread into the hospital environment. Emergency departments are particularly likely to have patients or family members who become aggressive towards the staff because of the stressful nature of the encounter; for example, in the case of an acute illness, an accident or an overdose. There is also the question of lengthy waiting periods in this department, which can lead to frustration. Stress and anxiety about the survival of a loved one frequently leads patients' friends and relatives to be abusive to staff in intensive- and coronary-care units. Cognitively impaired geriatric patients and some psychiatric patients may also become aggressive and inflict verbal and physical abuse on their care-givers. Although aggression may be more common in these specific

areas, all areas of the hospital are potential sites for aggressive behaviour (Shires, 1993). Roberts' study of nurse abuse (1991) suggested that some institutions consider aggressive behaviour towards the staff to be "part of the job." As a consequence, support services (medical, social and legal), which should be available to any staff member who is the victim of an aggresive assault, are not available. According to Engel and Marsh (1986), who looked at the problem of staff abuse in psychiatric care settings, "The problem of institutional violence is managed with only the patient in mind" (p. 160).

Meddaugh's (1991) study looked at the interaction between staff and aggressive patients. She attempted to identify factors contributing to staff abuse by elderly patients. Meddaugh noted that during her six-month observation period, acts of aggression went unreported; one subject punched a nurses' aide in the stomach one day and hit another the next day. Neither incident was recorded by the staff concerned. The reason given for not notifying anybody of these occurrences was "*they [care-givers] just take it [abuse] for granted*," "*It is part of the job*" (p.115). All of the abusive patients observed during the research were cognitively impaired. Meddaugh (1991) concluded that the satisfaction care-givers derive from their work stems from the patients' acceptance of their care. If care is refused or resisted then satisfaction can be replaced by insecurity and a doubting of one's skills, leading to a reluctance to care for that particular patient.

In her study of the prevalence of nurse abuse in Saskatchewan, Pekrul (1992) mailed questionnaires to a proportional stratified sample of 720 registered nurses. The

sample was representative of rural/urban work settings and of acute-care, long-term care, and community settings. The response rate was 49.3%. The age of the nurses covered the complete range, from under 20 to over 60, with the majority in the 21-40 age bracket. Seventy-five percent (261) of the respondents worked in acute-care settings, 16.6% (58) in long-term care and the remaining 8.8% (31) worked in the community. The nurses had been in their current positions from 2 months to 28 years, with a mean of 8.2 years (Pekrul, 1992:26-28). The majority (80.9%) of the respondents said that they had been verbally abused at least once in the previous twelve months. In the same period, 136 (38.9%) said that they had been sexually harassed and 188 (53.7%) said that they had been physically assaulted. The abuse came from patients, patients' families/friends and physicians. Nurses working in long-term care facilities reported the highest rates of verbal, sexual and physical abuse by patients. Pekrul interpreted this as probably reflecting "the realities of providing care to the confused elderly" (p.45). The nurses working in acute-care settings experienced the highest levels of verbal abuse from physicians and they were the only ones to report sexual harassment and physical abuse from physicians (11.9% and 2.3% respectively) (Pekrul, 1992:45).

Pekrul's study also identified what action nurses were likely to take once an abusive incident had occurred. In the case of verbal abuse, most nurses tried to resolve the issue with the person concerned. On average, only 8.7% of respondents who were abused filed a written report of the incident. Nurses were less likely to try and resolve the issue with the person involved when it was an issue of sexual

harassment, especially when a physician was involved. In these cases, as when a patient's family or friend was involved, the majority of nurses ignored the incident. When a patient was concerned, 10.5% of nurses filed an incident report, 9.7% filled one out when a physician was involved, but nobody made an incident report for any incident involving a patient's family or friends (Pekrul, 1992:51). In the case of physical assault, of which there were 191 incidents, nobody filed a written report to the union, although 19 written reports were submitted to supervisors. Nurses were highly likely to discuss all incidents of abuse with their colleagues, less likely to discuss them with their supervisors and even less likely to make a written report of the incidents. Only three nurses had reported a case of physical abuse to the police and only one of these actually laid charges.

"Sexual harassment in the health care sector can be defined in various ways, but it usually takes the form of male patients or male physicians harassing female nurses or other female members of the health care team" (Pekrul: 1992:18). Pekrul found that reports were rarely filed unless physical injury resulted from the attack and these findings are similar to another study by Thackery and Bobbitt (1990).

A survey by the Quebec Nurses' Federation (FIIQ) on the incidence of abuse found rates similar to Pekrul's. Just under 90% of respondents had suffered at least one form of abuse (FIIQ, 1995, Table 14). Once again, the main perpetrators of the abuse were the patients. This survey included threat of physical assault as a separate category of abuse.

Some of the subjective effects of being the recipient of abuse—verbal, physical or sexual—were low self-esteem, anger and frustration, sleeping problems, fear and powerlessness, and a drop in motivation or decreased performance (FIIQ. 1995: Table 22). This research only looked at the abuse suffered by women, as the percentage of male nurses is still very low, but there is no reason to believe that these male nurses are not also victims of abuse in the workplace.

An earlier study by Diaz and McMillin (1991) found that 53% of the nurses they surveyed had been sexually harassed by doctors at least once in their careers, and that 30% said that this type of harassment occurred at least once every two to three months. Their definition of sexual harassment included being sexually propositioned, touched or insulted. Many more nurses had experienced verbal or physical abuse, mainly from patients.

It is apparent from these studies that nurses are not infrequently aggressed by their patients and their co-workers. Unfortunately there are no such studies which look at the level of abuse endured by male nurses, nor are there any which look at the abuse of patient attendants. When planning measures to combat abuse within a given setting, it is essential to know the extent of the abuse suffered by all categories of employees.

4. Methodology

This exploratory study is based on a semi-structured interview guide which is grounded in the sociology of work and nursing literature cited above (Northcott & Lowe, 1987; Monahan & McCarthy, 1992) and on the study of nurse abuse in Saskatchewan (Pekrul, 1992). Accordingly, the semi-structured interview guide includes questions on basic demographic information, educational attainment, level of job satisfaction, job mobility, job risks and defence tactics, and career entry, as well as open-ended questions on the perception of self, work, co-workers, supervisors and clients/patients. A copy of the interview guide is appended. This study is part of a larger, ongoing study of the work experiences of various groups of service workers. The interview guide was developed for the larger study.

The interviews, which lasted 1 to 1½ hours, were conducted outside of work hours at a time and place convenient to the hospital worker. The interviewer, a member of the research group, asked the respondent the questions and recorded the responses. The interviews were conducted in English or French depending on the respondent's preference. The completed interviews were checked for consistency by the interviewer and then reviewed by another member of the research group, who checked internal consistency and asked for clarification, if necessary. On occasion, the interviewer contacted the respondent in order to make clarifications. The responses were coded and entered on the computer for SPSS analysis and the open-ended questions were entered on a WordPerfect file to facilitate textual analysis.

The interviews are part of a larger study, directed by Dr. F. Shaver, on the work experiences of service workers entitled A Study of Human Service Workers. For this larger study, a sample of approximately 50 respondents was recruited from three university-affiliated hospitals in downtown Montreal—Royal Victoria Hospital, Hôpital Saint-Luc and Montreal General Hospital. A variety of recruitment methods were used. The Royal Victoria Hospital agreed to send out letters to each patient attendant employee; the response rate was very low, and did not increase after a second letter was sent. Members of the research group tried to make personal contact with employees in the cafeteria of Hôpital Saint-Luc; flyers were also posted in strategic locations. The union representative, Carole Villeneuve, was extremely helpful in recruiting respondents. She contacted union members to explain the purpose of the study and asked those who were interested in participating to contact a member of the research group at the office. At the time of the interview, the snowball method was employed to try to find other respondents. When it became evident that we were not going to be able to recruit sufficient older women from the first two hospitals, I asked patient attendants at the hospital where I work—Montreal General Hospital—if they would be willing to participate.

The three hospitals had approximately 650 beds each at the time of the interviews, although they have all downsized recently because of government budget cuts. Each hospital employed similar numbers of patient attendants—234, 248, and 268 respectively. The Royal Victoria Hospital supplied data on the age and gender breakdown of their patient attendant employees. From the limited information

available from Hôpital Saint-Luc, we were able to determine that the ratio of men to woman and the percentage of females under age 31 was approximately the same for both hospitals. It was assumed from this information that the percentages for the other age groups, both male and female, would be similar. Based on this assumption, a stratified sample according to age group and gender was randomly selected from the initial fifty interviews, using a table of random numbers, for a total sample of 27—10 women and 17 men. This stratified sample of twenty-seven male and female patient attendants is the subject of my research project.

Patient attendants at all three hospitals were extremely suspicious of the research, probably because it was the first time that they had been asked how they felt about their jobs. In light of the impending health service reform, they may also have been fearful that this research would be used by management in some way to negate their role and close positions.

All of the patient attendants are unionized, although the actual union to which they belong can vary between hospitals. The number of full-time positions is not necessarily the same for all hospitals, although both the Montreal General Hospital and Hôpital Saint-Luc have an approximately fifty-fifty split between full-time and part-time positions. In the three institutions sampled, 45 to 50% of the female patient attendants and about 55% of the male attendants work part time. (The men working full-time make up 76% of our male sample and are, therefore, over represented). Patient attendants employed in permanent part-time positions have the same job security as full-time staff, but those employed on availability or on-call have no

minimum hours or job security. The conditions of employment are all specified in the various collective agreements negotiated between the government and individual unions. It is current hospital practice to employ staff on availability as a cost-cutting efficiency measure. Working on availability could have an effect on job satisfaction and perceived job-related stress, both of which could affect the subjects' desire to continue doing this type of work and adversely affect their work experiences.

As described earlier, hospital ancillary workers have different titles depending when and where they work. For the purposes of this study, I will use the title "Patient Attendant" (Préposé(e) aux Bénéficiares) which, together with Beneficiary Attendant, is currently used in most Montreal hospitals to reflect workers of either gender. This replaces the titles "Ward Aide" and "Orderly" used in the interview guide and which differentiated the female and male jobs respectively.

4.1 Description of the sample and the subjects

The sample of ten women and seventeen men reflects not only the ratio of women to men working as patient attendants at two of the three hospitals (gender breakdown was not available for the third), but also the proportion of men and women in each of the age groups (under-31, 31-to-50 and over-50) and can therefore be generalized to the patient attendant populations in these institutions

Of the 27 respondents, 22 were born in Canada, most of them in Quebec, three were born in western Europe, and two in the Caribbean. All of those born abroad are in the over-50 age group. All but one of the respondents have lived in the greater

Montreal region for at least 6 years, some for more than 40 years. One man has been in the Montreal area for just one year. The sample is overwhelmingly Caucasian, with only two women of colour.

There are two women in the under-31 age group, and four in each of the other two age groups (31-to-50 and over-50). As a whole their ages range from 27 to 61 years, with a mean of 43 years. There are seven men in the under-31 and the 31-to-50 age groups, and three in the over-50 age group. The men's ages range from 25 to 67 years, with a mean of 38 years.

The respondents' educational attainment is extremely varied, from less than high school to university graduate. Only 3 of the respondents did not complete high school, all of whom are in the over-50 age group. Of the others, 8 completed high school, 3 took some college courses, 5 completed college, and 8 attended university, 4 of whom obtained a bachelor's degree. As can be seen in Table 1, 5 women (50%) and 8 men (47%) have had education at the college level or higher.

Four of the women are single, four are cohabiting and two are married. Four of them have dependent children living with them and one has an adult child living at home. Three of the women live alone. Eight of the men are single, four are cohabiting and five are married. Only two of the men have dependent children living with them; another has an adult child living at home. Five men live alone. All of the respondents with dependent children are in a two-parent family relationship.

Three of the women speak only English and five speak only French. The other two women speak French and at least one other language well enough to work in that

language. Only two of the men do not speak French; five speak only French, and ten speak French and another language.

Their work as patient attendant provides the only source of income for 6 of the women and 18 of the men in this sample. Half of these women live alone as do a third of the men. Family allowances/alimony/child support/scholarships account for the other source of income for all of the women and for two-thirds of the men; only the men have investment income. Since all hospital patient attendants are unionized, their salary is governed by the collective agreement. For those with only this one source of income, their salaries range from $20,000 to $29,999, i.e. an average hourly rate for a 36-hour week of $10.68 to $16. This rate is considerably higher than the current hourly rate for attendants working in private nursing homes, which hovers around the minimum wage of $6.50 an hour.

Table 1. Selected demographic characteristics of the subjects by gender and number of respondents

	Women	Men
Place of birth		
Canada	7	15
Europe	1	2
Caribbean	2	
Age		
Range	27 - 61	25 -67
Mean	43	38
Education		
< High school	2	1
High school	3	5
Some college		3
College	3	2
Some university	1	3
Bachelor's degree	1	3
Family situation		
Single	4	8
Cohabiting	4	4
Married	2	5
Live alone	3	5
Language(s) spoken		
French	5	5
English	3	2
French + other	2	10
Salary only source of personal income	6	11
N =	10	17

5. FINDINGS

5.1 Work demographics

Patient attendant is the main occupation for 26 of the 27 respondents. The remaining respondent, a 37-year-old male, is a full-time student who works part time. Half of the women work full time as do three-quarters of the men (full time is 36.25 hours per week). The mean number of hours worked by part-time workers is 23.6 for women and 24.3 for men. Those with full-time positions are also those who have been in the job the longest. All of the women working full time have been employed in the same job for six or more years, as have almost half of the men. Of those working part-time, 4 of the women, but none of the men, have been there for more than six years, which I think reflects the reality of a person taking a part-time position either to make money while studying or in the hope of progressing to a full-time position. If a full-time position does not materialize, they leave. Women who are primary care-givers and who take a part-time job to supplement family income may be content to stay part time, especially while their children are small.

The respondents were asked to describe the circumstances surrounding their decision to begin working as a patient attendant; from their descriptions, it can be seen that they chose to become patient attendants for a variety of reasons. For those who came from other jobs, a dislike of their previous job is the most frequent response (25% of total), followed by a need for more job security (17%). Several of the men had been working in the construction industry, one of them said

> *"a friend of mine got killed (on the job), it changed my mind about working in such a dangerous field"* (R268).

Another said,

> *"J'étais en construction, pas d'emploi dans ce domaine pour une période. J'ai vu des cours de préposé dans le journal—pourquoi pas?" (R259)*

Previous job experiences included warehouse supervisor, waitress, mechanic, medical secretary and legal researcher. Most of the choices open to the women were in the service industries.

Reasons for choosing to do this type of work also vary by age; respondents in the 31-to-50 age group are more likely to report that they chose the patient attendant role because of the job security attached to public service employment. Those in the over-50 age group, however, are more likely to want to change to the patient attendant job because they disliked their previous employment.

Half of the women were already working in the health care system before becoming patient attendants. The other half knew someone working in the field who told them about the work. In contrast, only one of the men was already working in the system, although 12 of them had family or friends who were working in the field. There were, therefore, only 5 respondents (all men) who had no previous knowledge of what kind of work was involved in being a hospital patient attendant.

An inability to speak French well enough to be able to work in the language does not appear to have been a major barrier to job opportunities in Montreal. Only six respondents did not have other job choices at the time they began working as patient attendants; half were monolingual French speakers and half bilingual. Although five of respondents do not speak French well enough to apply for a job using French, all had other job possibilities and all of them are currently working in English-sector hospitals. Three-quarters of those with no other alternatives are in the younger age group, which

is probably more a reflection of the high unemployment levels in the Montreal region—i.e. lack of opportunities rather than a lack of education or interest.

Two of the men with B.A. degrees were in administrative positions before becoming patient attendants: one of them (R253) worked in a bank but found that the job there afforded him little autonomy "*no leeway, unable to make suggestions to improve the situation*" so he left. The other who had been working in a hospital administration said that he disliked "*the lack of contact with people*" (R263), both of them have been working as patient attendants for more than ten years.

When asked where they had acquired the skills needed for their present work, women and men responded somewhat differently. The majority of the women answered "on-the-job training," compared to just over one quarter of the men. Twenty percent of women compared to 41% of men said they had taken an independent training course, and 10% of women and 29% of men had received formal training from the hospital.

On-the-job training is described as including one-to-three days of central orientation to the hospital and one day to three weeks working with an experienced patient attendant. During central orientation, new employees are introduced to the physical environment of the hospital in general and their assigned units in particular, and to the basic safety procedures within the hospital, such as fire drill and infection control. One man said that his orientation also included training on how to deal with aggressive situations (R260). Working with an experienced attendant gives newcomers the opportunity to learn what is expected of them as far as the work is concerned. In addition, they also learn the "insiders" point of view—who to ask for

advice and who to avoid. Those who received formal training from the hospital—mainly the patient attendants at Hôpital Saint-Luc—were trained by a clinician from the nursing department. This training was reported to be from one-to-four weeks. Independent training courses of one-to-four weeks duration and costing between $275 and $400 are now required by most hospitals before hiring anyone for a position as a patient attendant, unless the applicant is already employed in the hospital.

The female respondents were slightly older than the men when they started work as patient attendants, having a mean age at entry of 32 compared with 28.5 for the men. Although the range for length of time employed as a patient attendant (not necessarily in the present position) is similar for both men and women, the mean length of time is much higher for women: 10.5 years compared with 5.6 for the men, indicating that women are more likely than men to make this a long-term career.

Just over half (59%) of respondents work on acute-care units covering a variety of specialties, including cardiac surgery, general surgery, obstetrics, psychiatry and the emergency department; the rest work in long-term care or geriatric settings. Half the respondents work the day shift, just over one quarter the evening shift, and about 20% the night shift. One man works split shifts,[1] depending on the hospital's needs and work availability.

During the day and evening shifts, patients on both the long-term care and acute-care units are likely to receive 30 minutes or less of care from both male and female patient attendants, whereas on the night shift they are more likely to receive

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[1] For the purposes of comparing the day, evening and night shifts later in our analysis, the man working split shifts is treated as a missing value. His responses did not seem to align with any particular group and it seemed inappropriate to force him into one of the other categories.

more than one hour of care. This may be more related to the fact that although at night the patient attendant potentially has more patients to care for, at least some of them can be expected to be asleep. Accordingly, it is probable that fewer patients will actually require care, so more time can be spent with those who do. In contrast, during the day, when the unit is at its most active with regard to hygiene care and ambulation, patient attendants are unable to spend as long with each client. Patient attendants working in long-term care units can have 20 or more patients per shift, whereas only 22% of those working in acute-care units are expected to care for this number of patients. On average, older patient attendants spend more time with their patients than do their younger counterparts.

In response to the question "*If you had to do it again, would you do the same type of work you are doing now?*" the majority (19/26) of respondents say that they would choose the same type of job again, given the same options. Among the reasons given, the one most often cited is that they like the work. This is true for both men and women. Other reasons given include contact with people (14% women and 8% men) and more job security (14% women). The availability of alternative job choices at the time they became patient attendants does not appear to influence whether or not they would choose the same type of job again.

Table 2. **Selected job-related demographic characteristics of the subjects by gender**

	Women	Men
Full-time	5	13
Mean part-time hours	23.6	24.3
Length of time working as patient attendant (in years)		
Range	1 - 26	1 - 29
Mean	10.5	5.6
Where patient attendant skills acquired		
On the job	7	5
Independent course	2	7
Formal hospital training	1	5
Age at entry		
Range	19 - 47	18 - 46
Mean	32	28.5
Type of unit		
Acute care	7	9
Long-term care/geriatrics	3	8
Shift worked		
Day	6	8
Evening	1	6
Night	3	2
Split	—	1
Would chose same job again	7	13
N =	10	17

Although almost three-quarters of women and men say that they would choose to do the same job again, there seems to be some variation in willingness to choose the same job depending on the shift worked. When the data are broken down by shift worked, we find that most women and men working the day shift say they would choose the same work again; all of the respondents working the evening shift would also choose the same job again, as would the man who works split shifts. However, two-thirds of the women and all of the men working the night shift would not choose the same type of work again. The main reasons given by all three of the women is that they would like to do some other type of work. From their descriptions concerning their circumstances before starting this type of work, it appears that this was their first job and that they did not have other offers of employment. One woman (R171) came to the hospital as a student nurse but did not finish her training and stayed on as a patient attendant. The four men who would not chose this type of work again also said that they would prefer to do something else. One of them (R266) said that he had been

> *"fed up with job as buyer for a jam manufacturer"*

and that he had also had other alternatives such as construction, but that the

> *"salary at the hospital was much better. Other job—10 to 12 hours a day, 6 days a week and was making more working here. The work most of the time is easier here".*

Later in the interview he said that he finds the work exciting, especially

> *"when a trauma comes in... I find it's rewarding work: helping people who aren't able to help themselves.....I get along with everyone."*

Nevertheless, he dislikes

"the shifts. Not knowing when and where I'll be working....Working weekends"

and feels that the job gives him no means of personal development and these sentiments appear to be the main factors influencing his negative response.

Two of the men had lost their previous jobs: one of them, who had worked as a designer, had exhausted his unemployment benefits and took the job as a patient attendant because he had a job offer, but he does not like the work and also feels that there is no room for personal development (R250). The other man learned of the patient attendant job from his bank manager; he likes the work with the patients, but dislikes the relationships with the nurses

"Trop de patron, trop d'infirmières—c'est eux mes patients" (R270).

The fourth man, who works the night shift, was a student who needed money to finish his studies; he knew other students who worked as patient attendants and the schedule was flexible enough to allow him to both work and study. However, he dislikes the repetitive nature of the work, the

> *"manque d'autonomie, pas droit aux dossiers, ... pas accès aux informations pertinents... salaire—c'est pas assez"* (R269).

Although at first, it appears that working the night shift may be the main influencing factor for why the respondents say they would not chose the same type of work again, there are in fact many reasons. The respondents all say that they like the contact with the patients, but they dislike other aspects related to working conditions.

None of the respondents who say they would not choose the same type of work again are actually looking for another job.

All respondents with university degrees and all respondents in the over-50 age group, regardless of educational qualifications, say they would choose the same job again. Nevertheless, the respondents with university degrees were all actively looking for another type of job at the time of the interview, even the two mentioned earlier who have been doing the job for more than ten years. Even if they are looking for another job, they say that they think they will still be doing this one for another two to three years. Again, I think this is a reflection of the high unemployment levels in Montreal and the effect of public service workers' job security.

All but one of the women have plans—or perhaps dreams—of doing something other than work as a patient attendant in the next five years. Three of them plan to retire, the others would like to do things as varied as writing a book to becoming a biochemist. While four of the men see themselves continuing to work as patient attendants, two plan to retire, seven want to finish their education, and the other two have other job plans.

I find it surprising that even those who said they would choose to do the same job again have plans to do something else within the next five years. I believe that the current climate of uncertainty in the health service contributes to this desire to change jobs. Even though job security is guaranteed in the collective agreement there has been evidence recently that the government of Quebec has considered reopening the

collective agreement and changing the conditions of job security, perhaps abolishing it altogether.

Difficulties meeting family commitments because of the shift worked do not appear to play a major role in whether on not the respondents would chose the same job again. Six of the respondents—four women and two men—have dependent children living with them. Two of the women work days and two work nights. The two men are also equally divided between the day and night shifts. None of the respondents said they would not choose the same job because of the job's negative effect on family life. Of the seven respondents who would not opt for the same work again, six are monolingual French speakers; the other one speaks English and French.

5.2 Attitudes to work

Three-quarters (20/27) of patient attendants say that they like their work, but there are differences expressed according to gender and the shift worked. All but one of the men (94%) like their work, compared with only half of the women.

Day- and evening-shift workers are more likely than those working the night shift to say that they like their job (Table 3). As will be discussed later, the majority of patient attendants enjoy the relationships they develop with the patients and the lack of contact with the patients may account for the night-shift workers not liking their work.

Table 3. Attitude to work by shift worked, gender and number of respondents

	Women			Men			
	Shift worked			*Shift worked*			
Attitude to work	Day	Evening	Night	Day	Evening	Night	Split
Dislike			1				
Neutral	2		2			1	
Like	4	1		8	6	1	1
N =	6	1	3	8	6	2	1

The type of setting in which the respondents work appears to have little or no effect on whether or not they like their work—at least for the men: all men working on acute-care units and most of the men (86%) working on long-term care units like their work. In contrast, not one of the women working in long-term care units says that she likes her job: all of them expressed neutrality towards the job, as did one woman working in an acute-care setting. The woman who dislikes her job (R155) works in obstetrics, an acute-care setting. However, it does not appear to be the setting she dislikes but rather the insecurity of working part time and on call. She said that she had been working in a restaurant which offered no security; she wanted to become a hospital patient attendant because she believed that there was *"lots of work,"* and that it would offer her more job security. Having made the choice, she paid $400 to take an independent training course. Once this was completed, she sent out over 100 CVs, but had to wait eighteen months before being offered her present part-time, on-call position (R 155).

Respondents were asked "*Is your work 1) very stressful 2) somewhat stressful 3) not very stressful 4) not at all stressful.*" Categories 2 and 3 were later collapsed to make one category—somewhat stressful. The reported level of stress engendered by the job does not appear to affect whether or not a respondent likes or dislikes the job (Table 4). This is true for men and women, regardless of the shift they work.

Table 4. Effects of stress on how well the job is liked by gender and number of respondents

	Women			*Men*		
	Overall level of stress related to work					
How well do you like your work?	Very stressful	Somewhat stressful	Not stressful	Very stressful	Somewhat stressful	Not stressful
Dislike		1				
Neutral		4			1	
Like	1	3	1	5	10	1

5.3 The effects of shift work on non-work activities

Working the night shift does not appear to have the negative effects of social isolation and disruption of diurnal rhythms described in the literature. Respondents were asked "*Thinking back over the past month, how many times did you go out to do each of the following activities... With whom did you go most often?*" From their responses (summarized in Table 5), it is apparent that those respondents who work the night shift spend the most time on leisure activities outside of their homes and are most likely to be accompanied to these activities. There is only one activity, going to

the movies, when night-shift workers are more likely to unaccompanied than are those respondents working either the day shift or evening shift. It appears that those who work the evening shift are the most socially isolated, with a lower percentage of respondents taking part in all the activities mentioned and also a higher percentage of them going to the activity alone. The man who works split shifts (who is not included in Table 5) says that

> *"shift work screws my system up to the point that I was so run down that I had to cancel (work and leisure activities) for health problems"* (R266).

Such a response is supportive of research showing that continually changing shifts disrupts diurnal rhythms and leads to illness (e.g. Harvey, 1993).

Table 5. Respondents leisure activities by shift worked[2]

	Shift worked					
Type of activity (at least once in the previous month)	Day		Evening		Night	
Sports	64%	(44)	57%	(75)	80%	(0)
Movies	57%	(25)	57%	(0)	60%	(35)
Courses	36%	(100)	14%	(0)	40%	(50)
Restaurant	93%	(8)	71%	(0)	100%	(0)
Meetings/Volunteer	21%	(33)	14%	(100)	60%	(7)
Visit relatives	71%	(30)	57%	(33)	100%	(20)
Shopping	71%	(45)	57%	(50)	80%	(40)
Other things	29 %	(25)	57%	(50)	40%	(0)
N =	14		7		5	

[2] The figures in parentheses represent the percentage of respondents who went to this activity alone.

5.4 Work-related stress

Older women find the work less stressful than do the older men. In contrast, younger women find it more stressful than do the younger men. In the 31-to-50 age group, some men find the work very stressful and others find it not stressful at all (Table 6).

Table 6. Degree of work-related stress by gender, age, and number of respondents

	Female			**Male**		
	Age of respondent			*Age of respondent*		
Degree of work-related stress	under 31	31-to-50	over 50	under 31	31-to-50	over 50
Very stressful	1			2	2	1
Somewhat stressful	1	4	3	4	5	2
Not stressful			1	1		

When the level of stress is looked at from the point of view of the shift worked and the age of the respondent, it can be seen that in the under-31 age group, those working the day and evening shift are more likely to see their work as very stressful than are those working the night shift (Table 7). In the 31-to-50 age group, the evening shift is most likely to state that they find the work very stressful, and this is also true for the over-50 age group. Only two of the respondents—one man under 31 and one woman over 50—report that they do not find the work at all stressful: both of them working the day shift. Five of the six respondents who say that their job is very stressful are men, all of them work in acute-care settings. From their responses to other questions concerning the presence of hazards or other stressful factors in the

workplace, the only common threads connecting these six respondents is a concern for their personal safety as regards the risk of infection and the risk of accident or injury. Interestingly, in the previous twelve months, only one of these six people had had any time off work with a work-related injury, whereas there were six other respondents who had had time off work for whom this risk was not a considered to be stress factor. Increased workload and pressure of work was mentioned by two-thirds of the men and half of the women.

Patient attendants are frequently interrupted in the course of their work to assist in the transfer of patients to and from stretchers, and to assist in ambulating heavy patients. These interruptions can be very time-consuming; they also disrupt the attendant's work plan and can decrease the feeling of accomplishment—having to rush a task or abruptly end a conversation with a patient. If the patient attendant does not respond as quickly as the other personnel would like then interpersonal tensions can be heightened, creating a more stressful work environment. It is difficult to envisage a solution if this is the problem. given the unpredictable nature of the occurrences.

Table 7. Degree of work-related stress according to shift worked by age and number of respondents

	Age of respondents								
	Under-31			31-to-50			Over-50		
	Shift worked								
Work is	Day	Eve.	Night	Day	Eve.	Night	Day	Eve.	Night
Very stressful	2	1		1	1			1	
Somewhat stressful	2	2	1	4	1	4	3	1	1
Not stressful	1						1		

5.5 Effect of AIDS on the work of the patient attendant

There are aspects of the patient attendants' work which could be regarded as potentially stressful, for example, the risk of contracting an incurable disease such as AIDS. When asked "*Has the AIDS situation affected your work?*" the majority of patient attendants (16/27) say that they feel that the AIDS crisis has increased their concern for their personal safety. This appears to be more of an issue for women than it is for men—three-quarters of the women compared to just over half of the men expressed this feeling. When asked to describe how the AIDS situation has impacted on their work, they gave a variety of responses. One woman and six men under 51 say that they are more cautious with their patients. Two older women and one man under 31 say that they are more anxious and afraid of becoming infected. The greatest impact that these concerns have had on the patient attendants' daily work is in the area of protection. Two-thirds of them say that they have increased their use of

physical protective barriers such as vinyl gloves, gowns and masks. Five respondents have increased their knowledge about the disease and its modes of transmission to help them feel more comfortable doing their job. One woman (R157) says that she double-gloves if she thinks or knows that the patient is HIV-positive because she believes that the gloves split easily and she wants to minimize her risk. Only one respondent said that he tries to find out more about the patient's HIV status, and the same respondent reports that he has been tested for HIV in order to protect his family from any risk of infection (R253). Those in the 31-to-50 age group feel most affected by the AIDS situation. The patient attendants say that they get the majority of their information about HIV and AIDS from the media and the hospital. There appears to be a fair amount of discussion and sharing of information on this subject among the male patient attendants; seven of them say that they get information from their co-workers, but only one female attendant mentioned getting information on the subject from her co-workers.

5.6 Work-related self-esteem

Work-related self-esteem can boost self-confidence and increase job satisfaction. When asked "*How good (skilled) are you at your work compared to other ward aides and orderlies in the hospital?*" the majority of the patient attendants in this sample think that their performance on the job is better than their co-workers. Four respondents (1 woman and 3 men) say that they do not know, or that they do not compare themselves to others, and 2 women and 1 man consider themselves to be

about the same as their co-workers or average. Of the remaining 20 respondents, 2 women and 4 men say that their work is the best and 5 women say that they are good, as do 9 men.

The reasons why the majority of this group think that the work they do is better than that of their co-workers seem to vary by gender. Men are more likely to be told that they are good by the people they work with. For example:

> "*The nurses that I work with say "We had so and so yesterday—he didn't know what to do-we're glad you're back today*" (R253).

He also said that he tries to help the nurses, looking for things that need doing before he's asked to do them. R266 reported that he hears the nurses say "*Thank God*" when he walks on duty, and he says that he makes more of an effort than most. Other men said:

> *"If there's a difficult patient, people come to me for advice on how to handle them. People feel comfortable with me. People (staff nurses) are happy to see me arrive." (R268)*

> *"Je me donne à 200%, j'ai peur qu'on me dise que je ne travaille pas assez, les commentaires sont très bons*" (R259).

Many of the men said that they go out of their way to do extras for the patients, taking their time with them even if it means staying late. Or as one put it:

> "*For me it's a total service*" (R263).

The women were more likely to say that they knew themselves that they did a good job and did not need to be told by others.

> "*(I am) better than others because I do it with my whole heart*" (R169)

and

"*J'ai une empathie naturelle.. je suis dévouée—quelqu'un de confus, je les aide. Je les écoute, je me préoccupe d'eux*" (R152).

Besides relating how they know that they are doing a good job, the female respondents expressed their opinions about their colleagues. Some of these views were extremely negative, more than half of the women expressing disapproval of other attendants' work:

"There are some I would not want to work with. They are disorganized. They don't wear gloves" (R173).

"Others try to leave things undone" (R174).

"Ils ne sont pas aussi conscients—ils voient le travail mais ils disent 'C'est pas mon travail'" (R152).

"Some orderlies are always hiding somewhere" (R169).

"Les autres—réguliers—le moins qu'ils font le mieux, c'est qu'ils veulent faire le moins que possible" (R155).

"Some of the others are lazy, I can't stand laziness. Don't leave it all for the next fellow" (R172).

Whereas only three of the men were prepared to be as critical of their colleagues:

"I try and give more of an effort than some orderlies. I don't go and hide in the utility room. I feel that there are a lot of lazy orderlies. I've had to work with them" (R271).

"Il y a des préposés qui ne veulent pas travailler comme il faut—je ne sais pas pourquoi ils font ce type de travail...Il y a des autres—paresseuses" (R270).

"There are those who are not interested and who don't do their job properly" (R271).

Five respondents said that they were more experienced than others and, therefore, it was normal that their work should be better.

5.7 Aspects which patient attendants like about their work

Individuals who like their job are more likely to perform well and be more productive in the workplace. When answering the question "*What do you like about your work?*" many of the patient attendants provide clues as to why they stay in the job. Men say that they derive satisfaction from working with the patients, that their work is intrinsically meaningful to them:

> "*What I do I attach meaning to ... When I do this work I find I am really doing work and contributing to society*" (R257).

He also said that you do not necessarily have to like a particular task, you do it because it makes the person you're doing it for feel good. Other men expressed similar opinions:

> "*You see results straight away, instant gratification*" (R259).
>
> "*I find it rewarding work; helping people who aren't able to help themselves*" (R266).
>
> "*It's gratifying when patient is in a bad state and you see them rehabilitated to go home*" (R268).
>
> "*C'est un travail valorisant pour moi-même, on fait plaisir à quelqu'un qui a besoin d'aide*" (R251).
>
> "*Je me sens utile*" (R259).
>
> "*It all has to do with human respect. I like helping people who need my help*" (R279).
>
> "*Je me sens d'une part responsable pour le guerissage.—Je suis aussi important que le médecin et l'infirmière, même si nous sommes le plus bas de l'hierarchie*" (R271).
>
> "*I like when I've done a good night's work—contented—self-confident—makes me feel appreciated—we work hard but we work good*" (R272).

"*I like that I help patients—that gives my job significance*" (R260).

Seven of the men also have family members who are happy or proud of the work that they are doing. There is only one woman with this positive family reinforcement of the value of her work. In addition, four of the women have family members who do not like or who disapprove of them working as patient attendants. Only three of the men experience this negative family influence. Family support for the work one is doing has been shown to be an incentive for staying in the job and it increases self-esteem (Wagner & Colling, 1993: Monahan & McCarthy 1991).

There is a general feeling that there is more autonomy in the emergency department and that the nurses working there show more respect for the patient attendants than in some of the other departments. For the most part, the patient attendants feel that they are part of a team, although they would like to be able to contribute ideas and have more input into patient care. The majority feel that the salary is acceptable and that the working conditions are good and clean.

Contact with people and helping others are recurrent themes for both men and women working all shifts and in both acute-care and long-term care settings, although the women are less expressive when they describe what they like about their work. Some of the things they say are:

"*I like helping people—doing for others...It's tough but satisfying*" (R172).

One women working on a geriatric unit expresses it this way:

> "*Aider les personnes âgées, leur apporter du confort—trouver un soulier pour un patient Alzheimers, c'est leur donner une sécurité*" (R152).

Contact with people is the main aspect that men liked about the job, whether they had been working for a year or for more than twenty years. Women who had recently joined this work force are more inclined to say that they like the variety in the job and the pay, but women with more than two years' experience like the human contact best.

From the responses to an open-ended question asking the patient attendants to give as full a description as possible of their working day, it is possible to see that many of them do more than is required by the job description. For example, one young man with a B.A. degree says:

> *"I collect the OR list for the next day on my way to the floor—it's not my job but I do it anyway—it helps me plan my shift. I can see right away who's for surgery tomorrow so I know who will need to be bathed, shaved or get an enema....I go round to see them (the patients) and evaluate who is heavy, who will need turning or getting back to bed....Socializing with the patients is really important, build up their morale. I joke with the patients—on a first name basis, even the old guys, I couldn't work with surnames—it's too cold and distant....Sometimes I read up on things (about the patients) discuss it with the nurses if there's time—makes me use my brain a bit"* (R253).

In this way he is able to develop his job to meet his own expectations, it gives him a measure of control and makes his work more interesting.

An older man who works in psychiatry says:

> *"Some, we do everything for them, dress, cut toenails, cut hair! We have to make them feel better, to motivate them. We encourage them to play...I organize games, encourage them to play, I play with them.... If there's time, I take a group for a walk outside. .. I tell them stories about the past"*

and he demonstrates his understanding of the patients' condition when he says:

> *"For violent patients—I don't stay too close—at arm's length. Paranoid patients—I give them space, room. I never contradict disturbed patients, allow them to ventilate feelings"* (R268).

Another older man working in geriatrics employs some psychology with his patients:

> *"I always encourage people to eat on their own - it gives them a sense of independence—if they see themselves as weak and sick they are not going to get better. If the patients aren't mobile, I have to wash them in bed, it's usually alright, they sometimes get upset, but a little joke usually helps.....To prevent bedsores, I have to change/move the patients around.... I ask the patient how he/she wants to lie/sit. It's a service—I'm there to please the customer/patient, If he/she is happy, I'm happy"* (R263).

One man who works the evening shift on an oncology floor feels that he is able to help people who are dying:

> *"la nuit je vais voir les patients qui vont mourir et leur dire qu'est-ce qu'il y a de l'autre coté. Ils ne vont pas être tout seuls—les infirmières viennent me chercher des fois pour le dire au patient—les infirmières savent que je fais ça"* (R255).

Some of the women feel equally involved with their clientele. An older woman working in general surgery says that;

> *"After lunch when it's quiet I make time to talk to the patients, especially those who don't have any visitors—those that are dying. I sit and hold their hands—just to let them know that they aren't alone. It can be very satisfying"* (R172).

Another older woman who also works in general surgery says:

> *"Serve lunch, feed with a spoon, use a bib to cover patient. I like doing it. I can get them to eat when the others couldn't.... I sit down and baby them, talking and making them laugh. I spend some time with them especially those who have had a stroke....I wrap dead people occasionally and accompany them to the morgue. I like to wrap. It finishes things"* (R174).

These patient attendants are making their job their own, adding another dimension, making it not just another task to be accomplished.

5.8 Aspects which patient attendants dislike about their work

It is not uncommon for individuals to dislike certain aspects of their employment. Whether or not this dislike interferes with overall job satisfaction or increases work-related stress depends on the degree of control that the individual feels that s/he can assert to improve or alleviate the situation. Only one woman says that there is nothing that she really dislikes about her work. Everyone else dislikes some aspect of their work. Two women say that they dislike cleaning feces either from patients or from equipment such as commodes. For others, it is the physical aspect of the work—lifting heavy patients. Providing intimate care for patients of the opposite gender was mentioned by several women:

> *"I think men should be washing men, women washing women— as before. It's really hard for me to change and it's hard on the patients. The women don't like to be washed by men, at least most of them don't like it, and I don't like having to wash the men, it's not right"* (R173).

Another woman said:

> *"En urologie—il faut faire les rasages pour les vasectomies....les pansements aux pénis—je trouve ça inapproprié à demander à une femme—ça devrait être un homme—je trouve pas que je devrais faire ça. Je vais plus, je dis 'non' quand ils m'appellent pour aller là"* (R158).

Others express feelings of being at the bottom of the ladder:

> *"Je déteste le terme de préposé, je trouve ça très froid, péjoratif, ça ne me valorise pas, j'ai honte, je ne m'en vante pas avec les autres"* (R157).

Another said:

> *"I dislike when people feel that according to your job you're nobody. You're lower than somebody, for example when nurses say 'I didn't go to school to do that'* (R169).

> *"On dirait que les infirmières nous donnent tout le travail qu'elles ne veulent pas faire"* (R158).

"*C'est pas valorisant... On n'est pas respecté*" (R152).

Three women mention the lack of communication between nurses and the attendants and that the attendants are not given sufficient information about the patients, either for the patients' benefit and or for the protection of the attendants. Another three say they dislike the fact that when the attendants propose changing something, other members of the health care team do not listen to them.

The men tend to dislike the lack of autonomy, pressure of work, night shift and weekend work. This is especially true for those men who do not have a permanent position, who are on call and who find themselves working nearly every weekend in order to make up enough hours. Men also express difficulties when being asked to do hygiene care for patients of the opposite gender:

> *"Will not wash females because there have been problems here before, for example a guy was fired because she said he sexually assaulted the woman. If told to bathe a woman, I'll say, if nurse assists, okay, otherwise won't do it"* (R266).

> *"If it is a female patient, I always take a nurse with me. They (patients) can be paranoid and accuse you of doing things—touching"* (R268)

> "*Baths, [I] feel uncomfortable giving them... uncomfortable with genitals, breasts, etc. Okay to wipe faces, necks, arms, hands of patients, but not comfortable with 'private parts'*" (R274).

Heavy workload, in particular caring for heavy patients, is a recurrent problem for men:

> *"Strain transferring patients from chair to bed, etc. Before I used to be able to get help, ring for the orderly on call to get 3-4 guys, it was easy, now there's no one to call on, I get the nurses to help, but I have to do the heavy part*" (R253).

An older man said

"*Workload-it's too much work, but maybe it's my age, but also they took away other orderlies so more work. Too much to do. Sometimes heavy patients-sometimes you can't find help so you have to do it yourself*" (R268).

Although more men than women complain about the heavy nature of their work, women suffer more back pains than their male counterparts; nearly half of the women say that they have back pain more than once a week compared with only one fifth of the men.

Several of the men referred to the effects of recent cutbacks. One man says that he does not

"*get time to get close to the patients, no time to be able to sit and talk with them, help them emotionally*" (R259).

Another says that the budget cuts

"*Puts stress on me personally because I can't give the care that is required.*"

He also thinks that some of the nurses are

"*very arrogant, they think they're better than you because they're a nurse and I'm an orderly*" (R266).

In the same vein, one man states:

"*Je n'aime pas des gens qui nous traitent comme si on est rien. Je ne comprend pas pourquoi on est considéré pas très important... on est comme les rideaux de décor...[ils] nous considerent pas partie de l'équipe sauf quand ils nous ont besoin*" (R266).

Others mention that they do not feel implicated in the care of the patients and one man commented that when he remarked about a patient's condition to a nurse she said:

"Qu'est-ce que vous savez la dedans?" (R250).

I had expected that the *dirty* work associated with looking after sick people, cleaning excrement, for example, would have been one of the main areas of dislike. However, this was not the case for the majority of respondents and issues related to dirty work will be dealt with in the next section.

The respondents were also asked what they did about the things that they disliked. The replies indicate an overwhelming sense of impotence, especially about the work structure and the feelings of being put down. Many made comments such as:

"Complain, but they say no money" (R274).

"There's nothing you can do about any of those" (R279).

"Nothing I can do" (R266).

"Nothing, there's nothing I can do, I'm just an orderly. Complaining is useless, because we're a public institution" (R260).

"That's the job" (R253).

"I have complained but they don't do anything so I take time off without pay" (R268).

"Les collègues de travail sont bien amiables. C'est pourquoi je reste— les autres choses, j'essaye de les ignorer" (R159).

"Je peux rien changer" (R157).

Several women say that they tolerate the things which they dislike in the hope of having something better in the future (a permanent position or a position on a unit that they like or, in one case, another job outside of the hospital). For some of the over-50 respondents, it is a case of tolerating whatever they dislike because they feel

that the chances of finding another job at their age and in the current climate of high unemployment are poor:

> *"I have thought about leaving, but I don't know where to go really, so I stay. I am not getting any younger either and it's not so easy to find a job nowadays" (R173).*

Fear of job loss means that respondents are more likely not to complain about aspects of their job which they dislike. One under-31 man with a B.A., who works on-call said:

> "*They are closing departments, and I'm scared because they are cutting people*" (R257).

Even when respondents were prepared to tell someone about their difficulties concerning lack of information or lack of respect, they felt that the effect was short-lived at best, so there really is not much point in risking being labeled a trouble-maker.

One man (R260), who said that a patient had threatened to kill him when he was discharged, said that he had talked to his superiors about it, but that

> "*There's not much they can do —it's part of the job.*"

Another man (R266) who dislikes working evening and night shifts, said that he does not have a choice:

> "*If I say that I want to work days then I can't pay my rent...nothing I can do.*"

If he refuses to work the shifts which he dislikes, he will not get enough work to make a reasonable wage. In spite of the negative aspects associated with the job and the feeling of impotence, very few of the patient attendants say that they are actively looking for another type of job.

5.9 Dirty work

Although dealing with unpleasant substances, such as vomit or feces, was not one of the major dislikes respondents mentioned about the work, they were still asked "*During your job, you come into contact with substances such as sputum, feces and urine, and perform tasks such as bathing patients and administering enemas. How do you feel about this?*". The majority (66%) have feelings ranging from discomfort to disgust when they encounter these unpleasant substances. Only 4 women and 5 men say that they feel comfortable dealing with these substances or that it does not bother them; 3 women and 3 men say that they are disgusted by them, and 3 women and 8 men feel uncomfortable dealing with them but acknowledge it as part of the job. One man (R278) says that he is scared of catching some infection from patients' bodily emissions. Vomit, odours and sputum are the substances which both men and women find the most offensive. Those who feel scared, disgusted or uncomfortable dealing with these so-called *dirty* substances use a variety of tactics to help them deal with their discomfort. For example, opening windows to disperse odours, making a joke about it with the patient to ease embarrassment for themselves and for the patient, trying not to think about it or trying to avoid having to deal with these substances, or when dealing with them is unavoidable, doing the work as fast as possible. Men and women employ these strategies equally.

The majority of patient attendants wear protective gloves. They will wear gowns and masks if they feel that the situation demands it, although this is often at their discretion. Some of them only wear gloves if they think that the patient may be

infectious, although it is not clear from their responses on what they base their judgment. One man (R269) says that he rarely wears gloves on the geriatric unit, implying that the elderly are not infection risks. One woman (R173) says that she wears gloves to protect herself from the patient, but also to protect the patient from her in case she is carrying any infection. Another man says that although he uses gloves when handling urine or feces, he does not wear gloves when washing the patients as he feels that this is impersonal and insulting to the patients. Even so, he went on to explain that when he is working in the emergency department he wears gloves to wash "*street people who haven't bathed in months*" (R266). Some of the patient attendants say that they do not mind cleaning the patients who could not help themselves:

> "*Sometimes it's not very pleasant, I see myself in a patient's bed, if something happened I'd like them to do that for me*" (R169).
>
> *"If they have an accident—clean up bathroom/sheets, reassure them that it's okay, everyone makes a mistake, make a joke out of it"* (R263)

Nevertheless, they dislike patients who they feel have deliberately soiled the bed, or who tell them that it is their job to clean it.

5.10 Job Satisfaction

Using questions similar to those used by Northcott and Lowe (1987) regarding subjective aspects of work satisfaction, I attempted to gauge the degree of satisfaction that patient attendants derive from their work. A composite measure of job satisfaction

was constructed from the responses, on a Likert scale of 1 to 5, to the following three questions:

A) "*How well do you like the work you are doing?*" 1. Strongly dislike to 5. Strongly like;

B) "*Do you find your work boring?*" 1. Not at all to 5. Very much;

C) "*Do you get any feeling of accomplishment from the work you are doing?*" 1. Not at all to 5. Very much.

The resultant Job Satisfaction Index had a range of 3 to 15; this in turn was collapsed to make three categories—dissatisfied, neutral and satisfied.

Overall, three-quarters of the respondents are satisfied, and only two of them are dissatisfied. There are marked differences between the men and the women and between the age groups. Of the men, only two express neutrality (neither satisfied nor dissatisfied), all of the others being satisfied, whereas only half of the women are satisfied, three are neutral and two are dissatisfied.

All of the women and the men in the older age group are satisfied, as are all of the men in the younger age group. The high level of satisfaction in these categories appears to be related to the degree of personal investment which the patient attendant makes in his/her job. For example all of those quoted earlier who have added an extra dimension to their work (R253, R263, R172, R268, R174) scored highly on this index. In the 31-to-50 age group, two men and two women are neutral; the two other women in this age group are dissatisfied. All of the women in this age group have dependent children living at home and their less-than-enthusiastic feelings

about their job may be an indication of role overload as described by Marks et al. (1993). This theory does not hold true for the two men with young children, who are both satisfied with their job. This may be because they are not the person doing the majority of care-giving in their particular family.

The satisfaction levels do not correlate with the amount of abuse that the respondent has been subjected to; indeed, several of those subjected to the most abuse indicate job satisfaction. This contradicts the theory that rejection of caring leads to low levels of satisfaction (Meddaugh, 1991). In making this analysis, I used the original score on the Job Satisfaction Index rather than the collapsed categories. The woman who has suffered a high level of verbal abuse from patients (R159) demonstrated job satisfaction with a score of 13/15, whereas the woman who has not been abused at all (R155) scored 4/15, the lowest score of any of the respondents. This is the woman already mentioned who dislikes the on-call nature of her job and its inherent insecurity. Nonetheless, the female respondent subjected to the most overall abuse—verbal, physical and sexual—(R157) does have one of the lowest scores 8/15.

There does not appear to be any relationship between a particular form of abuse and the level of job satisfaction. A woman who has been the victim of numerous physical assaults (R171), scored 10/15, while another woman (R174), who has also been assaulted a number of times, scored 14/15. On the other hand a woman who has not been physically assaulted at all scored 6/15 (R152), one of the lowest levels of job satisfaction obtained. The picture is similar for the men who have

been verbally and physically abused: R268 scored 15/15, and another man (R260), who has also been the subject of sexual harassment, scored 13/15, indicating a high level of job satisfaction.

The type of setting in which patient attendants work does not appear to be an important factor influencing the level of job satisfaction expressed by either men or women. While Northcott and Lowe (1987) found no differences between men and woman doing the same job, this does not hold true for this sample. Men and women have expressed different levels of job satisfaction and the main influencing factor appears to be that the women who are not satisfied with their job have young children at home. This would tend to support the gender model rather than the structural model.

5.11 Abusive behaviour and aggression in the workplace

The findings on abuse in the workplace are divided according to the type of abuse. The action taken by the patient attendants following an abusive incident is also discussed. The questions were adaptations of those used by Pekrul (1992) and the results will be compared with her findings.

5.11.1 Verbal abuse

The respondents were asked "*In the past month, how often were you insulted, threatened, or yelled at by... patients, co-workers, supervisors, others (specify)?*" and "*What did you usually do (about it)?*" In the month prior to the interview, two-thirds of

all the patient attendants had been verbally abused, mostly by the patients, but also by their co-workers and supervisors, and occasionally by a patient's family or friends. Just over one quarter of these patient attendants have received verbal abuse from more than one source. Six of the women (60%) and ten of the men (59%) have been verbally abused by their patients. This is a much higher incidence than Pekrul (1992) found in her study—only 33% of her respondents reported being verbally abused by their patients in the previous month. The incidence of verbal abuse from patients' family or friends is much lower, as it was for the nurses in Pekrul's (1992) study; only two patient attendants have suffered abuse from this source. Pekrul asked nurses if they had been abused by physicians, and 20% reported that they had; she did not ask nurses if they had been abused by their co-workers. In general, one quarter of patient attendants have been abused by their co-workers/supervisors in the previous month. Although it is difficult to draw any firm conclusions when comparing samples of disparate size, the overall trend is the same—abuse in the workplace is an everyday reality.

Men are slightly more at risk of verbal abuse than women: 70% of men compared to 60% of women have been verbally abused. Verbal abuse experienced by women from patients occurs equally on long-term care units and acute-care units. On the long-term care units, two of the women verbally abused work nights and the other works days. On the acute-care units, two verbally abused women work days and the other works evenings. The pattern was different for men. There are more men who experience abuse on the acute-care units than on the long-term care units. On

the long-term care units, three of the abused men work nights, the other works the day shift. On the acute-care units, four work days and the other man works split shifts. Therefore, on acute-care units during the day and long-term care units during the night, there is more risk of being verbally abused by a patient. Verbal abuse from co-workers and supervisors is five times more likely to occur on an acute-care unit than on a long-term care unit, but there is no shift-related difference. Verbal abuse from other people only occurred on long-term care units, one incident occurring during the day and the other at night.

Looking at the overall incidence of verbal abuse per work setting, I found that nearly two-thirds of all patient attendants working in long-term care had been verbally abused by the patients. This is probably reflective of the type of patient cared for in these settings; for example, many of the patients in long-term care suffer from Alzheimer's and other illnesses causing cognitive impairment, and they can become aggressive when they do not understand a given situation. Another factor to consider is the frustration felt by those whose physical capacity has been affected, perhaps by an amputation or a stroke, and who have to adjust to the loss of their independence. The rate of verbal abuse in acute-care settings is lower, but most of the respondents work in the lower risk areas of general surgery, urology and obstetrics. Verbal abuse from co-workers, although much less of a problem, still occurs in both long-term care and acute-care settings. Verbal abuse from a patient's family/others was only reported by patient attendants working in long-term care, which is surprising, as several respondents say that they work in the emergency department, which could be

considered a high-risk area for this form of abuse. Again, none of the respondents work in intensive care units which, because of the inherent high stress levels, are high-risk areas for verbal abuse from family and friends. Pekrul's study found that nearly half of nurses working on acute-care units were verbally abused by a patient's family or friends and this is probably a more accurate reflection of the reality of working in these settings.

We were also interested to know what action, if any, is taken following an episode of verbal abuse. We can see from Table 10 that when a patient is involved, men are more inclined to do nothing or take evasive action. Women are more likely to attempt to resolve the issue by dialoging with the individual concerned. Four men and one woman have refused to care for a patient because of verbal abuse. Respondents who are verbally abused by their co-workers are most likely to use confrontation as their main action, followed by informing their immediate superior. No one is prepared to ignore verbal abuse from a co-worker. There are two men who have been verbally abused by their supervisor and no action was taken following the incidents. Of the two attendants abused by other people, the woman spoke to the person being abusive to try and resolve the situation, while the man spoke to his supervisor about the incident. Nobody filed a written report or complaint, regardless of the source of the verbal abuse.

Overall, our patient attendants are more willing than are the nurses in Pekrul's study to take evasive or no action following verbal abuse. More than 10% of nurses filed written reports of verbal abuse and between 46% and 63% of them verbally

report the incident to their supervisor, depending on the source of the abuse; the higher rate is for when a patient's family/friend is involved. Nurses are predominantly female and I believe that in recent years they have been sensitized to the effects of abuse and are no longer willing to accept it as part of the job. The majority of patient attendants in this sample are men, and as men they are more likely to be seen as the perpetrators of aggression than as its victims. In addition, all patient attendants find themselves at the bottom of the hospital hierarchical ladder as regards status and they have already made comments indicating that their opinions are often ignored and they have little input into patient care or unit-related issues. These factors combined, it is little wonder that they are reluctant to complain of abuse from patients.

Table 8. Incidence of abuse by gender

Verbal abuse in past month	Times abused	Women	Men
From all sources		60%	71%
From patients	0	40%	41%
	1 - 9	20%	35%
	10 +	40%	24%
From co-workers/ supervisors	0	70%	88%
	1 - 9	20%	6%
	10 +	10%	6%
From others	0	90%	94%
	1 - 9	10%	6%
Physical abuse in past year			
From patients	0	60%	24%
	1 - 9	30%	59%
	10 +	10%	18%
Sexual abuse			
From patients	0	80%	88%
	1 - 9	20%	12%
Racial discrimination			
From patients and families		20%	
N =		10	17

5.11.2 Physical abuse

The respondents were asked "*In the past year, how often were you physically assaulted (pushed, slapped, struck, choked, etc..) by... patients, co-workers, supervisors, others (specify)?*" and "*What did you usually do (about it)?*" The majority of the patient attendants (64%) have been physically abused more than once in the previous 12 months. There is no evidence that these acts of physical aggression caused actual bodily harm requiring medical treatment. Physical damage appears to have been in the nature of scratches and bruises. Although no serious physical harm is occasioned, these aggressive acts can have a psychological affect that can also affect the physical well-being of the victim. Two patient attendants—one man and one woman—reported, respectively, as many as 50 and 60 incidents of physical abuse. More men are physically assaulted than women: 13 men (77%) reported two or more physical assaults compared with only 4 women (40%). Each incident involved a patient. There were no incidents of physical abuse involving co-workers or visitors.

The incidence of physical abuse varies between shifts: three of the four women were assaulted while working the day shift. The other woman who reported being assaulted more than 60 times in the preceding year works the night shift. Ten of the thirteen men assaulted had suffered between one and nine assaults—50% of these men worked days, 30% evenings and 20% nights. For the 3 men assaulted ten or more times, one of them works days and the other two work evenings.

Table 9. Incidence of physical assaults by shift worked, gender and number of respondents

	Women			Men			
# Physical assaults	Day	Evening	Night	Day	Evening	Night	Split
0	3	1	2	2	1		1
1-9	3			5	3	2	
10 +			1	1	2		

For men, the most assaults occur when working day and evening shifts in acute-care settings; only 2 of the men assaulted work the night shift and this in long-term care settings. In addition, part-time workers are more likely than full-time workers to be assaulted. They are also more likely to be assaulted more frequently; 80% of those physically assaulted work part time, which may indicate a lack of experience in dealing with potentially aggressive patients. The mean number of assaults per worker assaulted is 4.4 for full-time workers and 10.9 for part-time workers. Part-time workers have less time to get to know their clientele and those on-call frequently change their work location. Only one patient attendant mentioned having received any specific training in recognizing and dealing with aggressivity and abuse. Although patient attendants in all age groups have been physically assaulted, there are less assaults on the older, more experienced attendants. This finding would tend to support the argument that those with most experience are better able to recognize a potentially abusive situation or that they are better equipped to take evasive action before an assault occurs. Older patient attendants also mentioned that it is important to treat

patients with respect and to try and anticipate their physical and emotional needs. Recognizing and responding to a patient's needs may also reduce anxiety and frustrations, thereby reducing the risk of aggression.

These findings are similar to those of Pekrul (1992), although nurses are also physically abused by a patient's family or friends and physicians, whereas there were no reported incidents of this nature for patient attendants.

Following a physical assault, patient attendants react in different ways: almost half of them (7/17) do nothing or take evasive action by physically removing themselves from the vicinity of the patient, a similar number call or tell their supervisor or head nurse and/or co-workers, and 3 of them negotiate/argue the issue with the patient concerned. Pekrul's (1992) findings were similar, except that 14% of the nurses filed a written report with their supervisor.

Not one of the patient attendants in our sample filed an incident report or reported the incident to their union. Patient attendants who work mainly part time are less likely than their full-time counterparts to discuss incidences of physical abuse with their co-workers, and on occasion will try to ignore the incident all together. Part-time workers are less likely to develop a supportive rapport with their peers and co-workers or to develop a sense of belonging because they work less hours and change units more frequently and this could have a negative influence on their willingness to share unpleasant experiences with their colleagues. Half of those working mainly full time usually tell their supervisor/head nurse/co-workers about the incident, and no full-time worker is willing to ignore a physical assault. One man refused to care for a patient

because the patient looked dangerous. Women are more likely to take evasive action than are men. Only men are prepared to negotiate/argue with the patient concerned when physically assaulted. The women probably feel that there is a greater risk of a repeated attack if they report the incident or if they try to discuss the incident with the perpetrator.

Table 10. Usual action taken following an abusive incident by type of abuse, gender and number of respondents

Type of abuse	Action taken	Women	Men
Verbal			
From patient	None/evasion	2	5
	Tell supervisor/head-nurse/co-workers		1
	Negotiate/discuss with patient	4	4
From co-worker	Tell supervisor/head-nurse	1	1
	Negotiate/discuss with co-worker	2	1
From supervisor	None		2
From other	Tell supervisor/head-nurse/co-worker		1
	Negotiate/discuss with person involved	1	
Physical	None/evasion	3	4
	Tell supervisor/head-nurse/co-worker	1	6
	Negotiate/discuss with patient		3
Sexual	None/evasion	1	2
	Negotiate/discuss with patient	1	
Racial	None/evasion	2	

5.11.3 Sexual harassment

From the responses to the question "*In the past month, how often were you sexually harassed (received unwanted sexual propositions, insults or touching) by.. patients, co-workers, supervisors, others (specify)?*" we can see that the prevalence of sexual harassment is lower than for other types of abuse experienced by both the patient attendants and the nurses in Pekrul's (1992) study. Four patient attendants (15%) were sexually harassed at least once in the previous month. One respondent was sexually harassed four times during this period. In each case, the abuse was perpetrated by a patient. Males and females are both at risk, although females appear to be twice as likely as men to be sexually harassed. There were 5 incidents involving two females attendants (20% of the female sample) and four incidents involved two male attendants (12% of the male sample). When asked what they do about this form of abuse, one woman replied nothing, the two men say they take evasive action and the other woman tries to verbally control the situation. Once again, no formal complaint is made to a supervisor, management or union official. Three-quarters of the incidents occur on the day shift, the remainder occur on the evening shift. Respondents reported no incidents of sexual harassment on the night shift. One woman has refused to care for a patient who was sexually harassing her.

The nurses in Pekrul's (1992) study experienced a higher incidence of sexual harassment than the patient attendants. Physicians, patients' families and friends as well as the patients themselves were responsible for the sexual harassment. The majority of nurses attempted to resolve the issue with the person involved and discuss

it with their co-workers. Although some nurses are willing to file reports of these incidents, the percentages are still low and the willingness varies depending on who is doing the harassing. Eleven percent of sexually harassed nurses file a written report when the person harassing them is a patient, 10% when it is a physician. Nobody files a report when it is a patient's family or friend doing the harassing.

5.11.4 Racial discrimination

The two women of colour both said that they had been victims of racial slurs from patients and patients' families. None of the other respondents had been verbally abused because of their ethnic background. Both women try to ignore the incident. One woman said:

> "*Sometimes I ignore it. Sometimes I tell the person. If repeated, I ignore it*" (R0155).

Pekrul (1992) did not consider racial discrimination in her study.

Discussion of aggression and abuse

The levels of abuse, both verbal and sexual, are lower than those reported by Pekrul. I had anticipated that they would be higher because of the lower status of patient attendants in the hospital hierarchy. The percentage of patient attendants physically abused (64%) is slightly higher than reported by the nurses (54%) in Pekrul's (1992) study.

Only 2 of the women and 2 of the men in this sample had not suffered any abuse at all in the previous twelve months. Overall, 85% of respondents had been victim to one or more forms of abuse, which is similar to the 89.9% incident rate reported for Quebec nurses, and is certainly cause for concern. It is evident that patient attendants risk being abused on a regular basis in their daily work and mainly by the people who they care for.

Men may be exposed to more abusive situations because, in my clinical experience, they are called on by nurses to assist them with agressive or potentially violent patients, either in their role as a male, i.e. stronger and thus more able to restrain an aggressive patient, or as a member of the "mobile team": a crisis intervention team called upon in the case of uncontrollable patients, used most frequently in the emergency and psychiatric departments, although these situations can occur anywhere in the hospital. The high incidence of physical abuse directed towards the male patient attendants is especially important, as aggression towards men working in health care has been generally overlooked in other research, because they form a very low percentage of the nurses and private nursing home staff. The fact that the abuse is less likely to be acknowledged or treated with greater levity may increase feelings of impotence, anger and frustration.

Men and women both report the caring aspects of the work as reasons for liking the job and for choosing to do the same job again. Despite the high levels of patients' abusive behaviour, the majority (59%) of patient attendants describe their clients as interesting or pleasant. Three of the four men who describe the majority of

their patients as disrespectful/complainers have been physically assaulted 10 or more times. It is unclear whether the number of assaults engenders a more negative attitude towards the patients or whether a negative attitude on the part of the patient attendant has a tendency to provoke an abusive reaction from the patient. Women who are physically assaulted are most likely to describe their patients as confused and this may be a reason why no action is taken following an abusive incident. The age of the respondent and the shift worked have no influence on the patient attendant's attitude towards the patients. The cognitive impairment experienced by many older patients may account for the higher incidence in long-term care settings at night. The higher incidence on acute-care units during the day could be related to the high level of activity on these units and the limited amount of time that patient attendants are able to spend with each of their patients. They may not be able to fulfill all of the patient's needs during this short time and this could lead to the patient becoming angry and frustrated, which in turn could translate into verbal and/or physical abuse. If the patient attendants are aware that they have not been able to meet the patient's needs, this may also partly explain why they are prepared to accept abuse as part of the job. Further research in this area should try and ascertain the reasons why the patient attendants so frequently ignore abuse and do not take any action, verbally or in writing, to report it.

6. CONCLUSION

Patient attendants are an heterogeneous group of individuals who come from a variety of backgrounds and have diverse educational attainment. The majority of them chose the job knowing full well what the work entailed. They decided to do this type of work because they wanted to help people they know to be at their most vulnerable when they are ill. They continue to do this work for the same reason.

The men are generally better educated than the women and have a greater range of language skills. Nonetheless, they had fewer job options at the time they chose to become patient attendants and more of the men were unemployed when they took this job. The women's job options were mainly limited to other service industries such as restaurant work, whereas the men's options were in more typically male industries such as construction.

The frustration and work disaffection experienced by some patient attendants stems not from the tasks, unpleasant though some of them may be, but more from the structure of the work environment and their relationships with the nurses with whom they share the direct and indirect patient care. Patient attendants spend up to eighty percent of their work day with the patients and yet they have little or no input in the planning of care—their ideas are ignored at best, and ridiculed at worst. Patient attendants are more than "nurse extenders." Many of them, as we have seen, expand their job description to the benefit of the patient and their own satisfaction.

In addition, there are no opportunities for advancement. Perhaps a return to a system whereby patient attendants, with the inclination and abilities to take more advanced training, could be trained to perform more specific nursing delegated acts which would give them more status and reportedly more job satisfaction. Awards of excellence that acknowledge the quality of the work provided by patient attendants are a good way to raise their visibility within the hospital community and also increase their self-esteem (already in place at Montreal General Hospital). This has been shown to increase patient attendant involvement and job satisfaction, which may be an important factor to offset the negative elements engendered by the current trend to part-time work and availability positions, with the inherent lack of job security and little chance of a permanent position.

The majority of job satisfaction appears to come from being able to give the care that they feel is needed, including sitting and talking with the patients, joking with them to boost their morale, and doing little extras such as getting the newspaper or an extra cup of coffee. Frustration mounts with budget cuts and pressure to reduce non-essential care. If this trend continues, the result will be decreased job satisfaction and less involvement, and the patients—the users of the health care system—will be the losers.

Both of the theoretical models I was exploring received some support. Men and women expressed similarities in the aspects of the work that they like and dislike, which would tend to support the structural model, whereby individuals of either gender have similar subjective experiences in the same job. Nevertheless, there were

differences between the men and women in the areas of job satisfaction and abuse. Men express higher levels of job satisfaction even though they are subjected to more abuse. The main factors which appear to influence this finding are the nurses' verbal validation of the male patient attendants' contribution, and the positive family support that the men receive. Family commitments appear to have a negative influence on the women's level of job satisfaction and suggest a possible role overload since much of the daily work of a patient attendant is similar to that which women perform at home—washing, feeding and generally caring for their family. This supports the gender model of sex role differentiation and I have seen this dynamic at work in my own experience in this field.

Partial support for both models suggests that the work situation in hospitals may be somewhat more complex than in other service work settings. It is clear, for example, that both men and women invest emotionally in their work. Those who invest heavily in the work also appear to derive the most satisfaction from their work. This is not just another job: it is a job which demands intimate contact with other human beings who may be physically, emotionally and spiritually at their most vulnerable. The patient attendants in this study have clearly illustrated their awareness of this vulnerability and have demonstrated the caring and respect which they show their patients while trying to help them through this often difficult period of their lives. When dealing with potentially unpleasant or embarrassing situations, fecal incontinence, for example, the patient attendants behave in such a way as to minimize the embarrassment for the patient and the unpleasantness for themselves. They try to

maintain the patient's self-respect, not by ignoring the incident but by normalizing it, and reassuring the patient that this can happen to anyone. In many instances, they employ humour to diffuse embarrassing situations and also to motivate and encourage the patients towards independence. Although workers in other fields—poultry workers, refuse collectors, mechanics—must also deal with unpleasant substances, they are not in the same intimate interaction with other human beings. It is precisely this constant intimate interaction with other vulnerable human beings that makes the patient attendants' job different from that of many other service workers, including postal workers.

The findings from this project increase our knowledge about patient attendants but more research still needs to be conducted, particularly around the issue of job hazards such as verbal and physical abuse. In the course of their daily work, patient attendants are frequently subjected to verbal and physical abuse, and some of them are also the victims of sexual harassment and racial discrimination. This abuse is perpetrated against them, for the most part, by the very people they are trying to care for—their patients. The majority of this abuse in borne in silence. In order for abuse to be addressed, it must first be acknowledged and brought to the attention of management. Patient attendants should be encouraged to complete written reports of each abusive incident. This is the only way to have an accurate picture of the nature and frequency of the abuse. I believe that it is incumbent on the patient attendants' unions to undertake research involving a much larger sample than was the subject of this study. In so doing, they would be able to ascertain the frequency distribution of

abusive actions endured by their members in Quebec. Future research should also try to contextualize the abuse. Having an understanding of when, where and in what circumstances abusive situations arise may give indications about how to prevent them. These are the first steps towards validating the extent of the problem, and correcting it. I do not believe that this abuse is limited to patient attendants working in Quebec and, therefore, research should also be undertaken in other centres across Canada.

Increased involvement in the nursing care team, along with more information being given to patient attendants regarding their patients and a sharing of abusive experiences among unit staff could help decrease these incidents. Training in the recognition of signs of aggression could help avoid or diffuse potentially abusive situations before they arise. Reducing the level of staff abuse at all levels can only be beneficial.

Patient attendants are fulfilling a vital role in the health care system. For the most part, they are a dedicated group of individuals who are willing to put in an extra effort to help their clients. This extra effort often has the effect of making their job more interesting and more emotionally rewarding. Acknowledging the importance of their work by actively involving them in the organization of the unit and listening to and integrating some of their ideas for improving patient care could be advantageous for patients and staff alike.

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APPENDIX A

A STUDY OF HUMAN SERVICE OCCUPATIONS

Montreal, Summer-Fall 1993

We are conducting a study of women and men involved in different sectors of the service industry and would like to interview you about your work and experiences as a ward aide or orderly in the health care industry.

The purpose of the research is to investigate the extent to which the working conditions and experiences (e.g., job risks and hazards, social relations, chances for advancement, job satisfaction) vary from one service work situation to another. The findings from this study will be published in the form of several articles and a book.

The interview will be conducted in a comfortable place of your choosing. It could last up to an hour. Your responses will be kept confidential: neither your name nor your address will be linked to the completed interview. Further, members of the research team will be the only ones to see the interview.

If you find that there are some questions you would really rather not answer, please say so and we will go on to the next question. You are also free to withdraw your consent and to discontinue the interview at any time.

We will be happy to answer any questions you have about the study once the interview is completed. If questions arise later, you can always reach us through the Research Office at Concordia University (848-2168).

Frances M. SHAVER
Project Director
Department of Sociology and Anthropology
Concordia University

Martin S. WEINBERG
Co-investigator
Department of Sociology
Indiana University

CURRENT DEMOGRAPHICS

/__/__/__/__/__/
Respondent Number

1. What is your birth date? ___ ___ /__/__/ (5-6)
day month year

2. Sex/gender? (7)
female 1
male 2

3. In what country or province were you born? _____ /__/__/ (8-9)

(IF BORN OUTSIDE CANADA) Did you go to elementary school in Canada?

no . . 1 (10)
yes . . 2

4. How long have you lived in the Greater Montreal area?

_____ /__/__/ (11-12)

5. What is the highest level of education you have completed?

less than high school 1 (13)
high school degree 2
some community college, cegep, nursing school 3
some university 4
completed community college, cegep, nursing school . 5
completed university degree (B.A.) 6
post-graduate degree (M.A./Ph.D.) 7
other school/training (specify)

_____ . . . . . 8 /__/__/ (14-15)

6. In which languages do you speak well enough to apply for a job?

english only 1 (16)
french only 2
english and french 3
english and other 4
french and other 5
english/french/other 6

7. Are you ... | (1)

single 1
cohabiting . . 2
married 3

(IF SINGLE) Do you have a boyfriend or girlfriend? | (2)

no 1
yes, girlfriend 2
yes, boyfriend 3

8. Do you consider yourself to be ... | (3)

heterosexual 1
bisexual 2
lesbian 3
homosexual 4

9. a) Identify each of the persons WITH WHOM YOU LIVE by their relationship to you, sex, and age.

b) Tell me their current primary occupation or activity.

[NOTE: Activity includes such things as looking for work, student, housewife, retired, illegal activties etc....]

1. female 2. male

Relationship to Respondent	Sex	Age	Primary Occ/Act	
_____	/__/	/__/__/	_____	/__/__/ /__/__/__/
_____	/__/	/__/__/	_____	/__/__/ /__/__/__/
_____	/__/	/__/__/	_____	/__/__/ /__/__/__/
_____	/__/	/__/__/	_____	/__/__/ /__/__/__/
_____	/__/	/__/__/	_____	/__/__/ /__/__/__/
_____	/__/	/__/__/	_____	/__/__/ /__/__/__/
_____	/__/	/__/__/	_____	/__/__/ /__/__/__/
_____	/__/	/__/__/	_____	/__/__/ /__/__/__/

(4-67)

10. Do you have any children under 18 who DO NOT LIVE WITH YOU? If so, identify them by their sex, age, and whom they live with. [Probe for whether or not there is a social service agency involved.]

1. female 2. male

Sex	Age	Who Live With by Relationship to Respondent	
/__/	/__/__/	_____	/__/__/
/__/	/__/__/	_____	/__/__/
/__/	/__/__/	_____	/__/__/
/__/	/__/__/	_____	/__/__/ (1-20)

11. In what type of dwelling are you now living? Is it a. . .

Single detached	1	(21)
Semi-detached or double (side by side)	2	
Garden house, town house or row house . . .	3	
Duplex/Triplex	4	
Low-rise apartment (less than five stories) . .	5	
High-rise apartment (five or more)	6	
Other (specify)		
_____ . .	7	/__/__/ (22-23)

12. Is this dwelling owned by a member of your household?

no	1	(24)
yes	2	

(IF YES) Is there a mortgage on it?

no	1	(25)
yes	2	

13. During the last 12 months have you provided financial support to anyone inside or outside your household. [Probe for children.] Identify their relationship to you, sex, age, and where they presently live (with you or somewhere else?)

1. female
2. male

1. with you
2. somewhere else

Relationship to Respondent	Sex	Age	Where Live?	
_____	/__/	/__/__/	/__/	/__/__/
_____	/__/	/__/__/	/__/	/__/__/
_____	/__/	/__/__/	/__/	/__/__/
_____	/__/	/__/__/	/__/	/__/__/ (1-24)

NOTE: IF STILL LIVING WITH PARENTS ask the following questions otherwise GO TO Q18 CURRENT JOB.

14. What is the highest level of education your parents completed?

Father _____ /__/ (25)

Mother _____ /__/ (26)

15. When you were growing up, were there periods when your family depended on welfare/food banks?

no, not at all 1
yes, some of the time 2
yes, all or most of the time . . 3

(27)

16. When you were growing up, did the ADULTS with whom you lived own any one of the following items? [Check all that apply]

automatic dishwasher . . . _____	/__/ (28)
freezer (stand alone) . . . . _____	/__/ (29)
clothes dryer . . . . . _____	/__/ (30)
two or more cars . . . . . _____	/__/ (31)
VCR (video recorder) . . . _____	/__/ (32)
gas barbecue . . . . . _____	/__/ (33)

17. Overall, when you were growing up, would you say that you and your family were financially:

very poor 1	(1)
poor 2	
comfortable 3	
well off 4	
very well off 5	

CURRENT JOB

Now we would like to ask you about your current job as a ward aide/orderly.

18. In which type of setting are you currently working?

hospital/acute care unit 1	(2)
long term/extended care unit 2	
home care 3	

19. How long have you worked in this particular job? _____ /__/__/ (3-4)

20. Is it your primary occupation or activity?

no 1	/__/ (5)
yes 2	

(IF NO) What is your primary occupation or activity? [Probe for specifics i.e., waitress in a five star hotel, auto mechanic, etc.]

/__/__/__/__/ (6-8)

21. How many years in total have you worked as a ward aide/orderly?

_____ /__/__/ (9-10)

22. When you first started working as a ward aide/orderly how old were you?

/__/__/ (11-12)

29. We would like you as much as possible to provide a full description of the activities associated with your work. [Have the respondent think through a work day. Probe for as complete a listing as possible.]

Probe:
Direct patient care:
  hygenic comfort, mobilization needs,
  elimination needs, nutritional needs
Collecting and delivering specimens
Safety precautions
Stripping beds and changing linens
Maintaining supplies and utility areas

/___/___/

/___/___/

/___/___/

/___/___/

/___/___/

/___/___/

/___/___/
(8-21)

WORKPLACE ENVIRONMENT AND INTERPERSONAL RELATIONSHIPS

30. During your job you come into contact with substances such as sputum, feces and urine, and perform tasks such as bathing patients and administering enemas. How do you feel about this? [If they are unhappy about it, probe for how they deal with it.]

/__/__/

/__/__/

/__/__/ (1-6)

/__/__/

/__/__/

/__/__/ (7-12)

31. On average during a shift, how much time do you spend on patient care?

_____hr/min /__/__/ (13-14)

32. On average, how many patients are you responsible for on a shift?

/__/__/ (15-16)

_____

33. Have you ever avoided caring for a specific patient?

no 1
yes 2

(17)

(IF YES) What were your reasons for doing so? [Probe, recording responses in the order provided.]

/__/__/

/__/__/

/__/__/

/__/__/
(18-25)

34. In the past 6 months, how many patients have you avoided caring for?

_____ /__/__/ (1-2)

35. People in your line of work have to deal with patients that range from rude or aggressive, through lonely or unfortunate, to pleasant or interesting. How do you feel about most of your patients?

-

/__/__/

/__/__/

/__/__/

/__/__/ (3-10)

JOB HAZARDS/STRESSORS

Now, I am going to ask you questions about the more stressful and dangerous aspects of your job and how you respond to them.

36. Have any of the following things in your work environment caused you excess worry or stress in the past 12 months? [Check all that apply.]

Too many demands or too many hours of work? . . .	___	/__/ (11)
Risks of infection or disease?	___	/__/ (12)
Risks of accident or injury?	___	/__/ (13)
Poor relations with other people ?	___	/__/ (14)
Sexual harassment?	___	/__/ (15)
Other harassment?	___	/__/ (16)
Discrimination of any kind [age, sex, race, ethnicity, disability, sexual orientation]?	___	/__/ (17)
Threat of job loss?	___	/__/ (18)
		/__/ (19)

37. In the past 12 months, how many days of work did you miss as a result of a workplace illness or injury?

/___/___/ missed days (1-2)

(IF MISSED DAYS) What was the illness or injury? [List all of them.]

/___/
/___/
/___/
/___/
/___/ (3-6)

38. Now, I want to ask you about some of the more stressful and dangerous situations you may have faced at work. Tell me the number of times each event occurred and, where possible, please link each event to a specific person. I would also like to know what you usually do about about these situations when they occur? [Use the boxes provided and 0 for did not happen.]

	# times	What did you usually do?	
In the past month, how often did you receive unclear instructions from ...			
patients	/___/___/	_____	/___/___/ (7-10)
co-workers	/___/___/	_____	/___/___/ (11-14)
supervisors	/___/___/	_____	/___/___/ (15-18)
others _____ (specify)	/___/___/	_____	/___/___/ (19-22)
			/___/ (23)
In the past month, how often were you insulted, threatened, or yelled at by ...			
patients	/___/___/	_____	/___/___/ (24-27)
co-workers	/___/___/	_____	/___/___/ (28-31)
supervisors	/___/___/	_____	/___/___/ (32-35)
others _____ (specify)	/___/___/	_____	/___/___/ (36-39)
			/___/ (40)

38. Con't

	# times	What did you usually do?	
In the past month, how often were you sexually harassed (received unwanted sexual propositions, insults or touching) by ...			
patients	/__/__/	_____	/__/__/ (1-4)
co-workers	/__/__/	_____	/__/__/ (5-8)
supervisors	/__/__/	_____	/__/__/ (9-12)
others _____ (specify)	/__/__/	_____	/__/__/ (13-16)
			/__/ (17)
In the past year, how often were you physically assaulted (pushed, slapped struck, choked, etc...) by ...			
patients	/__/__/	_____	/__/__/ (18-21)
co-workers	/__/__/	_____	/__/__/ (22-25)
supervisors	/__/__/	_____	/__/__/ (26-29)
others _____ (specify)	/__/__/	_____	/__/__/ (30-33)
			/__/ (34)
In the past year, how often were you robbed by ...			
patients	/__/__/	_____	/__/__/ (35-38)
co-workers	/__/__/	_____	/__/__/ (39-42)
supervisors	/__/__/	_____	/__/__/ (43-46)
others _____ (specify)	/__/__/	_____	/__/__/ (47-50)
			/__/ (51)

38. Con't

	# times	What did you usually do?	
In the past year, how often were you sexually assaulted or raped by ...			
patients	/__/__/	_____	/__/__/ (1-4)
co-workers	/__/__/	_____	/__/__/ (5-8)
supervisors	/__/__/	_____	/__/__/ (9-12)
others _____ (specify)	/__/__/	_____	/__/__/ (13-16)
			/__/ (17)

39. Question non-applicable.

(18-34 leave blank)

40. Are there other aspects of your work that are stressful or dangerous that we haven't mentioned? Please tell me about them.
[PROBE for details on health risks and other forms of harassment.]

/__/__/

/__/__/

/__/__/

/__/__/
(35-42)

41. Overall, would you describe your work as ...

very stressful 1
somewhat stressful . . 2
not very stressful . . . 3
not at all stressful . . . 4

(1)

WORK AFFECTION/DISAFFECTION

42. What do you <u>like</u> about your work? [List respondents answer with as much detail as possible.]

Probe:
physical surroundings
duties
patient relations
co-worker relations
supervisor relations
workload
discretion/autonomy
salary
physical labour
emotional labour

/__/__/ /__/__/
/__/__/ /__/__/
/__/__/ /__/__/
/__/__/ /__/__/
/__/__/ /__/__/
(2-21)

43. What do you dislike about your work? [List respondents answer with as much detail as possible.]

Probe:
physical surroundings
duties
patient relations
co-worker relations
supervisor relations
workload
discretion/autonomy
salary
physical labour
emotional labour

/__/__/ /__/__/

/__/__/ /__/__/

/__/__/ /__/__/

/__/__/ /__/__/

/__/__/ /__/__/
(1-20)

44. You have mentioned a number of aspects of your work that you dislike. What do you do to improve each situation?

/__/__/ /__/__/

/__/__/ /__/__/

/__/__/ /__/__/

/__/__/ /__/__/

/__/__/ /__/__/
(1-20)

45. How good (skilled) are you at your work in comparison to other ward aides and orderlies in the hospital? [Probe for specific examples re judging self and others.]

/__/

/__/

/__/ (21-23)

/__/

/__/

/__/ (24-26)

46. If you were training someone else to do your job, what skills would you stress as being the most important?

/__/__/
/__/__/
/__/__/
/__/__/ (1-8)

47. What does your family think about your job? [Probe for impressions of parents, siblings, spouse/lover, children.]

/__/__/
/__/__/
/__/__/
/__/__/
/__/__/ (9-18)

48. If you had to do it again, would you do the same type of work you are doing now?

no 1
yes 2

(19)

(IF NO) Why not?

/__/__/
/__/__/
/__/__/ (20-25)

(IF YES) Why?

/__/__/
/__/__/
/__/__/ (26-31)

49. I'd like to ask for your opinions about several aspects of your current job. Do you agree or disagree or with the following statements? Is that somewhat or strongly? [Circle the number that best matches the respondent's opinion. Note if they have 'no opinion'.]

1 = Strongly Agree
2 = Somewhat Agree
3 = Somewhat Disagree
4 = Strongly Disagree

(a) The physical surroundings at your work are pleasant	1 2 3 4	(1)
(b) There is a lot of freedom to decide how to do your work	1 2 3 4	(2)
(c) You do the same things over and over	1 2 3 4	(3)
(d) Your job requires a high level of skill	1 2 3 4	(4)
(e) The pay is good	1 2 3 4	(5)
(f) Your chances for promotion/career development are good	1 2 3 4	(6)

50. The next five questions relate to how you feel about your job. In each case I would like you to rate your job on the five point scale provided by encircling the appropriate number.

(a) How well do you like the work you are doing?

Strongly Dislike				Strongly Like	
1	2	3	4	5	(7)

(b) Do you find your work boring?

Not at all				Very Much	
1	2	3	4	5	(8)

(c) Does your job give you a chance to do things you feel you do best?

Not at all				Very Much	
1	2	3	4	5	(9)

50. Con't

(d) Do you get any feeling of accomplishment from the work you are doing?

Not at all				Very Much	
1	2	3	4	5	(1)

(e) Does your work rate as an important job with you?

No Importance				Very Important	
1	2	3	4	5	(2)

INCOME/SAVINGS

51. From which of the following sources did you receive income over the last year? [Check all that apply.]

Work	____	/__/ (3)
Government (Family Allowance, UIC, Social Ass. Canada/Quebec Pension, Old Age Pension) . .	____	/__/ (4)
Interest, dividends, investments or private pensions . .	____	/__/ (5)
Exchanging, selling things	____	/__/ (6)
Other sources (Alimony, Child Support, Scholarships)	____	/__/ (7)

52. What is your best estimate of your total personal income from all of these sources during the last 12 months?

[Hand respondent Income Scale & have them indicate code] /__/__/ (8-9)

53. What is your best estimate of the total income of all members of your household from all these sources during the last 12 months?

[Hand respondent Income Scale & have them indicate code] /__/__/ (10-11)

54. Have you any savings? no 1 (12)
yes 2

(IF YES) Approximately how much do you have? $_____ /__/__/__/ (13-15)

FAMILY BACKGROUND

The next series of questions deal with your family background.
[NOTE: IF RESPONDENT LIVES WITH PARENTS GO TO Q65]

55. What was your age when you first left home? _____yrs /__/__/ (1-2)

56. How many people lived with you at the time you left? _____ /__/__/ (3-4)

57. What was the main reason for this move? Was it...

To get married	1	(5)
To move because of job	2	
To attend school	3	
Move into own place	4	
Other reason (specify)		
_____	5	/__/__/ (6-7)

58. Would you say you left your family on negative or positive terms?

negative	1	(8)
positive	2	

59. (a) Who were the ADULTS responsible for your care and support at that time? Identify their relationship to you and sex.

(b) What was their primary occupation or activity at that time?

[NOTE: Activity includes such things as looking for work, student, housewife, retired, illegal activities, etc....]

(c) What was the highest level of education they completed?

1. female
2. male

Relationship to Respondent	Sex	Primary Occ/Act	Education	
_____	/__/	_____	_____	/_/_/ /_/_/_/_/ /_/
_____	/__/	_____	_____	/_/_/ /_/_/_/_/ /_/
_____	/__/	_____	_____	/_/_/ /_/_/_/_/ /_/
_____	/__/	_____	_____	/_/_/ /_/_/_/_/ /_/ (9-36)

60. Did any of the ADULTS caring for you, own the dwelling you were living in at the time?

no	1	(1)
yes	2	

61. What type of dwelling did you live in at the time? Was it a...

Single detached	1	(2)
Semi-detached or double (side by side)	2	
Garden house, town house or row house	3	
Duplex/Triplex	4	
Low-rise apartment (less than five stories)	5	
High-rise apartment (five or more)	6	
Other (specify)_____	7	/___/___/ (3-4)

62. Were there periods before you left home when your family depended on welfare/food banks?

no, not at all	1	(5)
yes, some of the time	2	
yes, all or most of the time	3	

63. When you first left home, did the ADULTS with whom you lived own any one of the following items? [Check all that apply]

automatic dishwasher	____	/___/ (6)
freezer (stand alone)	____	/___/ (7)
clothes dryer	____	/___/ (8)
two or more cars	____	/___/ (9)
VCR (video recorder)	____	/___/ (10)
gas barbecue	____	/___/ (11)

64. Overall, would you say at that time you and your family were financially:

very poor	1	(12)
poor	2	
comfortable	3	
well off	4	
very well off	5	

CONTACT WITH FAMILY

The following questions are about contact with your family. We would like to know whether they are still alive and how often you see them. We will ask about your mother, father, the brother or sister with whom you have most contact, and another relative with whom you have the most contact.

65. Is ..... still alive?

	Mother	Father	Sibling	Other relative	
1. no 2. yes 8. don't know 9. not apply	/__/	/__/	/__/	/__/	(1-4)

66. During the past 12 months, how often did you see ..... ?

	Mother	Father	Sibling	Other relative	
1. Daily 2. At least once a week 3. At least once a month 4. Less than once a month 5. Not at all	/__/	/__/	/__/	/__/	(5-8)

(IF NOT AT ALL) How many years has it been since you've seen .....?

Mother	Father	Sibling	Other relative	
/__/__/	/__/__/	/__/__/	/__/__/	(9-16)

67. Do you see ..... .

Mother	Father	Sibling	Other relative	
/__/	/__/	/__/	/__/	(17-22)

1. Less often than you would like
2. More often than you would like
3. About the right amount

68. What prevents you from seeing ..... more often?

mother	_____	/__/__/ (1-2)
father	_____	/__/__/ (3-4)
sibling	_____	/__/__/ (5-6)
other relative	_____	/__/__/ (7-8)

69. During the past 12 months, how often did you have contact by letter or by telephone with ..... ? Was it...

1. Daily
2. At least once a week
3. At least once a month
4. Less than once a month
5. Not at all

Mother	Father	Sibling	Other Relative	
/__/	/__/	/__/	/__/	(9-12)

LEISURE ACTIVITIES

The next few questions focus on the amount of time you spent on leisure activities in the last few weeks.

70. (a) Thinking back over the past month, how many times did you go out to do each of the following activities...

(b) With whom did you go most often?

1. alone
2. spouse/partner
3. girlfriend/boyfriend
4. daughter/son
5. other relative
6. friend
7. other

	Times Whom	
Attend classes, courses or training sessions	/__/__/ /__/	(1-3)
Go to meetings or do volunteer work	/__/__/ /__/	(4-6)
Go to restaurants or bars	/__/__/ /__/	(7-9)
Go to movies, theatres or play bingo	/__/__/ /__/	(10-12)
Go out for sports, exercise or recreational activities	/__/__/ /__/	(13-15)
Shop (not groceries)	/__/__/ /__/	(15-18)
Visit with relatives in either of your homes	/__/__/ /__/	(19-21)
Visit with friends in either of your homes	/__/__/ /__/	(22-24)
Other activities not already mentioned	/__/__/ /__/	(25-27)

71. (a) During the past month, as a leisure activity (not for work or studies) did you spend time reading a ...

(b) During the past week, as a leisure activity (not for work or studies) did you spend time reading a ...

1. no
2. yes

	past month	past week	
newspaper . .	/__/	/__/	(28-29)
magazine . . .	/__/	/__/	(30-31)
book	/__/	/__/	(32-33)

ALCOHOL CONSUMPTION AND DRUG USE

The next few questions are about alcohol consumption and drug use.

72. In the past month how often did you take a drink of beer, wine, liquor or other alcoholic beverage?

Never	1	(1)
One to three times a month	2	
Once a week	3	
Two to three times a week	4	
Four to six times a week	5	
Every day	6	

(IF DRINK) How often would you say you get drunk?

Never	1	(2)
One to three times a month	2	
Once a week	3	
Two to three times a week	4	
Four to six times a week	5	
Every day	6	

(IF DRUNK) Is this usually ...

when you are working	1	(3)
when not working	2	
both	3	

73. In the past month, how often did you use each of the following drugs?

(IF USE) Which of them, if any, did you inject? [Record below. If do not use, go to the next section.]

1. Never
2. One to three times a month
3. Once a week
4. Two to three times a week
5. Four to six times a week
6. Every day

1. no
2. yes

	How often	Inject	
Pot/Hash	/__/		(1)
Heroin	/__/	/__/	(2-3)
Crack	/__/		(4)
Other forms of cocaine	/__/	/__/	(5-6)
Speed	/__/	/__/	(7-8)
Acid/LSD	/__/	/__/	(9-10)
Other	/__/	/__/	(11-12)

(Specify other) _____ /__/__/ (13-14)

_____ /__/__/ (15-16)

(IF USE) How much did you spend on drugs (not alcohol) in the past week?

$ _____ /__/__/__/__/ (17-20)

(IF USE) How often would you say you get high?

Never 1
One to three times a month . . 2
Once a week 3
Two to three times a week . . 4
Four to six times a week . . . 5
Every day 6

(21)

(IF HIGH) Is this usually ...

when you are working 1
when not working 2
both 3

(22)

HEALTH STATUS

The next few questions concern your physical health and emotional well-being.

74. Here is a list that describes some of the ways people feel at different times. During the <u>past few weeks</u>, how often have you felt ...

Was it ...	1. Never	2. Sometimes	3. Often	
(a) On top of the world?	1	2	3	(1)
(b) Very lonely or remote from people?	1	2	3	(2)
(c) Particularly excited or interested in something?	1	2	3	(3)
(d) Depressed or very unhappy?	1	2	3	(4)
(e) Pleased about accomplishing something?	1	2	3	(5)
(f) Bored?	1	2	3	(6)
(g) Proud because someone complimented you on something you had done?	1	2	3	(7)
(h) So restless you couldn't sit long in a chair?	1	2	3	(8)
(i) That things were going your way?	1	2	3	(9)
(j) Upset because someone criticized you?	1	2	3	(10)

75. How often, if at all, in the <u>past year</u> have you experienced the following?

1. Never
2. Less than once a month
3. One or more times a month
4. At least once a week
5. Every day

back pain	/___/	(11)
upset stomach	/___/	(12)
cramps (legs, period)	/___/	(13)
headaches	/___/	(14)
sore feet	/___/	(15)
shortness of breath	/___/	(16)
difficulty sleeping	/___/	(17)
diarrhea/constipation	/___/	(18)
fatigue/general weakness	/___/	(19)
difficulty in concentration	/___/	(20)

76. In the past year, how many times have you visited the doctor or a clinic?

/___/___/ times (1-2)

77. Have you ever contracted a sexually transmitted disease (STD)?

no 1
yes 2 (3)

(IF YES) How many times in the past two years? /___/ times (4)

78. Has the AIDS situation affected your work?

no 1
yes 2 (5)

(IF YES) In what way?

/___/___/

/___/___/

/___/___/

/___/___/ (6-13)

79. From what sources has most of your information about HIV and AIDS come? [Check all that apply]

community organizations (e.g., ACTUP, Cactus, CLSC) . . . . . ____ /___/ (14)
labour union . . . . . ____ /___/ (15)
media (t.v., radio, newspaper) . . . . . ____ /___/ (16)
co-workers . . . . . ____ /___/ (17)
hospital/facility . . . . . ____ /___/ (18)
other (specify) . . . . . ____ /___/ (19)

_____ /___/___/ (20-21)

80. In the past 12 months have you been tested for HIV (AIDS)?

no . . 1
yes . . 2

(1)

(IF YES) Why did you take the test?

/___/___/ (2-3)

/___/___/ (4-5)

Were the results good or bad?

good (tested negative) 1
bad (tested positive) 2

(6)

81. Compared to other people your age, how would you describe the state of your health?

very good . . . 1
good 2
fair 3
poor 4
very poor . . . 5

(7)

JOB HISTORY

82. The next few questions are about other jobs and jobless periods you may have had in the past. I would like to go back over at least five periods.

What were you doing just before you started the job you have now? For how long? Were you working for yourself or someone else? [Then ask ...] What were you doing just before that job/jobless period?

[Go back over a maximum of five periods. Different jobs include the same job in different locations, different duties with the same employer, or different employers. Be sure to get information on jobless periods.]

[PROBE for specifics i.e., waitress in a five star hotel, auto mechanic]

Job	Length of Time	Self(1) Other(2)	
_____	_____	/__/	/__/__/__/ /__/__/
_____	_____	/__/	/__/__/__/ /__/__/
_____	_____	/__/	/__/__/__/ /__/__/
_____	_____	/__/	/__/__/__/ /__/__/
_____	_____	/__/	/__/__/__/ /__/__/ (1-30)

(IF ONLY HOSPITAL WORK OVER ALL 5 PERIODS) What jobs, if any, have you had other than as a ward aide/orderly?

/__/__/__/

/__/__/__/

/__/__/__/ (31-39)

FUTURE JOB PLANS

83. How much longer would you like to work as a ward aide/orderly?

_____ /__/__/ (1-2)

84. How much longer do you think you will <u>actually</u> work as a ward aide/orderly?

_____ /__/__/ (3-4)

85. Are you currently looking for another type of job?

no 1
yes 2

(5)

86. What are your job plans for the next <u>five</u> years?
[Probe for specific examples.]

/__/__/
/__/__/
/__/__/
/__/__/
(6-13)

87. Is there anything we haven't covered that you would like to comment on?

/__/__/
(14-15)

Description of respondent:

To which visible minority does respondent belong?

White 1	(1)
Black 2	
Oriental/Asian 3	
Hispanic 4	
Native American . . . 5	
Other	
_____ 6	/__/__/ (2-3)

Interviewer's comments . . .
[Note whether other people were present during the interview]

/__/__/

/__/__/

/__/__/
(4-9)

Interviewer: _____ /__/ (10)

Location of interview: _____ /__/__/ (11-12)

Date of interview: _____ /__/__/ /__/__/
Day / Month / Year

/__/__/ (13-18)

Time of interview: _____ /__/__/ (19-20)

Language of interview: _____ /__/ (21)