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Risky Business: The Negotiation and Management of Work-Related Risk by Patient-Attendants and Prostitutes.

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A Thesis

in

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ABSTRACT

Risky Business: The Negotiation and Management
of Work-Related Risk by Patient-Attendants and Prostitutes.

Kimberly-Anne Ford

This thesis examines work-related risk in two "risky" human service occupations: the hospital patient-attendant and the street prostitute. The research question is twofold: what elements of service work give rise to work-related risk, and what conditions impact upon the negotiation and management of occupational hazards. The rationale for comparing these two occupations lies in their similarities: the emotional and physical contact with clients and patients, along with the performance of 'dirty work', yields similar risks such as violence, infection and occupational injury. Meanwhile, differences in each working environment, for example with respect to institutional legitimacy in the hospital versus illegitimacy and stigma on the street, provide an interesting context in which to study the effects of occupational organization on risk management by workers. This study applies a qualitative and quantitative analysis to the study of occupational risk, using interview data from a sample of 92 Montreal street prostitutes and patient-attendants. It was found that patient-attendants often cope with occupational risk in an institutional and routinized manner, while prostitutes often rely on personal rules and co-workers to manage various risks. It is concluded that the organizational structure of both occupations impacts upon risk management by workers.

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DEDICATION

To my parents, Richard and Diane Ford, for the hard work and sacrifices which brought me this far, and continue to sustain me along my path.

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I. INTRODUCTION

1.1 Contextualizing the problem: risk in two human service occupations

This master's thesis examines the negotiation and management of work-related risk in two 'risky' service occupations: hospital patient-attendant and street prostitute. Arlie Rusell Hochschild (1983) states that human service occupations require "some handling of other people's feelings and our own" (Hochschild, 1983: 11), and thus present potential emotional risks to workers. Service occupations place a burden on workers' feelings, in Hochschild's words, they "require personal contact with the public, the production of a state of mind in others, and the monitoring of emotional labor by supervisors" (Hochschild, 1983: 156). As such, fatigue, stress, irritability, and distancing or alienating oneself from emotions, are all possible outcomes of human service work.

What distinguishes the hospital patient-attendant and the street prostitute from many other human service occupations, is that both types of workers operate within environments of 'controlled intimacy'[1], in which they perform intimate acts on clients or patients, within the controlled environment of their work. Hospital patient-attendants and street prostitutes work in close proximity, and often have direct contact, with their clients' bodies. As such, physical threats such as violence and the transmission of contagious viruses, are present along with emotional risks, in both of these service occupations. In order to protect themselves, patient-attendants and prostitutes devise and maintain boundaries between themselves and their clients to safeguard their physical and

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1 I am grateful to Dr. Joe Smucker who introduced me to this descriptive phrase, I have not yet traced it back to the formal literature on occupations.

emotional well-being, and apply coping mechanisms to deal with various work-related hazards.

Street prostitutes are women and men in the sex trade, who exchange sexual services for money or other goods, and recruit their clientele on the street. Patient-attendants, commonly referred to as orderlies or ward aides, are health care workers who ensure patients' hygiene, restock supplies, transport specimens and samples to and from laboratories, and move patients around the hospital, among other things. The rationale for examining risk in these occupational settings, lies in the numerous employment characteristics shared by hospital patient-attendants and street prostitutes: both have emotional and physical contact with their clients; both perform a considerable amount of 'dirty work' on the job; and both experience similar occupational hazards such as the risk of infection, violence and physical injury. These similarities will be discussed in the second chapter of this thesis. However, despite their similarities, a number of oppositions characterize the occupations: health care is 'respected', while sex work is 'stigmatized'; health care is 'legitimate', sex work is 'illegitimate'; health care is 'institutionalized', sex work is 'informal'. These qualifiers, affect how work-related risk is negotiated and managed in each occupational setting, and provide an interesting context in which to study the effect of organizational factors on the negotiation and management of work-related risk. The organizational differences between sex work and hospital work will be addressed in chapter three of this thesis.

1.2 Motivations for the study of risk in hospital work and sex work

Many factors have motivated this research project. First, the hospital

patient-attendant and street prostitute are both under-studied occupations. Moreover, prostitution has yet to be integrated into the sociological literature on occupations; instead, much of the academic research on prostitution remains within the study of deviance or crime. Second, the street and the hospital are commonly understood as 'risky' environments -- one, a bureaucratic institution, the other, a deviant network. This study explores the effect of institutional legitimacy, or lack thereof, on workers' negotiation and management of risk. In sum, this M.A. thesis contributes to the existing body of research in the Sociology of occupations on several levels.

II. LITERATURE REVIEW and THEORETICAL FRAMEWORK

1. Similarities in sex work and hospital work

The literature on sex work and hospital work suggests that there are many similarities in the work of patient-attendants and prostitutes, especially regarding emotional labour, dirty-work and work-related risk. This chapter looks at each of these similarities: The first section discusses the importance of boundary maintenance in emotional work, and presents the risks associated with emotional labour. The second section looks at the impact of performing dirty work on the worker's sense of self. Finally, the third section presents many overlapping risks in prostitution and patient-attendants' work, as described in the literature. Also, it introduces other occupational hazards which can threaten these workers.

1.1 Emotional work and boundary maintenance in human service work

Arlie Russell Hochschild (1983) coined the term 'emotional labor' in reference to the manipulation of identity for the purpose of servicing others. In The Managed Heart: Commercialization of Human Feeling, she states:

> I use this term emotional labor to mean the management of feeling to create a publicly observable facial and bodily display; emotional labor is sold for wage and therefore has exchange value... This labor requires one to induce or suppress feeling in order to sustain the proper state of mind in others-- in this case, the sense of being cared for in a convivial and safe place. This kind of labor calls for a coordination of mind and feeling, and it sometimes draws on a source of self that we honor as deep and integral to our individuality (Hochschild, 1983: 7).

Hochschild demonstrates that we manage our emotions in everyday life (Hochschild, 1983: 13). She also states that the growth of the service sector has required people to

develop their interactional skills rather than mechanical skills, and that "the fact that individuals talk to other individuals, rather than interact with machines is the fundamental fact about work in the post-industrialized society" (Bell, 1973; cited in Hochschild, 1983: 9). Her central claim is that the management of emotions is bought for a wage in service occupations.

Hochschild clearly shows that most jobs involve handling other people's emotions as well as our own. For example, she writes that:

> The secretary who creates a cheerful office that announces that her company as "friendly and dependable" and her boss as "up-and-coming", the waitress or waiter who creates an "atmosphere of pleasant dining", the tour guide or hotel receptionist who makes us feel welcome, the social workers whose look of solicitous concern makes the client feel cared for, the salesman who creates the sense of a "hot commodity", the bill collector who inspires fear, the funeral parlor director who makes the bereaved feel understood, the minister who creates a sense of protective outreach but even-handed warmth -- all of them must conform in some way or another to the requirements of emotional labor (Hochschild, 1983: 11; her emphasis).

To this list of occupations we can add the patient-attendant who makes patients feel comfortable, and the prostitutes who provides sexual pleasure and temporary companionship for a fee.

Hochschild explains that jobs involving emotional labour often share three characteristics:

> First, they require face-to-face or voice-to-voice contact with the public. Second, they require the worker to produce an emotional state in another person -- gratitude or fear for example. Third, they allow the employer, through training and supervision to exercise a degree of control over the emotional activities of employees (Hochschild, 1983: 147).

So, although emotional work is common to patient-attendants and prostitutes, an important distinction is present: Patient-attendants' emotional work is overlooked by supervisors and co-workers. On the other hand, prostitutes are usually alone with their clients, and are often self-employed; as such, they will have no supervisors guarding their emotional labour, or helping them to cope with emotional strain.

Hochschild draws from the writings of Erving Goffman on the presentation of self and interactions, to show that face-to-face encounters are always a form of work in which the self struggles to control and display emotions. She explains that Goffman presents two vantage points when discussing the presentation of emotions: the 'affective deviant' i.e. the person with the wrong feeling in a given situation and for whom the right feeling would be a source of burden, and the 'fly on the wall' who views each situation as having a social logic unconsciously sustained by people in interaction. Hochschild states that:

> Each situation 'taxes' the individual, who in return gets protection from unpredictability and membership in something larger. The affective deviant is one who tries to avoid paying these social taxes. Taxes, in turn come in emotive currency. For example, embarrassment is an individual's contribution to the group in the singular sense that embarrassment indicates that the individual cares how he seems in company. Not to feel embarrassed in certain situations is to violate the latent rule that one should care about how the group handles or mishandles one's identity (Hochschild, 1983: 215).

Hochschild critiques Goffman's work, for lack of a self which manages feelings. She explains that Goffman emphasizes rules and feelings, but not the actor who mediates the two; she summarizes this shortcoming as follows: "When the self is dissolved into "psychological materials" no relation between social rules and private experience can be

developed" (Hochschild, 1983: 218). In contrast, Hochschild presents a new social theory of emotion as a bodily sense, which just as sight, taste, touch, hearing and smell, allows us to make sense of our world. Like Darwin, Hochschild connects emotion to actions. She states that:

> Emotion, therefore, is our body ready for an imaginary action. Since the body readies itself for action in physiological ways, emotion involves biological processes. Thus when we manage an emotion, we are partly managing a bodily preparation for a consciously or unconsciously anticipated deed. This is why emotional work is work, and why estrangement from emotion is estrangement from something of importance and weight (Hochschild, 1983: 219-220).

A possible outcome of emotional work is the distancing or estrangement of workers from their emotions. Hochschild states that:

> Display is what is sold, but over the long run display comes to assume a certain relation to feeling. As enlightened management realizes, a separation of display and feeling is hard to keep up over long periods. A principle of emotive dissonance, analogous to the principle of cognitive dissonance, is at work. Maintaining a difference between feeling and feigning over the long run leads to strain. We try to reduce strain by pulling the two closer together either by changing what we feel, or changing what we feign. When display is required by the job, it is usually feeling that has to change; and when conditions estrange us from our face, they sometimes estrange us from feeling as well (Hochschild, 1983: 90).

For sex workers, notably female sex workers, it has been argued that emotional labour also causes them to be estranged from their sexuality. Sexuality is said to be intimately connected to the sense of self, and thus estrangement in the context of sex work is particularly detrimental to prostitutes' well-being (Pateman, 1983). In Live Sex Acts: Women Performing Erotic Labor, Wendy Chapkis (1997) shows that anti-prostitution activists understand alienation in sex work as involving "a

fundamentally self-estranging process as a woman develops an instrumental relationship to her sex and hence herself" (Chapkis, 1997: 71). It is argued that payment for sexual services is inadequate and mystifying, serving to disguise abuse as work. Anti-prostitution theorists posit that in order to exchange sexuality in the marketplace, a woman "must treat it [her sexuality] as an object which can be relinquished and made use of as the possession of a stranger... She must have learned to split herself into an object and a subject. Her own sexuality must be an object that she can manipulate and transfer" (Hoigart and Finstad, 1992: 180; as cited in Chapkis, 1997: 71).

Many theorists subscribe to the perspective that sexual labour is morally problematic because the body is unbreakably linked to the sense of self. As Carole Pateman (1983) remarked: "Sexual service and labor power are connected to the body, the body is connected to the sense of self. Hence a prostitute sells herself" (Pateman, 1983: 563). According to Pateman (1988), what is morally problematic with prostitution is not the use of the human body alone; if this were the case, we would have to condemn athletes who exert their body for financial rewards. According to Pateman, what is particularly wrong with prostitution is the sexual use of a woman's body:

> In modern patriarchy, sale of women's bodies in the capitalist market involves sale of self in a different manner, and in a more profound sense than the sale of the body of a male baseball player or sale of command over the use of the labor (body) of a wage slave... When a prostitute contracts out use of her body, she is thus selling herself in a very real sense. Women's selves are involved in prostitution in a very different manner from the involvement of the self in other occupations. Workers of all kinds may be more or less "bound up in their work," but the integral connection between sexuality and sense of self means that, for self-protection, a prostitute must distance herself from her sexual use (Pateman, 1988: 204; cited in Chapkis, 1997: 72).

Chapkis responds to Pateman's argument by stating that: "In physically and emotionally intimate work, such as prostitution, boundary maintenance is essential. Whether this is necessarily problematic or even uniquely true of prostitution is much less clear" (Chapkis, 1997: 72).

Through testimonies by workers involved in various types of sex work, Chapkis (1997) shows how sex workers maintain clear boundaries between themselves and their sexual labour; moreover, she argues that clients are often looking for sexual satisfaction within clearly defined bounds when they solicit a paid sexual exchange. In an interview with Chapkis, Annie Sprinkle, a sex worker and erotic performer, indicates that her emotions are also exchanged upon payment for sexual services. Sprinkle confirmed that:

> Somehow, when the money is there, we can have a fabulous time with these people, really give and be loving and totally be of service. And if the money isn't there, forget it, don't even want you in the same room with me. It's so weird. What is that? What is it that the money provides? Maybe it's just a clear exchange, especially when you are with someone that you don't like that much, somehow if they give to you, you can give to them. You've been compensated in a clear, clean way. I mean, I actually like a person if they pay me that I wouldn't if they didn't (as cited in Chapkis, 1997: 74-75).

In other words, clients pay Sprinkle for an emotional display -- to 'like them' or to be loving with them, for example -- along with the performance of sexual acts. Part of her job is to make clients feel cared for, and the exchange of money helps her care for them by delineating their 'relationship'. In this case money serves as a symbol of the emotional boundary between worker and client.

Chapkis argues that sex workers do not 'shut themselves off' or become 'estranged' from the sex acts performed in the service exchange with clients, instead they negotiate clear boundaries on how they feel, and what they will express. Chapkis affirms that "the ability to summon and contain emotion within the commercial transaction may be experienced as a useful tool in boundary maintenance rather than a loss of self" (Chapkis, 1997: 75).

Chapkis concludes that the negotiation of boundaries in sex work cannot be reduced to an "abuse of feeling", she states that "it is experienced in more complex terms contributing to a sense of a multiply-positioned self" (Chapkis, 1997: 76). Other sex workers interviewed by Chapkis described many tactics employed to maintain clear boundaries within sexual labour: some women wear disguises, others role play and adopt different personas. San Francisco sex worker Carole Queen explains that the boundary is often what the customer is paying for in service relationships in general, and in the sexual exchange in particular; she states:

> We create sexual situations with very clear boundaries, for ourselves and for our clients. In fact, one of the things that people are paying us for is clear boundaries. It's like the person going to the massage therapist; you're paying to be touched without having to worry about intimacy, reciprocity, and long term consequences. We can argue about whether that is a good model for human relationships, but the fact of the matter is that there are plenty of people happy to have access to a massage therapist. Same thing as seeing a psychotherapist; there you are paying someone to tell your secrets to, someone you can trust will not judge you and who at least won't interrupt you in the middle and start telling you their secrets. Instead you are getting focused attention (cited in Chapkis, 1997: 77).

Sex work is largely the erection and maintenance of boundaries between the self

and the client. As such, a large part of sex work involves emotional labour which is present in other forms of service work. According to Chapkis:

> Sex work is no more a pact with the devil (in which the "soul" is exchanged for worldly fortune) than any other form of emotional labor. Sex workers may be assumed to run the same risks as others involved in emotional labor. Clearly, performing emotional labor, including sex work, can negatively effect the emotional life of the worker. But there is no more reason to expect that the effect is necessarily and simply destructive (Chapkis, 1997: 78).

According to Hochschild (1983), the distancing or estrangement of self from emotions is at risk in all service exchanges. A number of strategies adopted by workers to safeguard themselves against emotional alienation are provided, including: focusing on what the client might be thinking or feeling when they act unreasonably, in other words to "imagine a reason of that excuses his or her behavior". Another strategy is to find a non-offensive way of expressing anger, like chewing ice repeatedly, or thinking about putting ex-lax in a client's coffee (but not doing it) (p.113-114).

For Hochschild (1983), the best strategy to avoid alienation form one's feelings is to adopt 'deep acting' as opposed to 'surface acting' when doing emotional work. Hochschild argues that surface acting involves feigning concern for clients' well-being. On the other hand, deep acting involves the manipulation of emotions to produce an actual concern for clients. Annie Sprinkle's statement above, on caring for people in the context of a paid sexual exchange, is an illustration of deep acting. In Hochschild's words: "In surface acting we deceive others but we do not deceive ourselves... In deep acting we make feigning easy by making it unnecessary" (Hochschild, 1983: 33). She

further states that:

> When feelings are successfully commercialized, the worker does not feel phony or alien; she feels somehow satisfied in how personal her service actually was. Deep acting is a help in doing this, not a source of estrangement. But when commercialization of feeling as a general process collapses into its separate elements, display becomes hollow and emotional labor is withdrawn (Hochschild, 1983: 136).

Another strategy adopted by workers to maintain control over their feelings is practicing collective emotional work, working within a team of workers to lift morale and provide the desired emotional state in clients. Hochschild mentions that team solidarity can have two effects: It can improve employees moral and thus improve service, as in the case where workers lift each other's spirits. On the other hand, team solidarity can foster grudges against the company, co-workers or supervisors, and be detrimental to the quality of service provided.

In sum, emotional labour is an integral part of prostitutes' and patient-attendants' work, since they manipulate their display of emotion, in order to produce a desired state in their clients and patients. They must, therefore, create boundaries and adopt strategies to guard their emotional well-being. Hochschild states that a fundamental characteristic in emotional work is that emotional display is controlled by supervisors, and that coping skills are often taught during training sessions. We can assume that since the structure and organization of sex work and hospital work differs, the management of emotional labour in each setting will also differ. This research explores how differences in patient-attendants' and prostitutes' structural organization of work impacts upon their management of emotional labour. It is believed that prostitutes have more control over

their emotional display at work than do patient-attendants, because they often work alone and are self-employed; hence they have no supervisors to shape their emotional labour through surveillance and training. As a consequence, prostitutes will also have less support than patient-attendants from others in their work environment to help them cope with emotional labour.

1.2 Body work, dirty work and the sense of self

Prostitutes and patient-attendants both have physical contact with their clients' bodies, often performing activities which could be considered intimate, such as washing others' genitals and performing sexual acts. Goffman (1961) called this type of service work, in which other people's bodies are manipulated, 'people work'. He defines 'people work' as follows:

...the first thing to say about the staff is that their work, and hence their world, have uniquely to do with people. This people-work is not quite like personal work or the work of those involved in service relationships; the staff, after all, have objects and products to work upon, not services, but these objects and products are people (Goffman, 1961: 74; his emphasis).

The concept of people-work as defined by Goffman is performed by prostitutes and patient-attendants alike, since both are human service workers who work directly on other people's bodies. As Goffman explains, the crucial determinants of their work derives "from the unique aspects of people as material to work upon" (Goffman, 1961: 76; my emphasis).

Goffman shows that people-work is risky work, due to the closeness of the

labourer and the client. He identifies some of the risks involved in 'people-work':

> There are (staffs believe at least) special dangers in some kinds of people-work. In metal hospitals, the staff believe that patients may strike out "for no reason" and injure an official; some attendants feel that prolonged exposure to mental patients can have a contagious effect. In TB sanitaria and in leprosia, the staff feel that they are being specially exposed to dangerous diseases (Goffman, 1961: 75).

The notion of body-work or people-work, is key to understanding work-related risk in sex work and hospital work. Many of the potential hazards and sources of discomfort in both occupational contexts can transpire from the physical proximity between workers and clients. For example, in the hospital setting, a potential source of discomfort for patients and staff alike, may arise during hygiene care. Workers might not feel comfortable washing patients of the opposite sex, and likewise, patients might not be at ease with attendants of the opposite sex. In the case of sex work, a potential source of anxiety and stress for prostitutes can be clients' discomfort with their own sexuality. It is believed that prostitutes and patient-attendants manage these and other risky scenarios through physical barriers and other coping strategies.

Due, in part, to the direct contact they have with their clients, street prostitutes and hospital patient-attendants perform a considerable amount of dirty work on the job. Everett Hughes (1958) defines 'dirty work' as follows:

> Now every occupation is not one but several activities; some of them are the dirty work of the trade. It may be dirty in one of several ways. It may be simply physically disgusting. It may be a symbol of degradation, something that wounds one's dignity. Finally, it may be dirty work in that it in some way goes counter to the more heroic of our moral contemptions. Dirty work of some kind is found in all occupations. It is hard to imagine an occupation in which one does not appear, in certain repeated

> contingencies, to be practically compelled to play a role of which he thinks he ought to be a little ashamed. Insofar as an occupation carries with it a self conception, a notion of personal dignity, it is likely that at some point one feel that he is having to do something that is infra dignitate (Hughes, 1958: 49-50).

Strauss et al. (1985) also contend that it is important not to distinguish dirty work as a type of activity, but consider all work as potentially 'dirty'. They explain that work can be deemed 'dirty' for several reasons: Work can be boring or routinized; it can be exhausting or stressful; it can be dangerous and thus be viewed as dirty work; it can be physically disgusting, such as the handling of blood, urine and feces; or it can be 'symbolically dirty' because it is "socially and personally dishonorable or discrediting" (Strauss et al, 1985: 248). Patient-attendant and street prostitutes most likely perform all of these types of dirty work. This thesis examines the ways in which dirty work is negotiated and understood by workers, and how they maintain a positive outlook of their occupation.

According to Hughes (1958), work is strongly linked to the sense of self; as such, it is important for workers who perform dirty work to devise barriers to prevent 'ego-wound' or antagonism. Hughes states that work characterizes people: "thus a man's work is one of the things by which he is judged, and certainly one of the more significant things by which he judges himself" (Hughes, 1958: 42). People must therefore value their work in order to have a positive view of themselves. Hughes explains that: "even in the lowest occupations people do develop collective pretenses to give to their work, and consequently themselves, value in the eyes of each other and outsiders" (Hughes, 1958: 45-46).

A coping mechanism used by workers at the lower stratum of an occupation is provided by Hughes. He explains that workers at the low end of an occupational setting assume that they save those higher up from mistakes or trouble. Hence, by ensure that things run smoothly and dealing routinely with the crises of others, such workers can perform dirty work and maintain a positive evaluation of their occupation (Hughes, 1958: 46). We can reasonably assume that this defense mechanism is employed by patient-attendants, who may consider that they save nurses from dirty work.

Hughes affirms that another informal barrier or strategy employed in the hospital is to use 'emergencies' to stall patients off. Hughes states that "the physician plays one emergency against the other"; similarly, patient-attendants can utilize 'emergencies' in order "to maintain some control over one's decision of what work to do, and over the disposition of one's time and one's routine of life" (Hughes, 1958: 55).

In order to safeguard themselves from the dirty aspects of their work, sex workers use physical barriers and personal rules to maintain a sense of distance from their clients. For example, Jo Doezema, a staff worker at the Red Thread, a brothel in Amsterdam, explains that she maintains distance and reduces the possibility of receiving an infection from her clients by following a 'no kissing rule'. However, she stresses that her definition of boundary should not be used as evidence that she is alienated from herself through her work. In her words:

> Now it is true that there are parts of myself that I do not want to share with my clients. But drawing boundaries in my work doesn't mean that I am in danger of being destroyed by it. The way you deal with clients is different from the way you deal with friends or sweethearts. It's always used so negatively that you've got to separate your work from your private life, as

> if that's unique to prostitution, and as if you actually found it so disgusting that what you were doing in your work that you had to put up this kind of barrier so that you wouldn't be destroyed. I think that's how people understand it if I say that I don't kiss during my work. They think that I've got to save some part of myself from being horribly degraded by the transaction of money for sex with a client. For me personally, I don't like kissing someone if I am not attracted to them. Also part of it is the professional code, the whole idea of prostitutes don't kiss. I think, "Well, okay we won't." Kissing is also very unhegyenic; if you're having sex you use a condom, so the chance of catching anything, even his cold, stays pretty remote. But not if you're kissing. Besides, for me, kissing is very intimate. It's a kind of intimacy I do not want to share with my clients. But that doesn't mean that the rest of what I am doing with my clients is disgusting or damaging to me. So there are parts of my life I don't want to share at work. So what? Do I have to give all of myself and not hold anything back in order to legitimately be able to say that I like my work? (cited in Chapkis, 1996: 121-122).

In the hospital setting, delegating dirty work to someone else is a possible coping mechanism. Hughes (1958) shows that power relations are structured through dirty work. He states that: "Many cleanliness taboos and perhaps even many moral scruples depend for their practice upon success in delegating the tabooed activity to someone else. Delegation of dirty work is also part of occupational mobility" (Hughes, 1958: 51-52). Hughes sees hospital work as a high prestige occupation in which the delegation of dirty work is only possible to a limited extent; because the physician must work on patients' bodies, and 'body work' of any kind has the propensity of being deemed 'dirty work'. However, there is a distinction between the physician's 'body work' which is a source of prestige, and the dirty work which is done by lower level hospital workers such as patient-attendants. Hughes writes:

> The dirty work may be an intimate part of the very activity which gives the occupation its charism [sic], as is the case with the handling of the

> human body by the physician. In this case, I suppose the dirty work is somehow integrated into the whole, and into the prestige-bearing role of the person who does it. What role it plays in the drama of work relations in such case is something to find out (Hughes, 1958: 52; my emphasis).

In sum, patient-attendants and prostitutes routinely perform activities which can be considered 'dirty' -- either because they are dangerous, boring, or disgusting. It is hypothesized that patient-attendants and prostitutes will negotiate and manage dirty work differently as a result of the differences in structural organization in each occupation. According to Hughes, we can assume that dirty work is viewed by patient-attendants as an effect of their low hierarchical position in the hospital, and as a tabooed activity which is passed on to them by higher status workers. Hughes states that one of the deeper sources of antagonism in hospitals is the belief by people in the humblest jobs that physicians call upon them to do his dirty work in the name of "healing the sick", although none of the prestige and little of the money reward of that role reaches them (Hughes, 1958: 52). As such, we might presume that patient-attendants feel resentful of others in their work environment who call upon them to do dirty work. The role of dirty work in the work-relations of patient-attendants is investigated in this thesis, along with the negotiation and management of dirty work by prostitutes and patient-attendants. Due to the solitary nature of the prostitution exchange, prostitutes might rely more on personal rules or physical barriers to distance themselves from the dirty aspects of their work. Conversely, patient-attendants could attempt to pass dirty work on to other workers, by avoiding certain tasks which they deem to be dirty. Prostitutes may take on more personal control in managing dirty work, refusing to service certain clients and perform

certain activities, while patient-attendants have little control and must perform the activities within their job description.

1.3 The hospital and the street: two risky work environments

The hospital and the street are both hazardous working environments. The following review of the literature on risk in prostitutes' and patient-attendants' occupations, shows that many of the same risks are present in each work environment.

David Shires (1993), a physician and occupational health researcher, defines the hospital as a risky work environment. He writes:

> Hospitals and other health institutions are not necessarily healthy environments for workers. They have unique occupational hazards, including infectious diseases, contaminated puncture wounds, carcinogenic and mutagenic exposures, radiation, solvent and chemical exposures, physical injuries, poor air quality, and other expected risks of a multipurposed industry (Shires, 1993: 166).

Shires (1993) also states that violence is present in hospital work, and that it is often considered to be "part of the job". In his words: "Street violence has become a part of health care institutions, and violence against staff is common in emergency rooms of city hospitals, in psychiatric and geriatric wards, in parking lots, and in dark corridors" (Shires, 1993: 169). He suggests that proper support systems should be installed to deal with the problem of hospital violence. He asks that:

> response to violence be supported with appropriate hospital policies that state employees who are victims of violence within the institution must be provided with services appropriate to any victim of violence, including medical health care, legal advice, information on workers' compensation, counseling, and peer support programs (Shires, 1993: 169-170).

Sex workers also encounter many of the same risks in their job. Priscilla Alexander (1997) outlined these risks in a presentation at the International Conference on Prostitution in Van Nuys California; they include:

> Occupational Injuries... Examples include repetitive stress injuries, foot knee and back problems, bladder and kidney infections, injuries due to violence. Latex allergies are currently a serious problem in the health care industry, and may be a problem in the sex industry as well... Infectious diseases. Most familiar, of course, are sexually transmitted diseases (STDs), such a gonorrhea, syphilis and chlamydia, these infections include a number of viral diseases, such as HIV, Hepatitis (HBV and HCV). Human Papilloma Virus (HPV), and Herpes (HSV)... Moreover, sex workers are vulnerable to other infectious diseases because of their close contact with the public, especially respiratory infections... Emotional Stress... Sex work can be stressful due to such factors as the risk of and actual violence, exploitative working conditions, and the impact of stigma and isolation. A few studies have found a significant prevalence of depression, especially among street prostitutes, who face the greatest risk of violence and arrest (Alexander, 1997: 2).

Three occupational hazards stand out in the quotes above, as being common to both types of service work under investigation: violence, infection, and occupational injury. This thesis examines those common risks in both prostitutes' and patient-attendants' work, along with particular risks in each occupation. The following sections of this chapter discuss the three types of risk which overlap in the literature on risk in sex work and in health care, in more depth.

1.3.1 Violence and Aggression

Much has been written on violence in the hospital (see for example Feldt and Ryden, 1992; Meddaugh, 1990; Meddaugh, 1987). Meddaugh (1990) defines abuse

towards caregivers as follows: "Abuse may be physical, such as biting, hitting scratching, kicking and punching, as well as verbal, such as swearing and threatening the caregiver" (Meddaugh, 1990: 115). She relates patient aggression to isolation and patients' lack of choice (Meddaugh, 1990: 116).

Aggression against health care workers can be a patient's response to illness or treatment. Brown et al. (1986) attribute the risk of violence against social workers to "stress, isolation, and the disinhibiting affect of certain drugs" (p.57). Since much of the research on violence in the health care setting relies on examinations of official incident reports, two problems ensue. First, as is the case for violence in general, one can assume that much of the violence occurring in the hospital setting goes unreported. Second, by relying solely on incident reports, we have no way of evaluating how health care workers interpret the violence committed against them. Hence, as is the case in official crime statistics, hospital statistics based on incident reports alone are not indicative of total aggression experienced within the hospital. This thesis attempts to remedy the problem by examining workers' own accounts of violence, and reveal patient-attendant's reactions to and feelings towards the violence they experience in the hospital. Since patient-attendants have direct contact with the patients, it is important to determine how they feel about aggressive patients, in order to get an accurate understanding of their view of hospital violence. The literature provides little understanding of the management of work-related violence by hospital staff, except to show that some staff file official incident reports. Hence more research is needed to understand the coping mechanisms used by hospital staff to deal with the problem of violence.

Violence in the context of female street prostitution is largely documented in the existing body of literature (see for example Miller, 1993; Hatty, 1989; Miller, 1986; Silbert and Pines, 1983). Many researchers have argued that the subordination of women in patriarchal societies leads to a cycle of abuse which often culminates in women being abused in the context of prostitution. For example Hodgson (1997), who did a qualitative analysis of street prostitution states that: "The obvious consequences of this exploitation are manifest in the many fears, the limited disclosure and an emerging cycle of violence that often forces women into prostitution" (Hodgson, 1997: 86). Similarly, Silbert and Pines (1982), who investigated various forms of abuse of prostitutes on the street, for the Delancey Street Foundation in San Francisco, also documented a cycle of abuse culminating in violence in the context of the sex trade. They found that of the 200 female street prostitutes they interviewed:

> The majority [...] stated that they had no other options when they began prostitution. Once on the street, their victimization continued. The majority were victimized by customer rapes and by such things as nonpayment, robbery, violence, and forced perversion. Two thirds of them reported having been physically abused and beaten repeatedly by customers; and two thirds reported having been physically abused and beaten by their pimps (Silbert and Pines, 1982: 130).

Silbert and Pines conclude by stating that their study produces: "a portrait of women trapped in a life style that they do not want, yet psychologically feel paralyzed and unable to leave" (Silbert and Pines, 1982: 132).

Whether street prostitution is a 'freely' chosen activity, or whether it arises out of a coercive situation, violence is often present. Neil McKeganey and Marina Bernard

(1996), who studied female street prostitution in Glasgow, connect violence in street prostitution to the 'visibility' and 'illegitimacy' of the street. They state that:

> Prostitution provokes strong reactions from some people; women who work the streets are the most visible representatives of the trade and so also are they the easiest targets for some people's prurient fascinations or loathing or aggression. Steetworking prostitutes have to contend with the whole spectrum of behaviors provoked by the sight of prostitution ranging from name calling to physical assault, rape and murder (p.70-71).

In the street, McKeganey and Bernard (1996) found violence to be commonplace: "women expected it to happen at some point and considered themselves to be lucky if they had so far managed to avoid it" (McKeganey and Bernard, 1996: 70). The authors state that: "the women were in agreement that you had to be constantly aware of the possibility of violence and be one step ahead of the client at all times" (McKeganey and Bernard, 1996: 70). They argue that all violence is about power, and that the subordination of women lies at the root of violence against female prostitutes. Prostitute women defy male expectations about how women ought to act, in their words: "a good women is ideally a wife and a mother whose sexuality is expressed within the context of a loving family relationship" (McKeganey and Bernard, 1996: 79). Consequently, they assert that "violence within the prostitute/client encounter can be understood as part of the way in which women in this society, at least, are defined apropos of men", and maintain that:

> The prostitute violates fundamental expectations as to how women ought to act. In the first place she is overtly selling sex, dressing for sex, making herself available for sex... A woman who prostitutes already violates norms of how women ought to act and calls upon her own violation. That these attitudes are widespread in society is evidenced by the fact that

> hardly any of the violence to which prostitutes are subject is reported to the police. Rightly or wrongly, such women anticipate the reaction that they are in effect the perpetrators of their own violent assault, by placing themselves in the situation where such assaults are a likely occurrence (McKeganey and Bernard, 1996: 80).

McKeganey and Bernard (1996) demonstrate that prostitute women rely on themselves and on each other to find ways in order to reduce the risk of violence. The methods employed include: taking charge of the sexual encounter by issuing clear instructions on the price, place and manner of the sexual encounter (p.72); working in pairs or small groups so that one women can note clients' license plate numbers, and stand guard in alleys where sexual exchanges take place (p.73-74); using intuition in order to determine whether the client is potentially dangerous; imposing working rules on themselves, for example some women do not work past midnight and most refuse to service more than one client at a time; a small minority of female prostitutes also carried weapons for protection. McKeganey and Bernard contend that the effectiveness of these strategies to ensure women's safety cannot be assessed, however, they do provide women with a degree of confidence. In their words:

> None of these strategies ensured women's safety. Indeed, it is arguable that the very nature of what the women were doing, entering cars or dark alleys with complete strangers, can never be anything other than extremely dangerous. These strategies were the only means within the women's own grasp to try and reduce their chances of being attacked. It is impossible to know how effective any of the above strategies were in avoiding actual instances of violence. Nevertheless they provided women with a degree of confidence enabling them to work in the face of their own knowledge that they were dealing with men whose behavior was, for the most part, completely unpredictable. In this sense the women were like gamblers, only the risk was not of winning but of losing, and they each had their own systems for lessening the chances of that outcome (McKeganey and Bernard, 1996: 78-79).

The authors also note that in instances where women are under the influence of drugs and alcohol, or when women are relatively inexperienced sex workers, they have difficulty skillfully managing their encounters and lessening the risk of violence.

While the problem of violence in the context of female prostitution is dealt with in the literature, little research has focused on the interpretation or negotiation of violence by street prostitutes. Very few articles provide prostitutes' reactions to violence in the context of their work. Furthermore, violence against male street prostitutes is virtually ignored in the literature. This thesis addresses both of these gaps in the literature, by focusing on prostitutes' discourse on violence in their work, and by examining male prostitute's reactions to violence. McKeganey and Bernard (1996) propose several coping methods employed by prostitutes in order to manage violence, it will be determined whether these strategies are also used by the prostitutes in this sample.

In sum, violence exists in each work setting, however it emanates from distinct sources. In the hospital, violence often arises from a patient's inability to cope with hospitalization and illness. In the street, violence takes many shapes and has many theoretical causes. Some authors argue that it ensues because of what the female prostitute signals: control over sexuality and insubordination. Violence against street prostitutes is also present due to their visibility and susceptibility, on the street they are easy targets for harassment and assault. Moreover, violence against street prostitutes exists due to the illegitimate status of sex workers, and the lack of a regulatory system in

the sex trade. As Alexander (1984) suggests, violence against street prostitutes is often committed by the police; so, they can not count on the law to protect them. It is hypothesized that the risk of violence will be managed differently by prostitutes and patient-attendants. Shires (1993) implies that health care workers rely on the hospital institution to cope with violence. On the other hand, McKeganey and Bernard (1996) show that prostitutes depend on themselves and their co-workers to manage violence.

1.3.2 Infection and Disease

Infection is another hazard common to prostitutes and patient-attendants. As the following section illustrates, the risk of infection in both occupations is often overestimated, misunderstood and misrepresented.

Kimberly Bergalis' death of AIDS in 1991, ignited a debate on the risk of HIV transmission in the health care industry. Bergalis was believed to have contracted HIV from her dentist, David Acer who died of AIDS in 1990. It has been written that: "Her case caused mass panic in the USA and abroad, fueled by her impassioned deathbed pleas for routine HIV testing of health care workers" (Gorna, 1996: 49).

In an investigation of AIDS-related risks in the health care setting, William Flanagan (1993) states that there are no documented cases of HIV transmission from patient to health care worker in Canada, and approximately 35 cases in the US since the discovery of AIDS (Flanagan, 1993: 72). He also claims that "hepatitis-B virus (HBV), not HIV, is the major occupational health hazard in the health care industry" (Flanagan, 1993: 99). HIV transmission in health care is rare, furthermore, it is preventable through

the use of universal precautions. Flanagan affirms that:

> The available evidence also indicates that universal precautions can significantly reduce the incidence of occupational exposure to blood. Studies indicate that up to 93% of typical incidents of occupational exposure to blood can be prevented with the consistent use of universal precautions (Flanagan, 1993: 103).

Flanagan defines 'universal precautions' as follows:

> Blood and certain other body fluids of all patients are considered potentially infectious and treated accordingly. These precautions include appropriate barrier precautions such as gloves, masks, goggles, and gowns to prevent skin or mucous membrane exposure, especially in the case of invasive procedures such as surgery. Injury prevention, such as the safe handling and disposal of used needles is also essential (Flanagan, 1993: 100).

David Shires' (1993) list of occupational health hazards in medical institutions, includes the risk of infections such as AIDS, hepatitis B and its variants, tuberculosis, influenza, and childhood diseases such as chicken pox, measles and rubella. He also affirms that all of these can be controlled through measures such as universal precautions. So, there is a general consensus that when appropriate measures are taken, the risk of occupational exposure to infection in the health care setting is low. In support of this, Stine (1994) reports that there has been only one documented case of HIV infection among patient-attendants in the US up to and including 1994, and up to nine cases of HIV infection potentially caused by occupational exposure to blood or bodily fluids, but in which the mode of transmission of HIV remains undetermined (Stine, 1996: 264).

Risk of infection and disease in prostitution is understood as being high. Throughout history, the prostitute's body has been seen as a vector of disease, and

prostitutes are often scapegoated for the transmission of illnesses and infection into the 'general population'. As indicated by Shaver (1995): "Historically, the health and safety policies regarding prostitution that have been put in place embrace the assumption that the workers themselves -- especially the female workers -- are a threat to others" (Shaver, 1995: 3).

In her study of the "Making of the Modern Prostitute Body", Shannon Bell (1994) traces the practice of pathologizing prostitutes back to the British Royal Commission on the Contagious Diseases Acts of 1864, 1866, and 1896. In Bell's words: "The acts identified sex as a public issue, differentiated male from female sexuality, marked certain types of sexual activity as dangerous, and produced the prostitute body as the cite of disease and pollution" (Bell, 1994: 55). Bell also demonstrates that the Contagious Diseases Acts also served to define prostitution as a legal category, since until 1864, prostitution had been regulated under vagrancy laws. Bell cites various sections, to summarize the scope and purpose of The Contagious Diseases Acts, and to show that the intrusive medicalization of prostitutes can be traced back to the eighteen hundreds.

McKeganey and Bernard (1996) examined cross-cultural studies on rates of HIV among working prostitutes. They affirm that: "throughout Europe, Australia and North America, HIV infection among female prostitutes is really a tale of not one epidemic but two -- one among those prostitutes injecting drugs and those who do not inject" (McKeganey and Bernard, 1996: 61). The authors found great discrepancies in rates of HIV. In LA, where HIV infection among injection drug users is low, the rate of HIV among 600 prostitute women was 2.5 per cent. By contrast, in New York rates of

infection among intravenous drug using prostitutes was as high as 60% of the 538 prostitutes sampled (McKeganey and Bernard, 1996: 61-63. In sum, when addressing rates of HIV and other infections, it is important to take into consideration other determining factors like the use of injecting drugs.

Much research has shown that prostitutes consistently use condoms with their clients to protect themselves and their clients from infections. For example, McKeganey and Bernard (1996) state that condom use among prostitutes in developed countries is very high. They state that the European Working Group surveyed prostitutes from Amsterdam, Antwerp, Athens, Lisbon, London, Madrid, Paris and Vienna, and reported that 80.3% of prostitutes had always used condoms with clients in the six months prior to the survey. In the United States, among 1024 street prostitutes studied between 1990 and 1991, only 12% said that they did not use condoms when they last provided vaginal sex, and 20% reported not using condoms when providing oral sex (McKeganey and Bernard, 1996: 64-65).

McKeganey and Bernard (1996) also indicate that condom use among prostitutes differs when prostitutes are with clients or with partners. They state that:

> Within the developed countries, as shown by evidence from Europe, North America, and Australia, condom use with clients is reported as being very high. However, condom use with private partners has been shown to be very low. A number of reasons have been offered for this, including the concern on the part of prostitute women to maintain a clear distinction between sex for money and sex within the context of their private relationships -- the condom acting as a symbol of difference. It should also be remembered that many prostitute women will be involved in long-term relationships and that in choosing not to use condoms with their partners, they are actually making the same choice as most couples in long standing heterosexual relationships (McKeganey and Bernard, 1996: 65).

In a study of "men who have sex with men", based on interview data with the same sample of men prostitutes used in this thesis, and compared to studies of nnon-prostitute men's sexual behaviors, Shaver and Newmeyer (1996) support the notion that male prostitutes' condom use is higher in work sex than in personal sex (Shaver and Newmeyer, 1996: 14). They also demonstrate that in male sex work, condom use is positively associated with riskiness of activity, and the low risk activities are practiced at a much higher rate than high risk activities (Shaver and Newmeyer, 1996: 10-12).

In an American study of female prostitution for the National Committee on Prostitution, Priscilla Alexander (1984) states that:

> The US department of public health consistently reports that about five percent of the VD in this country is related to prostitution. Studies of prostitutes, on the other hand (and it is important to remember that these studies are probably of street prostitutes who have been arrested) generally find that about 20-25 percent of the women have some venereal disease. For comparison, it is interesting to note that about 30-35 percent of the VD in this country is found among high school age individuals. Prostitutes are usually quite concerned about venereal disease. They know, for example, that gonorrhea is asymptomatic among women 80 percent of the time, and if untreated, it can lead to a life threatening condition known as pelvic inflammatory disease... Therefore, prostitutes tend to be quite responsible about being checked for disease, to protect themselves as well as others (Alexander, 1984: 10).

Because of the movement to educate people about HIV, Hepatitis, and other infectious diseases at the local level, in community organizations and on the street, prostitutes have become more informed about risk of infection and more likely to consistently use condoms for work sex. Moreover, Alexander (1995) confirms that prostitutes have played an active role in AIDS prevention campaigns around the world.

She shows that an important repercussion of prostitutes' involvement in AIDS prevention has been the changing discourses around AIDS and sex work. Whereas prevention campaigns used to aim only at protecting clients and their families from infection carried via prostitutes, people are starting to recognize the needs and interests of prostitutes; or in Alexander's words: "The concept that prostitutes have the right to be protected from disease -- by routine condom use, by safe and clean working conditions -- is beginning to supplant the idea that it is only the health of clients (and of their "innocent" wives and girlfriends) that matters" (Alexander, 1995: 115). Furthermore, the onus is no longer only on the prostitutes: "most [infection prevention] projects today are increasingly stressing the importance of educating clients and men likely to be clients". Alexander further asserts that: "Increasing attention is also being paid to the owners and managers of sex work-related businesses, so that the task of preventing the spread of this disease [AIDS] can be shared by all the players" (Alexander, 1995: 115).

Both hospital workers and sex workers run the risk of infection on the job. However, in prostitution, the risk of infection seems to fuel the moral indignation against prostitutes in society. Furthermore, both prostitutes and health care workers are often blamed for spreading infection and disease to 'the general population'. The literature described above suggests that both prostitutes and patient-attendants use physical barriers to manage the risk of infection in their work. This study examines conditions surrounding the use of physical barriers and other strategies, by prostitutes and patient-attendants, to ward off infections.

1.3.3 Other occupational hazards

David Shires (1993) identifies numerous "non-violent and non-infectious hazards" within medical institutions, including: lower back pain from lifting patients and moving heavy items; occupational dermatosis; poor air quality; and adverse effects of shift work. Priscilla Alexander (1995) also mentions numerous stress injuries and other occupational hazards which threaten prostitutes. Hence the physical nature of prostitutes' and patient-attendants' work, also gives rise to similar work-related risks in both occupations.

Drug abuse has been documented as a potential risk in prostitution. For example, in a review of the literature on sex work, Alexander (1997) affirmed that:

> While there is an association between some kinds of sex work and the use of drugs, primarily on the street, several studies have reported that a majority of sex workers who use drugs did so before becoming involved in prostitution, and began using prostitution to earn enough money to pay for the drugs. Others begin using drugs after beginning the work to enable them to help them to stay alert and awake, for example, cope with anxiety and the risks they take, and/or sleep. Most off-street establishments discourage drug use by their employees, which is one of the reasons why most drug dependent workers tend to work on the street (Alexander, 1997: 2).

As such, drug use can be a condition of entry into prostitution, or a coping mechanism used by prostitutes to manage other risks. The rationale behind drug use as a coping mechanism provided by Alexander -- that prostitutes use drugs to stay awake, to deal with emotional stress and the effects of shift work-- implies that patient-attendants might also use drugs to cope with these same stressors. However, in a study by Mensch and Kandel (1988) it was demonstrated that job conditions do not influence the use of drugs including cigarettes, marijuana and cocaine; but that individual factors such as lack of

commitment to social institutions and not being married, are much better predictors of drug use. As such, it is hypothesized that both prostitutes and patient-attendants will use drugs to cope with the stressful aspects of their work, and that more prostitutes than patient-attendants will use drugs, based on the assumption that people who support a drug habit often enter into prostitution to finally support their addiction.

In sum, patient-attendants' and prostitutes' labour have many characteristics in common; most notable for the study of risk, is the performance of emotional work and body work. The literature reviewed above implies that they also face many of the same risks at work, and are likely to rely on physical and emotional boundaries between themselves and their clients or patients, in order to guard against these risks.

Although the research discussed thus far, points out many similarities in the labour performed by patient-attendants and prostitutes, many other authors suggest that the structure of each occupation will affect how risk is managed in the workplace. For example, Hughes (1958) explains that dirty work and risky work is passed 'down' the hierarchy in the hospital. Alexander (1984) implies that the illegitimate structure of prostitution increases the potential of violence and decreases prostitutes' ability to trust law enforcement institutions to protect them. Therefore, we can assume that although they may experience similar hazards, prostitutes and patient-attendants will negotiate and manage occupational risk differently, according to the organizational structure of their work environments.

The issue of control within occupational settings becomes central to this investigation of work-related risk. In some instances it seems that prostitutes will have

more control than patient-attendants in deciding how to manage work-related risk -- because of the informal structure and the solitary nature of their work. On the other hand, patient-attendants might have less control in deciding how to manage risk, but they can rely on the institution to provide some coping strategies. The following section discusses the structural differences in the occupations being studied, and proposes ways in which differences in occupational structure might impact upon the management of work-related risk.

2. Differences in the Hospital and on the Street

Despite the many similarities in prostitutes' and patient-attendants' work -- such as the emotional labour and physical contact with patients and clients, as well as the presence of many similar work-related risks -- a number of structural elements distinguish these the working environments: Health care is 'respected' while sex work is 'stigmatized'; health care is 'institutionalized', sex work is 'illegitimate'. Each of these oppositions characterize the work-worlds of patient-attendants and prostitutes. It is thus believed that they will also impact upon the management of risk in each occupational setting. First, the institutional organization of the hospital is addressed in order to comprehend the impact of structural administration on risk management. Second, Goffman's discussion of stigma is applied to provide insight on identity management by street prostitutes. Finally, the effects of illegitimacy in prostitutes' work-world are discussed and possible implications for the management of risk are outlined.

2.1 The hospital: institutional organization

Health Care is a socially respected, and highly organized institution. The hospital is often associated with cleanliness, regulation, and structure. Whether hospitals are seen as "temporary abodes, to be abandoned as soon as all prescribed diagnostic and treatment procedures have been completed", or as "huge boarding homes for the damaged and derelict of our society" (Roth, 1966: 54), the institutional nature of the hospital is visible at first sight: white lab coats; official announcements over loudspeakers; workers carrying charts, specimens, and various diagnostic instruments. These are some of the

symbols of the hospital's organization and legitimacy.

Hospitals are considered 'total institutions'. The concept of 'total institution' was first introduced by Erving Goffman (1961) as: "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (Goffman, 1961: xiii). Goffman states that: "the handling of many human needs by the bureaucratic organization of whole blocks of people... is the key fact of total institutions" (Goffman, 1961: 6). We can perceive the bureaucratic administration of needs in today's hospitals. For example: patients' hygiene and nourishment is on a schedule, their families must comply to visiting hours, staff take their breaks only at the designated times.

Goffman explains that a key fact in total institutions is that there is a formalized split between patients or inmates and staff. He shows that the separation of patients from staff and their disconnection for the outside world, along with the formal administration of their needs, provides safety to staff. He states that:

> When persons are moved in blocks they can be supervised by personnel whose chief activity is not guidance or periodic inspection... but rather surveillance -- seeing to it that everyone does what he has been clearly told is required of him, under conditions where one person's infraction is likely to stand out in relief against the compliance of others (Goffman, 1961: 7).

Hence the formal system of patient surveillance guards their actions, and has the effect of safeguarding staff, by limiting the number of anomalies erupting within the institution.

In The Social Construction of Reality, Berger and Luckmann (1966) imply that

the institutionalized nature of an institution can also protect its' staff by prescribing a ritualized pattern of responses and actions taken within the institution. The authors state that institutionalization develops through human habitualization:

> All human activity is subject to habitualization. Any action that is repeated frequently becomes cast into a pattern, which can then be reproduced with an economy of effort and which, ipso facto, is apprehended by its performer as that pattern. Habitualization further implies that the action in question may be performed again in the future in the same manner and with the same economical effort (Berger and Luckmann, 1966: 50).

They also affirm that "habitualization carries with it the important psychological gain that choices are narrowed" (Berger and Luckmann, 1966: 51).

Berger and Luckmann (1966) define institutionalization as follows: "Institutiontionalization occurs whenever there is a reciprocal typification of habitualized actions by types of actors... The typifications of habitualized actions that constitute institutions are always shared ones" (Berger and Luckmann, 1966: 52). As such, we can infer that patient-attendants' responses to given situations in the hospital are often pre-determined and organized. Berger and Luckmann (1966) also state that institutions imply control over human conduct:

> Institutions also, by the very fact of their existence, control human conduct by setting up predefined patterns of conduct, which channel it in one direction as [sic.] against the many other directions that would theoretically be possible... To say that a segment of human activity has been institutionalized is already to say that this segment of human activity has been subsumed under social control
> (Berger and Luckmann, 1966: 52).

In sum, institutions control individual behaviors. Therefore, we can assume that

patient-attendants do not have much control or decision-making power in dealing with crises or hazards in the hospital since much of the activities within institutions, including the management of work-related risk by patient-attendants, are performed according to protocols. It is thus believed that various protocols will also guide the management of work-related risk in the hospital setting.

2.2.1 The street prostitute: stigmatized identity

Prostitution, on the other hand, is a highly stigmatized activity (see Pheterson, 1996). Erving Goffman (1963) coined the term stigma. For Goffman, social identity comprises both personal attributes such as honesty and structural ones like occupation. According to Goffman, we always foresee how to interact with "anticipated others"; in his words: "we lean on these anticipation's that we have, transforming them into normative expectations, into righteously presented demands" (Goffman 1963: 2). Immediately upon perceiving someone, we make judgments about his or her character. Goffman states that:

> While the stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of the less desirable kind, in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive (Goffman, 1963: 3).

Goffman classifies the stigmatized or discredited person into three broad categories. Prostitutes are considered by Goffman as 'sexually discredited persons'-- his third

classification -- who carry "blemishes of individual character" such as weak will or unnatural passions (Goffman, 1963: 3).

The thesis of recognition or misrecognition proposed by Taylor (1994), introduces the notion that people must at times conceal and manipulate their identity to be accepted into society. Taylor shows that misrecognition is a powerful exclusionary force:

> The thesis is that our identity is partly shaped by recognition or its absence, often by the misrecognition of others, and so a person or group of people can suffer real damage or real distortion if the people or society around them mirror back to them a confining or demeaning or contemptible picture of themselves. Nonrecognition or misrecognition can inflict harm, can be a form of oppression, imprisoning someone in a false, distorted, and reduced mode of being (Taylor 1994: 25).

As such, it is important for those who are stigmatized or misrecognized to manage their identity. Goffman (1963) states that the stigmatized person often responds to his/her situation by attempting to correct or conceal stigma. For example, a person with a deformity might undergo corrective surgery and a blind person might learn how to rock climb. The importance here is that stigmatized individuals want to present or maintain a "normal" social image. Goffman calls normification "the effort on the part of a stigmatized person to present himself as an ordinary person, although not necessarily making a secret of his shortcomings" (Goffman, 1963: 31).

According to Goffman (1963), in order to manage one's identity, individuals must be concerned with the 'visibility' of stigma. He refers to actual seeing and perception of stigmatized attributes, and maintains that these character marks must be managed: "Visibility of course is a crucial factor. That which can be told about an individual's

social identity at all times during his daily round and by all persons he encounters therein will be of great importance to him" (Goffman, 1963: 48). We can thus assume that prostitutes are concerned with supressing the visibility of their stigmatized status. As mentioned previously, violence against street prostitutes is related to stigma and to their visibility as potential targets (McKeganey and Bernard, 1996). Hence, it is believed that in order to manage their identity and certain potential risks such as violence, prostitutes must take account of, and learn to manage their visible stigmatized status during their daily work routine and in their private lives[2].

Goffman (1963) explains that to manage stigma, individuals must adopt a number of selves and social roles. Stigma management is primarily associated with public life, while being true to oneself develops through intimacy, hence intimacy is in contrast with stigma management:

> Note that this embracing singleness of life line is in sharp contrast to the multiplicity of selves one finds in the individual in looking at him from the perspective of social role, where, if role and audience segregation is well managed, he can quite handily sustain different selves and can to a degree claim to be no longer something he was (Goffman, 1963: 64).

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2 At the International Conference When Sex Works, held in Montreal in September of 1995, Kara Gillis -- a street prostitute and spokesperson for CORP the Canadian Organization for the Rights of Prostitutes -- told an insightful story in a panel on prostitution and the law, which illustrated how her visibility as a prostitute impacts upon her private life. She stated that her communication for the purpose of prostitution is usually undetectable because she is very discreet. However, she can no longer frequent a local restaurant, simply because she is a recognized street prostitute. Often, when she is sitting in the restaurant having a meal or drink with a friend, they are both asked to leave the premises by restaurant owners and by the police. If they fail to comply and leave the restaurant both can be taken in to police station for questioning, their supposed offense is communicating for the purpose of prostitution.

Goffman later remarks that stigma management and identity can become merged parts of the self; in his words: "stigma and effort to conceal it or remedy it become "fixed" as part of personal identity" (Goffman, 1963: 65).

Goffman makes it clear that between the two extremes where no one knows about a person's stigma and the other where everyone knows, lie a vast range of scenarios. He describes a two-sided stigma management practiced by prostitutes, which require them to be carefully secret about their identity to one class of persons, the police, while systematically exposing themselves to another, their clients (Goffman, 1963: 73). Goffman also gives the example of how a prostitute's beat constitutes a threat of discovery as a discredited individual. He explains that every individual's world is partitioned into civil and forbidden places which "establishes the going price for revealing or concealing and the significance of being known about or not known about" (Goffman, 1963: 82). Hence prostitutes are likely to suppress stigmatized identity in some contexts but not in others.

Goffman describes different ways to manage a spoiled identity, which he calls personal information control: by concealing the signs of stigma; by presenting the stigma as something else; by dividing the world into areas where one is free to show signs of stigma and others where one conceals the signs of stigma; by taking physical and emotional distance for others; and finally by disclosing all (Goffman, 1963: 92-100). It remains to be seen how the prostitutes sampled manage stigma, and whether or not risk and management varies according to their stigmatized status.

2.2.2 The street: Illegitimate deviant networks

In contrast to the institutional nature of the hospital, the work-world of the street is often described as a web of deviant and informal networks (Hodgson, 1997; Miller, 1986; Stevens and Davidson, 1986). In a study of female prostitutes in Wisconsin and Milwaukee, Miller (1986) describes "deviant street networks" as "a source of information" and "a source of socio-emotional support, self-esteem, and courage". Similarly, in their account of Toronto's inner-city subculture, Stevens and Davidson (1986) describe informal ties between street prostitutes and cab drivers; prostitutes offering company to cab drivers awaiting a fare, while cabbies provide shelter and in some instances safety to prostitutes seeking clients. It is thus believed that networks of people working in the street at night are sources of support to street prostitutes.

What distinguishes prostitution from other forms of legitimate employment, is that many of its' facets are regulated by the criminal code. John Lowman (1995) provides a complete description of the history of Canadian legal control of prostitution. Lowman explains that Canadian prostitution laws do not aim at quelling the exchange of sex for money, instead they control the alleged nuisance created by streetworkers and bawdy houses. As such, prostitution laws do not strive to abolish prostitution, or even make it safer for everyone involved, instead these laws aim at controlling the amount of public outcry against prostitution and other "social evils" in a similar manner as did vagrancy laws in Britain (Lowman, 1995: 333).

Shaver (1995) shows that the laws put in place to protect women and children from the "evils" of prostitution often do more harm than good. She states that:

> Policies addressing the risks to workers -- the more common way to address occupational health and safety (OHS) issues -- tend to have been established in the form of criminal law and to impact negatively on those they were designed to protect (Shaver, 1995: 4).

Shaver explains that statutes enacted since Canadian Confederation prohibiting "the defilement of women under the age of 21" as well as vagrancy laws and laws "proscribing the procurement of women for unlawful carnal connection", were designed to "protect women and children from the wiles of the procurer, pimp and brothel keeper (Shaver, 1995: 4)". She further asserts that:

> As McLaren (1986) clearly demonstrates, these statutes -- and others which extended and strengthened the penalties -- failed to provide the protection envisioned and in many cases increased the risk for women. Our current prostitution related laws continue to impact negatively on women, often serving to place them in high risk situations, rather than to provide safer working conditions (Shaver, 1995: 4).

In Canada today, it is not a crime to work as a prostitute or to exchange sexual services for money or other material goods. However, many aspects of the sex trade are illegal. For example, keeping a "common bawdy-house" or brothel, transporting a person to a bawdy house, procuring, living on the avails of prostitution, and communicating in a public place for the purpose of prostitution are all illegal activities for which men and women can be charged under the Canadian criminal code. These laws often impede upon the private lives and work lives of prostitutes. For example, due to the severe legal implications of operating a bawdy house and living on the avails of prostitution

(pimping), many sex workers chose to work on the streets, alone. Often, they must service their customers in cars, since they can not bring them anywhere which could be considered a bawdy house. The communicating laws limit the amount of negotiation time in which a sex worker can 'deal' with a client. Hasty decisions to do dates in cars or other unsafe areas increases the danger to sex workers[3]. The laws surrounding prostitution today are often what makes this activity dangerous to those who work within the sex trade. Therefore, prostitution legislation also takes working decisions away from prostitutes, making it very difficult for Canadian sex workers to conduct their business safely and free from the risk of arrest.

Shaver (1993) clearly shows that prostitution laws negatively impact on the lives of those involved in the sex trade. She states:

> First and foremost, the illegality increases the risks women face by impeding the flow of information between prostitutes and customers and increasing the prostitutes' dependency on pimps and other profiteers in order to contact clients. Since the sentences based on operating a bawdy-house are much more serious, more women work on the street than would like to. The hazards and risks they endure, regardless of their base of operation, are seen as part of the job. As a consequence, prostitutes who have been beaten and raped are often told by the police that they have no right to protection. This tends to add to their feelings of stigmatization and decrease their feelings of positive self-worth. Finally, their family ties are very vulnerable: the adults they live with face the risk of being charged with living on the earnings of prostitution, and their children are likely to be placed in custody once their identity comes to the attention of the authorities. This is a particular problem for women [sex

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3 These ideas were expressed by Dr. John Lowman (a criminologist from Simon Fraser University in B.C.) and Kara Gillis (a member of CORP - Canadian Organization on the Rights of Prostitutes- and a Toronto sex worker) in a panel on legal reform in Canada, at a Montreal international conference on prostitution When Sex Works, 1996.

> workers] because they are more likely to be cohabiting than the men and are more likely to have children (Shaver, 1993: 164).

Moreover, Shaver demonstrates that: "of all the participants [in the sex trade], female prostitutes are most likely to end up with criminal records, and are more likely than their male clients to receive severe convictions" (Shaver, 1993: 164).

We have seen that prostitution laws have the potential to increase risks to prostitutes and limit the ways in which prostitutes manage their work. McKeganey and Bernard (1996) also show that stigma can prevent prostitutes from managing potential hazards. By working on the street as a prostitute, a woman can lose all rights to be treated with respect, she gets shouted at, insulted and can be assaulted. McKeganey and Bernard (1996) state that:

> One might argue that the shouting of insults could scarcely be classified as violent. However, it is indicative of a pervasive attitude towards women who prostitute, that in so doing they forfeit the right to be treated with respect or even sensitivity and can be the object of people's outrage or anger or derision or be a spectacle for entertainment (McKeganey and Bernard, 1996: 71).

McKeganey and Bernard also show that the social stigma against prostitutes is demonstrated in their refusal to report violence committed against them to the police. In their words:

> Hardly any of the violence that occurred in the area was reported to the police. Unless the violence itself was of a particularly extreme kind, most of the women seem to feel that there was little to be gained from such reporting. In the first place, there seemed to be some doubt that the police would successfully pursue the men concerned, and a belief that even if they did, and the case came to court, it would not result in a conviction once it was known that the women was working as a prostitute (McKeganey and Bernard, 1996: 74).

Not only do prostitutes fail to report violence or aggression to the police, often it is the police who harass them the most. For instance, Alexander (1984) illustrates that police are a serious threat to street prostitutes. She writes:

> The police, who are sworn to protect people from violence, are largely negligent in that duty when it comes to people who are seen to be powerless, and that includes prostitutes. Even worse, because prostitutes are seen to have few supporters in the outside world, police (particularly undercover vice officers) feel free to insult and roughly handle the prostitutes they arrest, with the physical abuse ranging from tightly handcuffed hands being pulled roughly up the back, to outright beatings and kicking. The verbal abuse ranges from specific insults about the individual prostitute's body, to taunting about the potential for a free blow job with no one the wiser, to suggestions that the prostitute give the sheriff a blow job to get out of jail. Most prostitutes accept this abuse as part of the job, and so the few accounts that surface must be seen to be symptoms of a much larger problem (Alexander, 1984: 9).

In sum, the illegal nature of the sex trade has the effect of increasing certain dangers to prostitutes, especially the risk of violence and harassment. As well, some of the dangers of prostitution are augmented for female prostitutes, due to the discriminatory enforcement of the law. Because of the stigmatized and illegal status of their work, prostitutes are not likely to solicit formal means to manage these risks, instead it is believed that they rely on themselves and on street networks to ensure their safety.

This study of work-related risk examines the effect of illegitimacy or legitimacy of an occupation, on risk management within. The context of the night street is compared to the structure of the hospital, providing an opportunity to study the effects of variations in organizations on risk management. Due to the organization of the health care industry,

it is hypothesized that patient-attendants will have more tools and guidance on the job to help cope with the various risks involved in their work. Also, it is believed that the institutional nature of the hospital will limit the amount of control and decision making power of patient-attendants to manage work-related risk. Hence, it is argued that patient-attendants will cope with various risk factors in a similar routinized manner using strategies provided by the hospital administration. Conversely, it is hypothesized that because of the stigmatized and illegal nature of the night street, sex workers will have fewer formal resources and support to help them cope with emotional abuse, physical threats, and occupational injuries experienced on the job. The illegal and stigmatized nature of prostitution is thought to further limit prostitutes' options when dealing with risk.

3. Theoretical framework

The literature discussed in previous sections of this chapter, posits a relationship between job structure and management of risk by workers. The following section serves to sharpen the theoretical framework, by showing the importance of understanding risk as a subjective negotiation, and by providing a logical use of gender in research on work-related risk.

3.1 Subjective Negotiation of Risk

The concepts of risk and risk management have become popular topics in the sociological study of occupations. Researchers often seek to determine the various factors involved in the decision to undertake risky work. For example, Kip Viscusi (1983) writes:

> Whose life is worth how much? To some it seems immoral even to ask, but to others-- to the worker, say, who is offered a dangerous but lucrative job-- the question inevitably presents itself... Workers often have at least partial knowledge of the hazards they face, but in some instances they may encounter an unanticipated rendezvous with destiny (Viscusi, 1983: 1).

In this paper, work-related risk is not surveyed simply as an objective reality; in fact, the 'subjective interpretation' of risk is emphasized. The worker is assumed to understand the various risks which may be encountered on the job and consequently undertakes a process of 'negotiation', which may lead to a series of actions in order to manage these risks. Emphasis is thus placed on workers' perceptions and descriptions of the risks

encountered in their job. Luhmann (1993) defines risk as a 'subjective negotiation', he states:

> We can speak of risk only if we presuppose that the person who perceives a risk and eventually assumes it draws certain distinctions, namely the distinction between good and bad results; advantages and disadvantages; profits and losses; and the distinction between the probability and the improbability of their occurrence... only then can we speak really speak of risk awareness or risk communication (Luhmann, 1993: 219).

Work-related risk is thereby only fully understood when the subjective interpretation of risk is considered. This requires a qualitative analysis of workers' narratives with respect to the risks involved in their job. Therefore, a case study methodology is employed to understand work-related risk.

3.2 'Job' and 'Gender' and the Subjective Interpretation of Risk

Shaver (1995) argues that gender structures occupational risk in sex work and in other human service occupations. Furthermore, she argues that women's occupational health must to be explored in more depth, since jobs deemed to be 'female occupations' have often been left out of occupational health studies; this masks many of the realities of occupational risk. In her words:

> A final feature common to many jobs deemed to be women's, is that women and men in those occupations are treated differently and have different experiences. This in turn means that their risks are different. Furthermore, as Messing argues (Messing 1991: 29), the failure to recognize that women and men are doing different jobs within the same occupational grouping serves to conceal important differences in the occupational safety and health risks they face. Gender patterns with respect to these factors are also evident in street prostitution (Shaver, 1995: 11).

This analysis of risk management is founded upon the 'job' and 'gender' model of response to work. The paradigm is defined as follows:

> The gender model emphasizes personal characteristics and differential sex role socialization and argues that men and women bring different perspectives into the work situation (Kauffman and Fetters, 1980: 251; Miller 1980: 338; Miller, Schooler, Kohn and Miller, 1979: 67). Consequently, men and women in the same job are thought to react differently to the conditions of work. Alternatively, the job model takes a structuralist perspective and, in Kanter's (1977: 9) words, argues that work conditions shape employee perceptions and reactions. Men and women in the same job, therefore, are thought to have similar subjective work experiences (Northcott and Lowe, 1987: 118).

Although the 'job' and 'gender' models are often used in the sociological study of work and workers' subjective experiences, this theoretical framework has also been extensively critiqued. The principle critique is grounded in the argument that the models proceed along sex-segregated lines. As explained by Feldberg and Glenn (1979):

> For men, it is assumed that economic activities provide the basis for social relationships within the family and in the society generally. For women, it is assumed that family care-taking activities determine social relationships. These different spheres of activity are, in turn, assumed to be combined in a nuclear family through the sexual division of labor - that is, man as economic provider and woman as wife and mother. Furthermore, male-female differences in relation to the family are expected to lead to differences in the nature of men's and women's connection to other parts of the social structure. For example, social class is assumed to be determined by economic position (i.e. relation to the means of production, occupation) for the male, and by position in the family (i.e. wife, daughter) for the female. Similarly, the work attitudes and behavior of men are seen as consequences of occupational experiences (for example, conditions of employment or occupational socialization), while the responses of women are viewed as outcomes of family experiences (for example household burden, feminine socialization) (Feldberg and Glenn, 1979: 25-26)

A further critique by the same authors suggests that: "Each model assumes homogeneity among member of each sex. Variations in the situations of members of each sex are ignored, and no allowance is made for class and ethnic differences over time" (Feldberg and Glenn, 1979: 26), and: "everyone knows that women and men have personal lives and that they work (whether paid, unpaid or both) and that experiences in each area have a continuous and closely linked impact on feelings and behavior related to work" (Feldberg and Glenn, 1979: 24).

In Locating Gender: Occupational Segregation, Wages and Domestic Responsibility, Janet Siltanen (1994) contends that the effects of gender are necessary, but insufficient to fully comprehend differences in workers' experiences. She argues that gender differences within employment can only be understood when the larger social context is considered. In her words:

> The significance of gender in the structuring of experience and understandings is undeniable, but, as this research shows, there is considerable variation in the extent to which gender is a meaningful component of understandings. When variation in the salience and nature of gendered experience is identified, variation in the salience and of gendered conceptions can also be observed (Siltanen, 1994: 3).

Siltanen contends that gender is a negotiated process of 'gender appropriateness' by men and women who are steered into 'sex-typed jobs'. However, she emphasizes the lack of uniformity in workers' experiences, and thus points to the problems in considering men's work and women's work as mutually exclusive categories of meaning:

> Attempting to understand variations in employment circumstances in terms of an opposition between women's work and men's work involves the use of categories that do not correspond adequately with the nature and complexity of either women's or men's employment experience (Siltanen, 1994: 16).

Siltanen (1994) therefore challenges the salience of gender as a meaningful component of employment experience. She shows that gender can only be considered a meaningful concept in the analysis of employment experience, when social processes such as domestic responsibility, wages, and employment segregation are also considered. She agues that: "there is considerable variation in the extent to which gender is a meaningful component of understandings" (Siltanen, 1994: 3), and that:

> If "gender" is to have explanatory force, its use in sociological research requires reconsideration. Two practices have been especially detrimental to the development of a full appreciation of women's and men's employment experience: the a priori judgment that gender is a meaningful component of the social circumstances being investigated; and the assumption that the meaning of gender will be of a pre-specified form. These practices are related, but each can be associated with specific difficulties in the analysis of employment and its location in wider social processes (Siltanen, 1994: 9).

Hence, Siltanen shows that gendered experience must be evaluated within a broad range of social arrangements over the course of individual lifetimes; she affirms that: "differences in work experiences run within, as well as between, gender categories" (Siltanen, 1994: 12).

An informed use of gender in the analysis of work-related risk, should therefore account for a broad range of personal experience, class, and ethnic differences, between workers. In response to past critiques of the gender model, the effects of gender are

controlled for, and gender differences are evaluated and reported. As such, this examination of work-related risk takes into account gender differences within work settings, while responding to critiques against the job and gender models. In other words, it is understood that gender influences subjective experiences of work, however, it can not be taken for granted that the negotiation and management of work-related risk will proceed along gender segregated lines.

III. METHODOLOGY and ANALYSIS

The central question of this research project is twofold: First, what are the work-related risks perceived by street prostitutes and hospital patient-attendants, and what conditions give rise to risk in these occupations? Second, how do workers in each work setting manage these risks?

The literature has inspired three sets of testable propositions, the first set relates to the practice of emotional labour: It is believed that emotional labour gives rise to risk in each occupational setting. Second, it is hypothesized that prostitutes have more control than do patient-attendants over their emotional display and over the strategies employed to manage emotional labour.

The second set of propositions relates to the close physical contact between workers and clients/patients, i.e. to the practice of 'dirty work' or 'people work'. It is held that people work yields many hazards, namely the transmission of infections and the potential for violence, in each occupation. Again, it is postulated that prostitutes have more control in deciding how to manage the risks associated with body work, than do patient-attendants. It is also believed that both types of workers depend on the use of physical barriers to manage the risk of infection.

The last set of propositions relate to other occupational risks and injuries: It is assumed that the physical labour involved in both occupations, for example spending numerous hours standing, walking, and moving people, is a source of risk for workers. Physical labour in both settings is believed to cause repetitive stress injuries, fatigue and

other occupational injuries. It is hypothesized that hospital patient-attendants and prostitutes both use drugs to cope with some of the hazardous aspects of their work, notably to manage physical and emotional labour.

The underlying thesis argument is that organizational structure of prostitutes' and patient-attendants' occupation governs risk management: institutionalization in the hospital establishes protocols, so patient-attendants will respond to risk in a routinized manner. This provides a source of safety, while also limiting patient-attendants' decision-making ability to deal with risk. The informal networks which make up prostitutes' work-world, allow for more personal control over working decisions. Due to their stigmatized status, however, prostitutes can not rely on legitimate institutions such as the law, to ensure their safety. Hence, prostitutes rely on individual strategies and on others in their work environment to cope with risk factors.

1. Sample Selection

Each of the propositions are evaluated, and the general hypothesis is tested, using interview data gathered by Dr. Frances M. Shaver, and her Concordia University research team, in the summer of 1993. The interviews are part of a larger project on the work experiences of various human service workers, directed by Dr. Shaver, entitled A Study of Human Service Workers.

Street prostitutes and hospital patient attendants were recruited for interviews at their place of work: prostitutes were recruited by the research team on the street, patient-attendants were recruited in various Montreal hospitals. For the prostitute sample,

through a purposive sampling technique, the research team attempted to interview a representative group of street prostitutes working in two particular geographical locations in Montreal, commonly referred to by Montrealers as *the main* and *the gay village.* At first, members of the research team spent numerous evenings on 'the stroll' introducing themselves to prostitutes, speaking about the goals of the research project, and assessing the population of working prostitutes. After two or three weeks in the field, the research team began making arrangements for interviews. A sample of 52 men and women were interviewed by the research team. Interviews usually lasted between one to two hours, and were usually conducted off the street in a local restaurant over coffee. Respondents were paid twenty dollars for their participation.

The sample of Montreal street prostitutes was then 'matched' with a sample of patient-attendants, interviewed at Montreal's St-Luc Hospital. Hospital patient-attendants were contacted by the team in the hospital cafeteria, and fliers were posted announcing the research project in various strategic locations in the hospital, inviting people to contact the research team. The union representative was also helpful in recruiting respondents.

When possible, hospital workers and sex workers were matched on the basis of several characteristics, including: gender, number of dependents, marital status, and number of years on the job. Moreover, all of the subjects work night shifts. The total sample of workers consists of 20 women and 26 men street prostitutes, and 20 women and 26 men hospital patient-attendants, for a total sample size of 92 respondents.

2. Demographic Information

The sample of prostitutes was younger than the sample of patient-attendants: prostitutes were, on average, 24 years old, while patient-attendants were, on average 33 years old at the time of the interview. Prostitutes started their line of work at a younger age than did the patient-attendants: men prostitutes were on average 17, women prostitutes were on average 18 years old; while men patient-attendants were 27 years old and women patient-attendants were 24 years old, at the onset of their current employment. Prostitutes also left home at a younger age than did the patient-attendants: prostitutes left home around the age of 15 on average, while patient-attendants left home at an average age of 20 years old. The majority of men prostitutes (18/26) and men and women patient-attendants (16/20 and 23/26 respectively) were born and raised in Quebec; most of the women prostitutes were born and raised in other Canadian provinces or in the United States (13/20). Most workers in the sample are white; only 14/92 are visible minorities. The educational level attained differed between patient-attendants and prostitutes: the majority of prostitutes (33/46) had not completed high school, while all of the patient-attendants had a high school diploma and most had some college education or higher (33/46). Table 1 shows the sample's demographic information in more detail.

Table 1

Demographic Information

	Prostitutes ♀	Prostitutes ♂	Attendants ♀	Attendants ♂	Total Sample
Average age in years					
At time of interview	24	24	32	34	28
Standard deviation	4	4	7	10	8
Missing cases	-	-	-	1	1
At onset of employment	18	17	24	27	22
Standard deviation	3	4	7	8	8
Missing cases	-	-	-	1	1
Average number of years					
At current job	5.4	5.1	6.8	6.2	5.8
Standard deviation	3.3	4.8	3.2	4.8	4.3
Missing cases	-	-	-	-	0
Number of workers Birthplace*					
Quebec	5	18	16	23	62
Other Canadian province	9	8	3	0	20
United States	4	0	1	0	5
Europe	1	0	0	2	3
South America or Caribbean	1	0	0	1	2
Missing cases	-	-	-	-	0
Number of workers' Visible status					
White	15	20	20	23	78
Black	1	2	0	2	5
Asian	0	1	0	0	1
Native	1	2	0	0	3
Mulatto	3	1	0	0	4
Middle Eastern	0	0	0	1	1
Missing cases	-	-	-	-	0
Number of workers' Education level					
<High School	12	21	0	0	33
High School Degree	6	4	6	7	23
Some College	2	1	5	5	13
College Degree	0	0	2	6	8
Some University	0	0	3	2	5
University Degree	0	0	4	6	10
Missing cases	-	-	-	-	0
Total	20	26	20	26	92

*Note: Of the ten subjects born outside of Canada, 3 female prostitutes, 1 female attendant, and 1 male attendant, went to elementary school in Canada.

The prostitutes were more likely than hospital patient-attendants to come from economically deprived family backgrounds: When asked to describe their family's financial situation while growing up (Overall, when you were growing up, would you say that you and your family were financially very poor? poor? comfortable? well off? very well off?), all of the patient-attendants said that their family was comfortable, while a sizable proportion of prostitutes said that their family was poor (15 /46). As another measure of their social and economic status while growing up, subjects were asked whether their family regularly depended on welfare and food banks; all of the patient-attendants said that their family never depended on welfare of food banks, compared to a third of prostitutes (15/46) who said that their family sometimes depended on welfare and food banks and another third who said that their family always depended on welfare and food banks. The majority of prostitutes are self employed, only 5/20 women and 1/26 men work for someone who can be considered a pimp.

Interviews were conducted in English or French depending on the respondent's preference. Workers were asked a combination of eighty-seven open-ended and closed-ended questions about their work and work-related experiences. A number of questions pertain to subjects' personal experiences surrounding the decision to begin working in their particular field, and addressed subjects' job histories. For example, the workers were asked to describe the circumstances surrounding the decision to work as a prostitute or patient-attendant. The patient-attendants and prostitutes interviewed were also asked to discuss the unpleasant and/or dangerous aspects of their job through many

open-ended questions. Other interview questions illustrate the ways in which workers manage the risks involved in their work.

The complete interview guide is included in Appendix A. Completed interviews were checked for clarity and consistency by the interviewer and reviewed by another member of the research team. The interview data were coded and entered on computer to enable statistical analysis. The responses to open-ended questions were input into a word processing document to facilitate qualitative analysis.

3. Analysis

Both quantitative and qualitative interview data are evaluated to investigate the negotiation of risk and management techniques used by workers. Quantitative analysis, i.e. SPSS, presents a picture of the various risks experienced in each work setting by workers.

The focus is then directed at quotes illustrating reactions to, feelings toward, and methods of preventing work-related risk. Qualitative responses to open-ended interview questions provide a measure of variation in the subjective negotiation and subsequent management of these risks. The following open-ended questions were asked of subjects: (Q23) Describe the circumstances surrounding your decision to begin working as a patient-attendant (or prostitute); (Q29) We would like you as much as possible to provide a full description of the activities associated with your work. Here the respondent was asked to think through a typical work day and probed for as complete a listing of activities and tasks as possible; (Q30) During your job you come into contact with

substances such as bad breath, sweat and sexual fluids and perform tasks such as washing clients and performing sex acts on strangers. how do you feel about this (if they were unhappy about this they were probed about how they deal with it)?; (Q35) People in your line of work have to deal with clients that range from rude or aggressive, through lonely or unfortunate, to pleasant and interesting. How do you feel about most of your clients?; (Q42) What do you like about your work?; (Q43) What do you dislike about your work?; (Q44) You have mentioned a number of aspects of your work that you dislike. What do you do to improve each situation?; (Q45) How good (skilled) are you in comparison to other prostitutes (or patient-attendants). It is the responses to these open-ended questions which make up the qualitative data used in this analysis. In some instances, responses to open-ended questions were coded and responses were entered into the statistical database for analysis. These numerical data also serve to measure experiences of risk and coping tactics used by workers.

To highlight workers' testimonies, a considerable amount of thought and time was spent determining the best way to handle qualitative data, in order to present a complete and accurate picture of work-related risk. Bryman and Burgess (1994), Neuman (1994), Silverman (1993), and Strauss and Corbin (1990), were all consulted to determine how to manage qualitative data. The method of analysis employed in this thesis is based upon Anslem Strauss et al.'s (1990) grounded theory procedures (Strauss et al. 1990: 49-61). The procedures were followed to develop the relevant categories and concepts uncovered in the literature. The authors state that the aim of grounded theory research is to "discover relevant categories and the relationships among them" (Strauss, 1990: 49). By

following Strauss's technique of combining what is presented in the literature, with a quick reading of subjects' responses to open-ended questions, many relevant factors relating to risk became aparent; they are: infection and bacteria, violence and aggression, physical injury, police, patients' death, emotional work, job structure and body work.

Responses to open-ended questions were then read through a second time, passages relating to any of the eight factors listed above were color coded. Summary data from each category were then transferred to data cards, one for each respondent, for a total of 92 cards. Each card is an eight by ten sheet of white paper, with the respondent number and demographic information (job, gender, circumstances surrounding the decision to begin this line of work and department/position and type of training-- for patient-attendants) at the top. The eight categories of inquiry are represented by letters A to H. Besides each letter, it was indicated whether yes or no, the subject discussed this factor in response to any of the open-ended questions. In some cases it was written whether the risk factor in question was discussed as a positive or negative aspect of work. Under this, summary notes on coping techniques were recorded. It thus became easy to determine, for example, how many workers mention violence as a negative aspect of their job, and how they cope with it. For more detail, the full interview or responses to one question were consulted. The following is one example of a data card:

#0250 Male Aide
Alt. yes: lost job as a designer... took the patient-attendant's course out of curiosity. 'Equipe volante' (traveling team: indicates that he works in different wards)

0250 A) YES
Wear gloves when there is blood, when dealing with AIDS patients and other infections. Watch out for needles.

0250 B) YES
Use personality, talking, calming patients.

0250 C) NO

0250 D) N/A

0250 E) NO

0250 F) YES (+)
Puts himself in patients' shoes...
Talk... find out how patients are doing, this helps with their treatment since he tells nurses... Keep distance to protect emotional self (p.23).

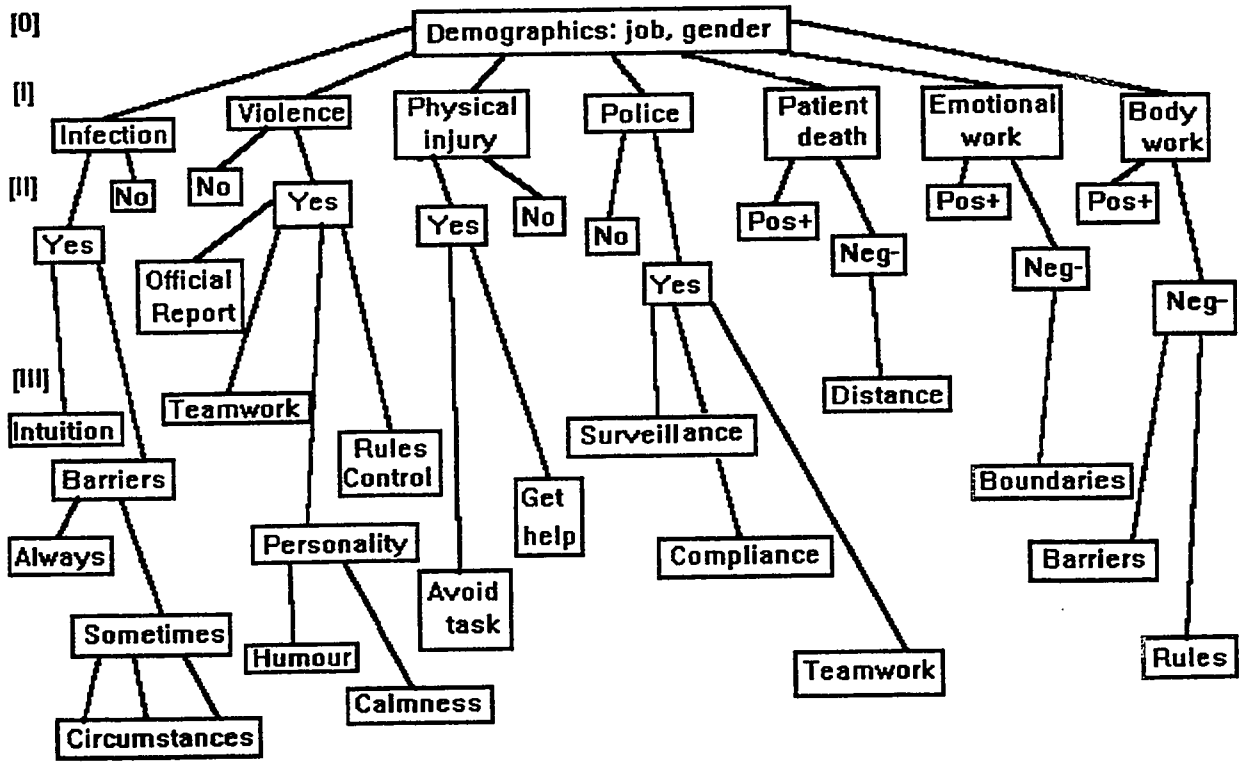
0250 G) YES (-)
Hospital hierarchy, bad relations with some nurses.
ex. when he told a nurse about a patient's care she said "what would you know about that".

0250 H) *

* In most cases, patient-attendants described body work, for example washing patients and moving them, as part of their daily routine, but gave no indication that this was a cause of stress or difficulty for them. In this case, it was simply not noted on the card.

Relationships between risk factors were conceptualized using a flow chart. Level 0 contains basic demographic information including. Level I holds risk categories including: infection, violence, physical injury, police, patient death, emotional work, job structure, and body work. Level II contains the negotiation of risk: Whether or not (yes or no) the risk factor in question was mentioned in workers' responses to open-ended questions and in the case of patient-death, emotional work, job structure, and body work, it was also indicated whether this constitutes a positive or negative aspect of work to subjects. Level III indicates management techniques used by workers to cope with each risk factor. Diagram 1 depicts the flow chart.

Diagram 1 **Conceptualizing the Negotiation and Management of Risk**



IV. FINDINGS

1. Dislikes and general risks

This first section of this chapter describes the unpleasant aspects of both occupations, since the elements of work disliked by workers are often also a source of risk to them. A general discussion on coping mechanisms illustrates some of the basic differences in the methods used by prostitutes and patient-attendants to cope with risk.

Workers were asked what they dislike about their work. A list of negative job aspects for both types of workers was generated. The following table illustrates the number of times a particular response was offered by each type of worker. Responses have been classified to display first the elements of work which are disliked by prostitutes and patient-attendants alike, second those which are mentioned more often by prostitutes (at least twice as often as they are mentioned by patient-attendants), and third those mentioned by patient-attendants at least twice as often as by prostitutes.

Table 2

Elements of work disliked by prostitutes and patient-attendants

	Prostitutes		Attendants	
	♀	♂	♀	♂
Disliked by prostitutes and patient-attendants:				
Hours	1	2	1	2
Language issues	1	0	0	1
Repetitious boring work	0	3	2	2
Physical surroundings and lifestyle	2	2	3	3
Physical Labour (including walking)	6	4	3	3
Lack of respect	2	5	3	3
More prostitutes dislike*:				
Relations with Co-workers	9	8	2	6
Relations with Clients	16	19	6	6
Police	12	7	0	0
Relations with public including residents	2	3	0	0
Relations with Drug addicts	1	4	0	0
Relations with family/ romantic partners	0	3	0	1
Illegal	1	1	0	0
Working on the street or in the park	0	2	0	0
Duties	10	20	7	8
Loss of self respect	3	3	0	0
More patient-attendants dislike:				
Relations with Supervisors or Pimps	2	1	9	10
Relations with Patients' Family	0	0	2	1
Autonomy (and/or lack of)	0	1	4	3
Lack of teamwork	0	0	3	5
Hierarchy	0	0	8	2
Workload	2	2	11	14
Money/ Salary (not enough)	5	2	4	11
Opportunity to meet people	0	0	2	0
Lack information to do job properly	0	0	3	1
Job schedule	0	0	1	3
Union	0	0	1	1
Budget	0	0	2	1
Lack of job security	0	1	0	5
Emotional Labour	0	3	4	2

* 'Lack of support networks' and 'violence' were also mentioned once by a male prostitute.
** 'Working in a hospital' and 'lack of career development' were each mentioned once by a male attendant; 'foul smells' was mentioned once by a female attendant.

A closer look at the table indicates that the dislikes by patient-attendants' and prostitutes' alike, are largely related to structural and environmental factors, and dirty work. The lack of respect these workers experience can be attributed to structural factors in their work environment: hospital hierarchy for patient-attendants and stigmatized status for prostitutes. As discussed in the second section of chapter two, the physical labour and repetitive tasks which they mention are two forms of dirty work. According to Hughes (1958), this dirty work, at least in the hospital setting, is also related to structural factors.

Prostitutes' dislikes generally involve relations with others; some of whom are in their work environment, such as clients, co-workers, police, drug addicts, and others who are not, like family and romantic partners. Their relationships with others can also be affected by the stigmatized nature of their occupation. Patient-attendants are most concerned by structural and organizational factors in their work environment, including their relations with supervisors.

The workers used several tactics to cope with the unpleasant elements in their workplace: Do nothing, live with the problem or ignore it; take evasive action including avoidance; take indirect action, such as reporting it to superiors or complaining to others in the workplace; take direct action in a friendly or constructive manner; take direct action in a destructive or angry fashion; take a direct neutral action; disengage from the problem, think about something else, or 'tune out -- turn self off'; set limits or personal rules to follow; change expectations, or learn to accept the problem as part of the job.

Table 3 shows the number of times each of the coping tactics was mentioned by workers, when asked how they deal with the unpleasant aspects in their work environment.

Table 3

Tactics used by workers for coping with the unpleasant aspects of work

	Prostitutes		Attendants	
	♀	♂	♀	♂
Do Nothing	16	27	43	54
Evasive Action/ Avoidance	14	10	1	3
Indirect Action (report or complain)	0	0	8	13
Direct Constructive Action	5	2	14	11
Direct Destructive Action	2	4	2	1
Disengage	6	20	0	1
Set Limits/ rules to follow	9	12	3	3
Change Expectations	2	4	1	2
Don't know	2	1	0	0
Direct Neutral Action	9	4	0	2

Patient-attendants and prostitutes are both likely to do nothing in response to the aspects of their work which they dislike. When they do take action, prostitutes tend to take evasive action, disengage, or set personal limits and rules, while patient-attendants most often take indirect action, or direct constructive action.

A supplementary coping mechanism is more often used by prostitutes than patient-attendants: the refusal of certain clients or patients. Prostitutes are almost twice as likely as patient-attendants to have refused to service clients or patients: 19/20 women and 22/26 men prostitutes, compared to 10/20 women and 12/26 men patient-attendants

have refused to service a client in any given shift. Of those workers who have refused clients, Table 4 shows the first reason offered for doing so.

Table 4

Number of workers' reasons for refusing clients

	Prostitutes		Attendants	
	♀	♂	♀	♂
Gender discrimination against worker	0	0	0	1
Other discrimination against worker	0	0	0	1
Verbal abuse/ disrespect	6	0	3	5
Physical treat/ danger	1	2	2	1
Risk of infection	0	1	1	2
Service requested	2	4	0	0
Appearance/ looks	0	2	0	1
Hygiene	1	7	0	0
Police	1	5	0	0
Not interested/ too busy	0	0	0	1
Bad vibes	8	1	1	0
Wants sex	0	0	2	0
Is dying	0	0	1	0
Total	19	22	10	12

Women prostitutes mostly refused dates when they got bad vibes, or if the potential client was verbally abusive or disrespectful (14/19); hence in these cases refusing clients protected prostitute women from aggression. Men prostitutes most often refused clients as a way to manage body work -- 7/22 clients were refused for hygiene

reasons, 4/22 were refused because of the service they requested -- or to manage police harassment: 5/22 were refused because they appeared to be undercover police. Meanwhile, women patient-attendants refused to service patients to manage harassment: 7/10 patients were refused due to verbal, physical or sexual harassment. The majority of patients refused by men patient-attendants (7/12) either presented a risk of infection or caused verbal abuse. Therefore, the refusal of clients/patients by workers does have the effect of helping them to manage various risks in their environment. Furthermore, this coping tactic is most often used by women prostitutes: not only are women prostitutes most likely to have ever refused a potential client, women prostitutes also refuse more potential clients per month than do men prostitutes and patient-attendants: In the month prior to the interview, female prostitutes had refused an average of 23 potential dates, compared to 6 potential dates refused by men prostitutes and one patient by men and women patient-attendants.

A major difference between patient-attendants' and prostitutes' occupational structure relates to the training they receive to learn the skills necessary for their job. In the hospital setting, common sense, intuition and personal experience of workers, is combined with official norms and guidelines acquired through formal training sessions. All but one of the patient-attendants took a private training course before being employed by a hospital: These courses, which are offered in many private technical training schools, cost between $200 and $600 dollars and last anywhere from 2 to 8 weeks. Patient-attendants usually took this type of course to increase the likelihood that they would be hired or secure permanent position in the hospital. Other types of training for

patient-attendants include orientation sessions offered at the hospital, in which they are given theoretical information and practical training, and intensive training courses, which they take when they start working. Only 1/46 had no formal training and said that she learned all her skills on the job (R# 0159).

On the street, prostitutes describe informal training which they acquire by observing other prostitutes and having informal discussions with them. Obviously, there are no formal training sessions to learn the skills required to be a prostitute. One man describes his 'informal' training as a prostitute as follows:

> "I had gay friends that were prostitutes they showed me the stroll. Told me it was easy. I learned a lot of skills from my mother, who is a prostitute who works in Montreal. I listened to what she used to say about working. I guess I just picked it up [from her]" (R#0217).

The majority of prostitutes say that they learned the tricks of the trade -- how to look out for under cover police, how to pick up a client, how to work with others, and so forth -- by observing prostitutes at work and by asking questions.

2. Emotional Labour

This section demonstrates the different tactics used by prostitutes and patient-attendants to cope with emotional labour. First, prostitutes' negotiations of their relationships with clients, and their management of emotional interactions, are discussed. Second, findings on the management of emotional labour by patient-attendants are presented.

2.1 Prostitutes and emotional distance

Much of prostitutes' work involves soliciting people through eye contact, smiling, talking to them, and then negotiating price once the date is made. The following quotes illustrate the emotional labour involved in prostitution:

> Come in restaurant, relax. Look at traffic. Walk around track once to look for "morality" squad and other girls. Ask how money is tonight. Go to corner, catch dates, go back to corner, stand, make eye contact, wave, smile. Girls all charge same prices. I can always charge more and can "get more" out of customers, when they agree, we trick them, that's whey we call them tricks. [What she described as "getting more" out of customers was getting them in the room and convincing them to pay to see her breasts. Or, describing a half-and-half and convincing them to pay for it, or convincing them to stay for an hour --which costs more -- She said she does this by being nice to them, treating them well]... Between clients, stand in street try to get another one (R#0100; woman prostitute).

> I talk money they talk sex. ... Sometimes I'll carry on a conversation with him. If he wants to talk for an hour - he pays $250 to talk or to have sex... In this business, time is money (R#0112; woman prostitute).

> Y'a gotta be personable. Stand on the corner - 'chat them up'... A lot don't want sex - they're looking for love, a lot of guys are lonely. After sex, have a cigarette, drink, chit chat -- make like you want to get to know them, make them feel important -- cater to their needs. I'm always paid after. I leave first. I let clients offer their phone #. If they enjoyed it, they'll give it to me, I won't beg for it (R#204; man prostitute).

Most men prostitutes do not engage in an emotional contact with their clients. 19/26 men say that they use a variety of tactics to 'disengage' from clients, especially during the performance of sexual acts, many of them think about women or their girlfriends, or they think about the money they will get, or the drugs they will buy. Other

tactics include: "I pretend they're someone I want" (R# 0223); "C'est juste une relation comerciale, c'est surtout pas de l'amour pas de la tendresse" (R# 0205); "Je me sens croche, j'ai envie que ça finisse... je pense à rien, faut pas que tu pense..." (R# 0221); "I'm a better actor than most" (R# 0207); "Je fais de la comédie, c'est tout un acte" (R# 0208); "Je m'enferme, je pense à plein d'affaires sauf eux, je ferme les yeux" (R# 0214); "I feel they [clients] are lonely depressed individuals... I don't feel sorry or sympathetic towards them, I'm only feeling for the money" (R# 0209).

The remaining 7/26 men prostitute do engage socially with their clients and emotionally with their clients, this is shown in a few male prostitutes' descriptions of their work: "Most clients are lonely... Most feel guilty about liking men... Most clients want conversation, not just sex..." (R# 0207); "Je me demande pourquoi ils ont besoin d'affection... il y a des gens qui veulent juste parler de leurs problemes..." (R# 0215);

> Beaucoup des prostitués font leur job vite, moi je vois ce boulot comme les autres, comme un serveur. Quand il [le serveur] est poli et respectueux de ses clients, ils sont contents. C'est la même affaire pour un prostitué. Des fois les clients prennent un rendez-vous pour aller souper avec eux, mais il n'y en a pas beaucoup comme ca... Le contact avec les gens, parler avec les clients, ce n'est pas toujours sexuel, des fois c'est le fun. C'est plaisant si je rencontre un client et quelque chose "clique" entre nous... Je ne crois pas que c'est possible de rester insensible entre moi et mes clients. C'est toujours un respect entre nous, autant de moi que moi de lui. Je respecte mon corps et j'aime les clients qui se respectent eux-mêmes (R# 0222).

Only 5/20 women prostitutes say that they do not mind connecting with their clients emotionally, one woman said: "You have to feel comfortable with yourself [to show emotion], I do" (R# 0124). They said that they are good at conversation, and that

this is importantant in their work, as one woman put it: "Little things make you better [than other prostitutes] jokes, eye contact, smiling, not only what you do [service provided]" (R# 0102).

The remaining 15/20 women prostitutes either did not mention emotional labour (in 2 cases) or they stated that contact with clients bothered them, and disclose tactics used to disengage from clients emotionally, including: block sex out of their mind; think of something or someone else; think of the money or their quota; "you have to be cold" (R# 0105), "you have to be very cold" (R# 0106); and "get high to deal with clients, to be friendly, to be in control..." (R# 0104).

The majority (34/46) of prostitutes manage emotional labour by disengaging with their clients. For the most part, these workers consider their encounters with clients as an 'act', and distance themselves emotionally by thinking of something else. In sum, they practice what Hochschild (1980) refers to as 'surface acting', because they can maintain an emotional display for their clients while completely disengaging from the emotional exchange.

2.2 Patient-attendants and emotional contact

Emotional contact with patients is a large part of patient-attendants' work. In many cases, patient-attendants believe that their contact helps patients' with recovery. For example, here is how one man attendant describes his relationship with patients:

> Socializing with patients is really important, builds up their morale. I joke with the patients, on a first name basis, even [with] the old guys. I couldn't work with surnames, it's too cold and silent (R# 0253).

Another woman attendant echoed these sentiments; like many other patient-attendants, she enjoys the human contact in her work: "I talk to them, make them understand what I am doing and why I am doing it... I enjoy human contact, that's how I cope" (R# 0153).

The majority of men patient-attendants enjoy the emotional labour they perform in their job: 21/26 men patient-attendants stated that they enjoy the emotional contact they have with their patients. Most feel gratified by emotional work, and feel lucky to have an emotional contact with their clients. As one man said: "Je me trouve chanceux de ne pas travailler avec des machines" (R# 0269). Most patient-attendants say that they are making a difference in patients' recovery, because when they talk to patients they find out important information which they can pass on to nurses. One man said that humour is the best medicine (R# 0263) for patients.

This tactic of dealing with emotional labour, is reminiscent of Hochschild's notion of 'deep acting' because clients 'feel' for their patients, and emotional interaction is part of the exchange. Moreover, we can take this notion one step further using Berger and Luckman's (1966) view of institutionalization of emotions, and presume that emotions are institutonalized in the hospital setting. In other words, to be a good patient-attendant, one must be caring of patients.

The remaining 5/26 men patient-attendants who view emotional labour as a negative aspect of their job, pointed out some of the difficulties of this type of work:

> Sometimes I feel depressed. I see them and I wish that I am not going to be like them when I get old. I don't want to suffer like them. I feel sorry for them. I talk to them when I have time (R# 0262).

Another man gave the following advice:

Do not think too much about what's wrong with patients otherwise you would be a very unhappy person (R# 0266).

Similarly, most women patient-attendants say that they enjoy the human contact with patients, and feel that this is important work (13/20). For example, one woman stated that she makes patients realize that their attitude is fundamental to their well-being. She said that she chose to work in a hospital because she thought the "human aspect would be interesting", in her words:

> You have a sample of people and you get to see how people in general are towards pain. How people are when they are confronted with illness, death, authority, conformity. I like to observe this. The mechanism of professionalism that allows us to work like this. The professional secret, the sympathy, these things are getting to be a part of me. I like this... (R# 0153).

This woman indicates that her emotions are becoming institutionalized when she says that sympathy and caring are becoming a part of her.

Many patient-attendants say that they were drawn to this type of work mainly because they enjoy human contact. For example one woman said: "J'etais toujours attiré vers l'hopital pour donner beaucoup de moi, pour leur donner de l'amour..." (R# 0151).

At times the emotional human contact was discussed as a difficulty of the job. For example, when asked "what do you dislike about your work?", one female PA responded: "Feeling helpless toward suffering patients, towards the family who have to deal with the patients" (R# 0156). One women affirmed that emotional work is as hard as physical work (R# 0170); another stated that she often brings emotional work home and has

trouble letting go at the end of the day (R# 0161).

To cope with this difficulty, some attendants distance themselves emotionally from patients, for example one woman explained: "Je ne peux pas changer tout le monde, donc, il faut m'isoller un peu. Je fais mon travail, ce n'est pas ma vie, ma vie c'est ma famille" (R# 0165).

Most patient-attendants form an emotional bond with their clients and enjoy the close human contact they share with patients on the job (34/46). The remaining (12/46), who have difficulty connecting with their clients, either did not mention what type of coping methods they use, or said that they distance themselves from patients, usually by not thinking about them too much. Others feel emotionally depressed or helpless in the face of emotionally taxing work.

When comparing prostitutes' and patient-attendants' management of emotional labour, we find that patient-attendants are more likely than prostitutes to enjoy emotional interactions with clients. However, the patient-attendants who find emotional work difficult or do not like interacting with patients, are more likely to feel helpless towards this aspect of their job and less likely to discuss coping methods used than. For the most part, prostitutes do not engage emotionally with their clients. They are more likely to describe precise methods of 'tuning out' emotionally while servicing their clients and maintaining an emotional display.

3. Body Work

Many of the risks associated with patient-attendants' and prostitutes' work are

linked to the physical contact between these workers and their clients, for example the risk of infection and the risk of violence. As such, it is important to understand how workers negotiate and manage body work and dirty work in general, to fully comprehend how they manage other occupational risks.

3.1.1 Patient-attendants' negotiation of body work

Workers were asked how they feel about coming into contact with dirty substances such as feces, sputum, urine, and sexual fluids. Patient-attendants usually said that they feel disgusted or uncomfortable with this aspect of their work: 17/26 men and 13/20 women feel disgusted or uncomfortable when they come into contact with 'dirty substances'. One man attendant said that he feels scared. The remaining 8/26 men and 7/20 women patient-attendants said that they feel comfortable with this aspect of their job. They were also asked how they feel about performing 'dirty tasks' like bathing/ washing others and giving enemas. Again the majority said that they are disgusted or uncomfortable with this aspect of their work (16/26 men and 12/20 women), while the remaining 10/26 men and 8/20 women were comfortable with this part of the job.

When examining responses to all of the open-ended questions, a more complete picture of patient-attendants' negotiation of body work appeared. The closest physical contact between a patient-attendant and a patient occurs during hygiene care -- when the worker washes patients. In some departments of the hospital, patient-attendants only wash patients of the same sex as them; while in other departments, attendants must wash patients of either sex. This is a source of discomfort for some of the patient-attendants: five men attendants and four women attendants specifically stated in their job

descriptions that they are uncomfortable washing patients of the opposite sex. This is one example of how body work is set up by hospital and departmental protocol, while patient-attendants have little control.

Particular problems and risks do arise out of body work in the hospital, especially during hygiene care. For example, one man described a patient who was an exhibitionist, she would masturbate in front of everyone and make people uncomfortable. So, they transferred her to the psychiatric ward (R# 0269). Another man attendant described two scenarios in which body work was a problem to him:

> Une femme confuse elle a pris panique, elle voulait plus que ce soit moi qui la lave, elle voulait une femme. Je pense qu'elle avait été abusée et elle a eu un "flash back"... Un homme très gêné, je mettais une serviette pour le cacher [one guy was very embarassed and he had to wash him with a towel over him] (R# 0259).

Another man was always afraid that he would be accused of sexual harassement when washing women patients, this made him feel uncomfortable. Now, he says that he no longer thinks about it (R# 0277).

Some women patient-attendants experienced unwanted sexual advances during hygiene care with patients. Two women gave specific examples of this: "Ils me dit que j'ai pas les mains dure comme les hommes, quelques fois c'est quelques choses de sexuelle, les hommes aiment être lavés par une femme..." (R# 0164). "Y'en a qui sont vulgaire, quand je change leur culotte ils disent "vient voir mon cul"... (R# 0152).

3.1.2 Coping with body work in the hospital

Patient-attendants cope with 'dirty' substances and tasks in many different ways, including: using protective barriers, like gloves, masks and gowns; taking other precautions like opening windows or offering gum to patients to curb bad breath; avoiding situations or substances; using strategies like humour or finishing the job as fast as possible; not thinking about it; or a combination of these methods. The following strategies were most often employed by women patients-attendants to cope with 'dirty' substances: avoid situations or clients (6/20), no information on how they cope with this (5/20), and a combination of avoidance and physical barriers (2/20). To cope with dirty tasks, they mostly gave no information (6/20), put it out of their mind (5/20) use physical barriers (3/20).

Men patient-attendants most often gave no information on how they cope with dirty substances (7/26), they don't think about it (5/26), or they do nothing (3/26). To cope with dirty tasks, they gave no information on how they cope (6/26), don't think about it (5/25), use physical barriers (4/26), or do nothing (7/26). Here is how body work came to be accepted by two men: "It doesn't bother me. It did when I first started the job. I used to carry a bottle of cologne, wear a mask and spray it. I got used to it. If it smells really bad I might "gag". I can't stand vomit" (R# 0266). "Avec le temps je me suis habitué. Le premier mois, ça lève le coeur, mais maintenant c'est normal. Il faut faire attention avec les sécrétions et mettre des gants pour se protéger le plus possible" (R# 0256). Most of the patient-attendants say that they simply do their job, often handling the disagreeable sights and smells with humor, and get of the room as quickly as possible.

It is import to understand how body work is managed, since this type of work often leads to risk in the hospital setting. For example, one woman patient-attendant shows that body work can sometimes lead to aggression, she copes with this through humour, or by doing her job quickly:

> Sputum, always wear gloves. To me it's worse than feces and urine. Try not to get any on me. The smell disgusts me; I don't mind doing except when you have someone who is very confused and makes the job more difficult by not understanding what I ask them to do. Patients find it humiliating. They yell at us. I talk to them. I do it as fast as I can, or I make jokes (R# 0153).

3.2.1 Prostitutes' negotiation of body work

In response to the question: how do you feel about the dirty subtances/ tasks encountered in your job, prostitutes most often said that they are disgusted and uncomfortable with the dirty substances encountered in their line of work (19/26 men and 9/20 women). The majority gave no information on how they feel about dirty tasks (12/26 men and 8/20 women) or said that they were disgusted by this (10/26 men and 6/20 women).

Many prostitutes say that they do not get close enough to their clients to be bothered with bad breath or sweat; when they are disturbed by clients' bodily smells, they deal with it in a direct manner, offering to buy gum, or by having them wash. As one woman prostitute explains: "I'm not too close to their face so don't worry about it [bad breath]. I will on occasion put a towel between me and them [if they're sweaty] or tell him to wipe himself off" (R# 0102). One man prostitute expressed fear of infection due to physical contact, in his words: "[I am] Scared... I'm worried about diseases, AIDS

especially. I use condoms all of the time..." (R# 0217).

3.2.2 Prostitutes' management of body work

In response to the question asking them directly how they deal with the dirty substances and tasks encountered in their work, prostitutes mentioned a variety of coping tactics including using physical barriers, avoidance, precautions, not thinking about it, and combination of these methods. The numbers of prostitutes using these different coping mechanisms was evenly dispersed, between one to four of them mention each of the coping mechanisms. In other words, there was not a majority of prostitutes favoring one coping technique over the others. What follows are three examples of the management of body work by prostitutes, by a women first, and then two men:

> I always provide the condom that's my "am-ex" card - that's the only one I can get! Don't leave home without it. He drops his pants - then whatever he paid for he gets. Use condom, he never touches it and if a guy says can I take it off, I say well then you do it. I ain't touching you. I do everything with a condom on. [Here I probed: she said, "I tell him I'm not going to finish the blow job without the condom.] I wash him before I put his condom on. And after every date I wash up. I wash up in the hotel. The hotel has fresh towels and soap all the time. Wash up and leave (R#0112).

> Use condom all of the time. Usually take a shower before and after - if they smell or are dirty - get them to shower as well. No receptive anal sex - I give but don't get. No contact with semen/body fluids (kissing). Blow jobs/hand jobs too... He takes his condom off -- I don't want to touch his cum (R# 0204).

> I lay down on the bed and that's it. He gives me a hand job, blow job. I only receive. I never use condoms. They always pay me first. They don't know that I only receive. They sometimes get mad. Nothing much

happens... I don't get an erection, I don't get off (r# 0220; male prostitute).

What is similar between these three quotes is the personal control held by prostitutes to rely on personal rules and manage their body work. When giving descriptions of physical encounters with clients, it is clear that prostitutes make the rules.

The majority of women prostitutes (15/20) employ a number of strategies to maintain physical distance between themselves and their clients. These strategies include: following personal rules, for example no kissing, and not letting clients touch them; remaining partially clothed, some women wear 'crotchless pantyhose'; employing particular body positions to minimize clients' contact with their body. In many cases, this physical barrier also provides prostitutes with a sense of emotional distance, as one women said: "I try not to take off my clothes to avoid intimacy" (R# 0110).

The maintenance of physical boundaries through rules or other strategies, is much less frequent among the men prostitutes: only four say that they follow particular rules such as no kissing/ caressing, while another says that he performs those acts but maintains that he does not enjoy them or get excited. It is unclear why men prostitutes do not erect physical boundaries as do women prostitutes, but perhaps it is because more of the men enjoy the sexual activities they perform with their clients: None of the female prostitutes allude to the enjoyment of the sex practiced during their work, however, ten of the men specifically say that they enjoy and are exited by the sex in their work.

It should be noted that body work is risky work in both occupational contexts. Often, the management of body work in the hospital is guided by protocols, for example

in the case of hygiene care. On the other hand, prostitutes usually employ personal rules and take more control over the management of physical distance and body work, for example, by defining acceptable behaviors and sexual services in the context of the exchange and/or by refusing certain clients.

4. Infection

Risk of infection is present in the work of prostitutes and patient-attendants. The media has been directing our attention to the threat of HIV, hepatitis, and other dangerous infections, but we can not ignore the fact that due to their physical contact with people, health workers and prostitutes also run the risk of contracting many less serious infections, such as colds and flu, on a daily basis. In order to manage the potential transmission of infections, prostitutes and patient-attendants use a combination of tactics, two of which are described in detail in this chapter: First, they the use intuition to evaluate or 'size up' their clients and patients. Second, they employ physical barriers such as latex gloves, condoms, sheets, masks, and clothing, to guard against disease and to establish a physical boundary between themselves and their clients. This section examines how infection is managed in both occupational contexts. General rates of infection among workers are presented first. Second, the management of infection by patient-attendants and prostitutes is discussed. Finally, the third section explores the impact of HIV in each work setting.

4.1 Infection rates in prostitutes and patient-attendants

Prostitutes and patient-attendants did not miss many days of work in the year prior to the interview due to infections, colds, or flu. Men prostitutes missed the most days of work due to infections or colds, in total five working days per year, on average. When asked whether or not they had contracted any sexually transmitted diseases (STDs), there was no difference in the rate of STD contraction between male prostitutes and male patient-attendants. On the other hand, female prostitutes were five times more likely than female patient-attendants to say that they had contracted a sexually transmitted disease in the past year. In the following sections, coping mechanisms employed by patient-attendants and prostitutes to manage infection will be discussed in depth.

4.2 Managing the risk of infection

David Navon (1992), who wrote a paper entitled "How to Affect Undesirable Effect" for the Journal of Behavioral Sciences, states that:

> Experts who try to combat diseases... often take measures to reduce the probability of their occurrence, recurrence, or endurance... (these) experts probably use their common sense, intuition, experience, or learned rules... (Navon, 1992: 181).

In the hospital setting and in prostitution, personal experience, learnerd rules, intuition combines with the use of physical barriers to manage the risk of infection.

4.2.1 Infection management by patient-attendants

Many (one in five) male and female patient-attendants use intuition to determine which of their patients are infected with communicable diseases. In some cases, this will foreshadow their decision to use gloves during intimate care or for the handling of specimens. For example, one woman patient-attendant said: "Je porte des gants quand il y a des plaies ouvertes, le Sida, c'est intuitif" (R#0158). She later went on to say that she only wears gloves when she can be in contact with bodily fluid of patients which she knows are infected, she trusts her instincts to determine that. Another female patient-attendant disclosed that she does not always use gloves for bathing patients, she says: "[I] Wear gloves sometimes yes or no. Depends on the hygiene of the person (e.g. the smell). Or whether that person is known for having infectious diseases" (R# 0153). A man patient-attendant (R# 0269) said that he uses gloves in the hospital emergency room and in the intensive care unit, because he feels that since the population of patients is younger they are more at risk of having an infectious disease. On the other hand, he does not wear gloves in the geriatrics ward unless the patient has an infection. One man PA said that he does not always wear gloves for bathing, when the interviewer asked him how he decides, he said: "Je regarde l'aspect de santé de la personne, peut-etre c'est un préjuger, je me lave les mains régulièrement..." (R# 0271). Similarly, another man said: "You have to know what the patient has, determines whether or not you wear gloves for bathing. If they have AIDS, you obviously wear gloves" (R#0277). Infectious patients, and those who must be kept in isolation, have stickers on the door to their room, and on the viles containing their body fluids, indicating their condition. Aside from these formal

indications of infection, four women and seven men patient-attendants also use their own presumptions about patients to determine potential infection.

In the health care setting, research has shown that the risk of infections such as AIDS, hepatitis B and its variants, tuberculosis, influenza, and childhood diseases such as chicken pox, measles and rubella, can all be controlled through appropriate measures such as the consistent use of universal precautions. In an article on the ethical dilemma of enforced HIV testing of health care workers, William Flanagan (1993) defines 'Universal precautions' as follows: "Blood and certain other body fluids of all patients are considered potentially infectious and treated accordingly. These precautions include appropriate barriers such as gloves, masks, goggles, and gowns to prevent skin or mucous membrane exposure... (Flanagan, 1993: 100).

Patient-attendants use latex gloves to guard against the transmission of infection between themselves and their patients, and from one patient to another. However, as shown above, latex gloves are not always consistently employed when patient-attendants could potentially come into contact with blood and other bodily fluids. The application of universal precautions implies that the blood and bodily fluids of all patients should be considered potentially infectious, however, as we have seen, not all patient-attendants follow this guideline. The majority of patient-attendants --over half of males and over two thirds of females -- say that they wear gloves always when washing patients, during contact with bodily substances, and for transporting specimens to and from the lab. This still means that less than 60% of the patient-attendants follow universal precautions in the strictest sense. Six of the male patient-attendants said that they do not wear gloves for the

handling of specimens, unless there is a sticker on the vile alerting them that the specimen is infectious. This decision is rationalized based on the low risk of direct contact with infectious material when handling specimens. The remaining patient-attendants -- over one quarter of them -- make their own judgments about when to use gloves with patients. What follows are some examples of the discretionary decision process by patient-attendants on the use of gloves: One man stated that he wears gloves when there is blood, when dealing with AIDS patients and other infections (R# 0250). Another explained: "Je porte des gants souvant pour les bains, toujours pur les selles, urine et champignons" (R# 0271), meaning that he wears gloves often for bathing, always if there is feces, urine or STDs on patients' genitals. Another says he uses gloves sometimes, when he's in contact with blood, feces, urine, of AIDS patients (r# 0270). One man in psychiatry says that he never wears gloves. His work involves very little direct care of patients, but if he does bathe or clean up after patients he does not use gloves. A woman attendant made the following comment on using gloves for bathing: "depends on the smell of the patient and if they are known for having infectious disease... If I have gloves on me, I wear them, if not, I don't. [It's] an impulsive decision". She also commented that: " I know I should always wear gloves..." (R# 0153). One woman patient-attendant said that she wears gloves for bathing only when patients have open wounds or if they have prostate cancer (I suppose because they have trouble controlling their bladder) (R#0168).

Patient-attendants use a combination of physical barriers and personal rules such as intuition and common sense to manage the risk of infection in their work environment.

As we have seen, they do not always adhere to 'universal precautions' to combat infections.

4.2.2 Infection management by prostitutes

Latex condoms are used by male and female prostitutes to safeguard themselves from infection and bacteria. Many of the prostitutes expressed concern about the transfer of bacteria from their clients to them, for example, one woman commented that: "They [clients] never touch condom... you don't know where their hands have been" (R#0104).

All of the women prostitutes said that they use condoms always, that is during any sexual service provided. Female prostitutes usually offer masturbation and oral stimulation, arguably low risk activities for the transmission of HIV. Usually, they will make the client ejaculate through oral stimulation and masturbation, thus the exchange will be terminated without intercourse. When the client does pay for intercourse -- arguably a higher risk activity -- and whether or not he receives it, female prostitutes will often put two condoms on him. None of the women prostitutes will provide any sexual service if the client refuses to wear a condom. One woman argued the costs and benefits of the risk of infection as follows: "I'd just as soon go home clean and safe without money than have something (a disease) for 100$" (R# 0108). Therefore, women prostitutes do not use intuition or common sense to manage infection, they simply rely on the consistent use of physical barriers.

Very few male prostitutes offer penetrative or insertive anal intercourse, when they do, ALL say that they use condoms, and sometimes up to three condoms, for this sexual service. Half of the male prostitutes say that they use condoms and have their

clients put on condoms always, for any sexual exchange including masturbation and fellatio. The remaining half perform and receive masturbation without a condom, and some (7/13) will perform and receive oral sex without a condom. Those who do receive and perform fellatio and masturbation without a condom argue that their risk of infection is minimal in these activities, four of them state that there is no risk of infection because they only perform receptive sexual services and do not let clients ejaculate in their mouths.

Three male prostitutes rely on visual cues to determine whether or not to use a condom for fellatio and masturbation, in one man's words: "If I see red sores, I'll put a condom... " (R# 0207). Finally one man argued the cost/ benefits of risk of infection by stating that he "will take more money for unsafe sex" (R#0223).

In sum, women prostitutes, who always put condoms on their clients before they engage in any sexual exchange, were the only group which, as a whole, consistently use barriers in all intimate interactions with clients to prevent infection. Men prostitutes' and men and women patient-attendants' use of physical barriers varies, depending on individual interpretation of the riskiness of a given situation or activity. Some male prostitutes and male and female patient-attendants use barriers consistently to protect themselves from infection; however, a large proportion rely on their intuition and common sense, which can be faulty, to guide their decision to use barriers.

4.3 The impact of HIV on work

Most prostitutes (28/46) and patient-attendants (35/46) said that the AIDS situation has affected their work in many ways. Women prostitutes said that the AIDS

situation has lead them to be scared, that clients seem more scared and cautious, and that AIDS has caused them to increase their use of protective barriers; men prostitutes said that AIDS has caused them to be scared and has lead them to be more selective of clients and to increase their use of protective barriers. Men and women patient-attendants say that due to the AIDS situation, they have become more cautious when selecting patients to care for, and use protective barriers more often. Prostitutes and patient-attendants get information on AIDS from a variety of sources. Workers were presented a list of AIDS information sources and were asked to check all source of AIDS information applying to them. Men prostitutes were most likely agree that they get their AIDS information from community service organizations, such as CACTUS or ACTUP (21/26). The majority of women prostitutes (18/20), along with the majority of men and women attendants (13/20 and 19/26 respectively), agreed that they get AIDS-related information from the media, including newspapers, television and radio. Another source of AIDS information was co-workers. Patient-attendants also agree that they get much of their information on AIDS from the hospital organization (12/20 women and 27/26 men).

Prostitutes were more likely than patient-attendants to have gotten tested for HIV in the twelve months prior to the interview: 17/20 women and 20/26 men prostitutes, compared to only 3/20 women and 7/26 men patient attendants got an AIDS test in the year prior to the interview. Plus, one man prostitute did not get tested because he already is HIV+. All women prostitutes who got tested received negative results; two men prostitutes received a positive result, and one more still has not gotten results.

5. Violence

Violence occurs in the hospital and on the street. First, frequencies of violent experiences in each setting and coping mechanisms in general are addressed. Second, the negotiation of violence by patient-attendants, followed by their management of this risk, is presented. Finally, the negotiation and management of violence by prostitutes is discussed with an additional focus on police harassment.

5.1 Frequencies of violent incidents

Violence was present in both types of service work, and experienced by men and women; however, female prostitutes experience double the amount of violent incidents per month than other workers. Prostitutes and patient-attendants were asked how many times in the twelve months prior to the interview they were robbed and physically assaulted, and the number of times in one month prior to the interview they were insulted or verbally abused, and sexually harassed. Table 5 shows the average number of violent incidents experienced within each category of service work.

Table 5

Average number of violent incidents experienced by workers

	Prostitutes		Attendants	
	♀	♂	♀	♂
Experienced in one month:				
Insults, Threats, Being yelled at	29	6	7	10
Sexual Harassment	7	5	1	1
Experienced in twelve monthes:				
Physical Assault	4	1	5	5
Robbery	0	1	0	0
Rape	1	0	0	0

Over two thirds of these violent incidents were committed by clients or patients. Prostitute women most often experienced various forms of abuse in their workplace from other perpetrators. They were most likely to be verbally abused by 'others' -- including the police and the public: on average 17 verbal assaults per month and 2 incidents of physical assault per year were committed by 'others'.

To manage these violent incidents, a number of tactics were used: To deal with verbal abuse from clients, men and women prostitutes often do nothing or evade the situation (in half of the cases), or use physical and verbal retaliation (over one quarter of the times they are verbally abused). When prostitutes are being abused by the public, they most often simply leave the area (in two thirds of the cases). Patient-attendants also most often tell supervisors, or verbally negotiate the situation with patients (in almost half the cases of verbal abuse), or else they do nothing in reaction to verbal abuse (in one third of the cases).

5.2.1 Negotiation and management of violence by patient-attendants

Violence was seldom discussed in patient-attendants' descriptions of their work, or in response to the open-ended questions (13/26 men and 9/20 women do not mention violence in response to open-ended questions). When they do speak of violence, they describe aggression as part of their job. For example one man patient-attendant stated that: "When (patients) misbehave they throw things, they scream, call you names, refuse to take their medication... Most have good times and bad times..." (R# 0268).

Four of the men patient-attendants discuss violence, not as a potential hazard, but as a routine element which they are called upon to manage for others in the hospital. This is referred to as a code seven: when the patient-attendants hear 'code seven' over the loudspeaker, they are to report to a designated area to restrain a violent patient. Here is how one man attendant describes a code seven:

> In violent situations (code seven) we assemble and deal with it as a team. For example, if patient is very agitated and throwing things around, I stand in front of him and put myself in a defensive stance. The code is to restrain patients. If patients go willingly, escort them, if not restrain them to their bed. (R# 0260).

One man patient-attendant said that he usually responds to two 'code sevens' per week (R# 0266). Hughes (1958) would argue that this is another example of lower status workers being called upon to do the dirty work of others. Three of the women patient-attendants also said that they usually call upon men attendants to help them cope with aggressive patients. This shows that violence is often negotiated and dealt with by

patient-attendants as a routinized part of their work and as a team.

Two women patient-attendants say that some 'violence' (verbal abuse mostly) occurs in the context of intimate care, when patient-attendants wash patients. For example, one patient-attendant said that she has a patient who always mutters vulgarities as she is washing him. She deals with it by sticking out her tongue at him. This woman exemplifies the fact that patient-attendants often forgive aggression when they see it as a part of patient's condition, for example if they are confused or senile; in her words: "Il y en a qui sont vulgaire. Quand je change leur culotte ils disent: "vient voir mon cul", les hommes et les femmes. Quand ils ne sont pas confus c'est pire à cause qu'ils savent qu'est-ce qu'ils font. Moi je rache la langue [sticks out her tongue]" (R# 0152). This is an example of a personal method used to cope with violence. Seven of the men attendants and nine of the women attendants deal with violence using personal methods. for example: by talking them out of their aggression, by using humour or a calm tone of voice.

5.2.2 Negotiation and management of violence by prostitutes

Generally, violence is discussed as a potential threat in prostitutes' work: only 6/20 women and 10/26 men did not mention the threat of violence in their responses to open-ended questions. The remaining 30/46 prostitutes expect and prepare for violence from the start of their working shift.

Two women and one man explained that they work in pairs or in small groups to prevent violence; that way, one prostitute will take note of license plates when another

gets in a car, or someone will stand watch at the end of an alley or parking lot.

Both men and women prostitutes depend on their intuition and 'people skills' to size up a potential date. For example, one man describes how he dodges violence:

> Je m'organise toujours de pas avoir de problemes avec les clients comme agression sexuelles ou viol. Je fais attention à moi que ces choses m'arrive pas. Si un client insiste α quelque chose que je ne veux pas (sado-masochisme), je m'en vas. [Probe: how do you know what to look for?] Quand tu leurs parle, tu peux voir comment ils sont (S'ils sont agressifs) (R# 0222).

Another woman said that she avoids anybody who seems aggressive or looks as though they've done drugs.

Many of the men (10/26) and women (12/20) who work on the street have personal rules or rituals they follow to prevent aggression and remain in control of violent situations. For example, many of them (5/20 women and 6/26) avoid dangerous situations -- like getting into cars with clients, or going with more than one man at a time -- and clients who seem aggressive. One man said that he takes boxing lessons to be able to protect himself (R# 0200)

Six of the female prostitutes described different body positioning used to prepare for and fend off attacks. For instance, one woman says that she always has one knee strategically placed for security. Many say that they are always on top of clients so that they cannot be strangled. Another woman said that: "I'm always on my back. I have control, I'm always pushing up on him" (R# 0124). Although different tactics and positions are used, the goal is always to maintain a sense of control over the clients' potential movements. Control is mentioned in most of the women's accounts of

aggression prevention: they remain in control by sticking to personal rules, setting firm limits about price and service, negotiating with clients, maintaining physical distance from clients while servicing them, and being prepared for violence. One women affirmed that the street is not a place for naiveté: "You fight with customers, never let the trick know you're afraid of them. If you can't protect yourself you should not be out there" (R# 0116).

5.3 Police harassment in prostitution

Since the legal aspect is particular to sex work, questions regarding criminal arrest were asked only to the prostitutes in the sample of workers. It was determined that prostitutes often express a distrust in the institution of the law to protect them from violence. Hence stigma and criminalization of prostitutes impacts upon their experiences and management of work-related violence.

Approximately three quarters of sex workers interviewed had been arrested in the twelve months prior to the interview. Men and women prostitutes were arrested two times per year, on average. In most, cases, the charge against them was related to prostitution: approximately 60% of women and 40% of men prostitutes who were arrested in the twelve months prior to the interview, were charged with a prostitution-related offense -- i.e. communicating or soliciting. Men prostitutes were also arrested for drug-related offenses, property crimes and personal assault. In most cases, the charges against prostitutes either resulted in a fine, or the verdict was still pending at the time of the interview.

The majority of prostitutes -- almost two thirds of females and half of males -- cited 'police harassment' as another dangerous or stressful aspect of their work. Furthermore, four out of five women and almost half of men prostitutes mentioned police harassment and the risk of arrest in their work descriptions and in response to open-ended questions.

Eleven of the women devise tactics to determine whether potential clients are under cover police, to avoid arrest and police harassment. For example, they often ask clients to undress first, or they get them to quote a price or name a service[4]; others work in small groups to warn each other when many police are out. In their words: "clients always undress first, otherwise he might be a cop" (R# 0122); "girls work together to avoid the police, we warn each other" (R# 0113); "I don't go out before 11:30 because cops are out to harass you... having to run from the police all the time disturbs my work" (R# 0118); "Younger clients may be police, you have to get them to quote a price or name a service to see if they are police" (R# 0115).

Women also expressed a lack of options for dealing with police harassment, as women said: "we're always running from them and the way they treat us... [there's] nothing you can do about it" (R# 0116). Another woman clearly spells out the problem, she says: "You can fill out complaint forms, but that makes things worse because then they know where the complaint comes from and they harass you more..." (R# 0105).

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4 Since it is now illegal to communicate for the purpose of prostitution, prostitutes think that a police officer will not name a service or a price because this is illegal for him as well as the prostitute.

Fear of police harassment and arrest was evident in ten of the men prostitutes' discussions. For example, one man said: "police always harass us, don't they have anything better to do?" (R# 0202). Another man clearly indicated that police officers are a stress factor in his work: "I work evenings and try to keep hidden, I have to change my look all the time" (R# 0209). These men describe tricks they employ to determine whether a solicitor is an undercover officer. For example some will touch their groin to 'see if he's a cop' (R# 0229); or they get to know which cars are ghost cars; some will simply talk to the men and ask them questions, if the potential client is the least bit shy or nervous, prostitutes assume that the client is not an undercover police -- implying that police officers are too arrogant to be shy (R# 0208).

In sum, the major difference between prostitutes' and patient-attendants' experiences of violence, is that prostitutes prepare for and prevent aggression through personal rules and by relying on co-workers, while patient-attendants accept aggression as part of their job and deal with it through team work, routine tactics or personal skills. Prostitutes define methods to avoid aggressive clients and potentially dangerous situations -- like car dates. On the other hand, patient-attendants habitually see aggression as a consequence of illness or medication, and manage aggression as it happens.

6. Physical injury, stress-related symptoms and other risks

This section looks at other work-related illnesses and injuries experienced by workers and examines how they cope with these risks.

6.1 General findings on illness and injury

Workers were asked the number of days of work missed in the 12 months prior to the interview, as a direct result of workplace illness or injury. Women attendants were found to have missed the least amount of work, an average of three sick days per year; men attendants missed an average of fourteen days of work. Men and women prostitutes both missed an average of eight work days due to illness or injury. Table 6 presents the various illnesses or injuries given as reasons for missed work days.

Table 6

Number of workers who missed work for medical illnesses and injuries

	Prostitutes		Attendants	
	♀	♂	♀	♂
Sprains	1	2	2	2
Fractures	3	3	0	0
Beating	2	1	0	0
Stabbing	1	0	0	0
cold/flu	3	2	0	0
Infection	0	3	1	0
Various (including burn out, stress)	0	2	2	4
Trauma	1	1	0	0
Hangover/ no sleep	2	0	0	0

Strains, fractures, and beatings are the most common reasons to miss work among

prostitutes, while patient-attendants said that they usually miss work due to burn out and sprains.

Prostitutes and patient-attendants experience numerous stress-related symptoms such as difficulty sleeping, difficulty concentrating, shortness of breath, cramps, sore feet, sore back, etc. Table 7 shows the number of workers who experience each of the symptoms at least once per week, over the twelve months prior to the interview.

Table 7

Number of workers who experience symptoms at least once per week

	Prostitutes		Attendants	
	♀	♂	♀	♂
Back Pain	6	5	7	7
Upset Stomach	6	8	1	3
Cramps	5	11	1	2
Headaches	4	9	6	4
Sore Feet	14	12	3	5
Shortness of Breath	9	7	1	4
Difficulty Sleeping	6	8	4	9
Diarrhea / Constipation	3	3	3	0
Fatigue/ Weakness	8	9	8	6
Difficulty Concentrating	2	11	4	3

It was found that the number of symptoms experienced by each type of worker was similar. To determine how many workers experience multiple symptoms at least once per week, an index was constructed. It was determined that over two thirds of all workers experience eight or more of the ten symptoms at least once per week.

6.2 Managing illness and injury

Women prostitutes were found to visit doctors or clinics most often, that is 13 visits per year, on average; while men prostitutes visited the doctor approximately 5 times per year, and male and female patient-attendants paid 3 visits to their doctors per year, on average. The workers were asked to compare their state of health to other men and women around their age; over three quarters of all workers said that compared to others, their health was either very good or good.

6.3 Patient-Attendants' negotiation of physical labour

The physical arduousness of the job is evident in patient-attendants' and prostitutes' descriptions of their work. Half of the men and women patient-attendants spoke of the difficulties of physical labour, often stating that many tasks are strenuous on their back, shiftwork is tiring, and that the heavy workload is hard on their immune system, often causing them to get ill. The following quotes illustrate the difficulties of physical labour in the hospital:

"Back injury is a big stress in this job because there's not always other attendants to help you lift things... Driving a bed on wheels is hard for the back -- [I] try to have a good body position" (R# 0153); "Physical work is difficult... lifting heavy people alone. [I] come home at night with a sore back" (R# 0167); "Physically it's a little too heavy... Shift work screws up my system to the point that I was so runned down that I had to

cancel for health problems... Physical labour is especially present in geriatrics where people are heavy and cannot move on their own" (R# 0260).

Note that two men and one woman said that they do not mind the physical part of their work, as one man stated: it "helps keep me fit" (R# 0277).

A major problem is that due to budget cuts, patient-attendants often do not have the necessary equipment or help to perform physical tasks safely. For example, when asked what he dislikes about his job, one man explained that since the budget cuts he has to do all of the heavy lifting by himself:

> Strain transferring patients from chair to bed, etc. Before I used to be able to get help -- ring for the orderly on call 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. [Probbed: Can you use mechanical hoists?] Yes, but there's always something wrong with them, either they don't work properly or they're difficult to use. It's easier and more comfortable for the patient to lift them physically (R# 0253).

Another women explained that much of the equipment in the hospital is old and places additional strain on them: "if they had proper equipment and materials the job would be easier... chains over gernies and beds are all old and dangerous" (R# 0161).

6.4 Prostitutes' negotiation of physical labour

One quarter of men and women prostitutes also made reference to the physically demanding components of their job. They say that their work is tiring, they get sore feet from all of the walking and running from the police, and that they get sore mouthes, hands and arms, from the sexual acts they perform. One women explained how tiring her

work is, and how she copes with this aspect of her work: "Working on [my] feet is physically painful. My legs, feet, eyes, hands -- from hand jobs-- get sore and tired. I'm with my kids all day, I only sleep one hour before I come out to work, it's very tiring... [When I am] Physically tired, I take a couple of days off, go to a Spa, get a facial" (R# 0120). One woman describes the sexual acts as physical labour; in her words, she dislikes: "the physical labour, just doing it,... I wish they could just give me the money" (R# 0124).

Male prostitutes speak of the problem of physical labour; five of them say that it is extremely demanding to be with several clients, and often be expected to ejaculate, several times per night. Two of them said that they cope with lack of energy during their shift by drinking alcohol or taking drugs. One man said: "I don't like to cum four times a night, it's very physically demanding... I drink a lot of beer, it gives me energy, a boost" (R# 0224). Others simply say that to combat fatigue, they take breaks or vacations.

6.5 Drug use as risk and coping mechanism

A differential use of substances such as alcohol and drugs was found among workers: men prostitutes were more likely than other workers to consume drugs and alcohol on a regular basis, and are also most likely to get stoned and drunk on a regular basis. Table 8 shows the number of workers who use a variety of drugs at least once per week.

Table 8

Number of workers who use drugs at least once per week

	Prostitutes		Attendants	
	♀	♂	♀	♂
Alcohol	11	20	6	14
Pot/Hash	6	11	0	1
Crack	0	3	0	0
Cocaine	0	13	0	0

More prostitutes than patient-attendants consume drugs and alcohol regularly -- at least once per week--, and more men prostitutes than women prostitutes use drugs and alcohol regularly. Men prostitutes are also most likely to consume drugs and alcohol to the point of being drunk or high: Of the workers who drink alcohol, 6 women and 10 men prostitutes get drunk regularly, and of the prostitutes who use drugs, 6 of the women and 20 of the men get 'high' at least once per week. The one attendant who uses pot, said that he gets 'high' once per week.

There is some indication that drug and alcohol use by prostitutes may be a method to cope with various aspects of their work: Men prostitutes who get drunk regularly are most often drunk while working, and both the men and women who get 'high' are more likely to be 'high' while at work. Moreover, six prostitutes mention specific uses of drugs or alcohol to manage an aspect of their work: For example: three men said that they use drugs, or think about the drugs they will buy, to 'disengage' from sex acts; two men use drugs to combat fatigue or loss of energy; one woman uses drugs to help her cope with

clients. The two examples which follow show how drugs help workers cope with different aspects of their work: When asked what he dislikes about his work, one prostitute responded "The self destructive lifestyle. You don't respect the money, you abuse your money and yourself... I drink a lot of beer, gives me energy and a boost, helps me forget..." (R# 0210). One woman said that she smokes a joint at the start of each shift, then another between each clients. This helps her deal with her clients, she says: "When I'm high, I'm friendly. I can't deal with these guys straight, they give me attitude. I have more control high, I don't let my temper flare when I'm high" (R# 0104).

Many of the men prostitutes said that when they began working as a prostitute, they were already addicted to drugs: 11/26 men said that they started working as a prostitute because they needed money for drugs. Furthermore, in describing the circumstances surrounding thier decision to start work as a prostitute, nine of them said that they had no other alternatives but to start in prostitution because of their drug addiction.

In sum, drugs are sometimes used by prostitutes to cope with various factors in their work. Drug use was found to be an antecedent factor, often leading men into prostitution. Very few patient-attendants use drugs regularly, and for the most part their consumption is limited to alcohol.

V. DISCUSSION and CONCLUSION

1. Emotional labour

Emotional labour is a difficult aspect of service work. Both prostitutes and patient-attendants struggle to reconcile their feelings and display of emotion. Prostitutes generally disengage emotionally from their clients while displaying an act, similar to what Hochschild (1983) calls 'surface acting', meaning that they "change how they outwardly appear" (Hochschild, 1983: 35) while disengaging internally. For example, they can perform sexual acts and feign excitement, when all they are thinking about is the money that they are making. Hochschild cautions that this method of 'surface acting' can be emotionally tiring in the long run. However, prostitutes do not say that keeping up an emotional display contrary to their feelings is difficult. They often compare themselves to actors and can maintain their display within fixed emotional boundaries.

Patient-attendants often emotionally interact with their clients. They practice what Hochschild refers to as 'deep acting', in other words they "directly exhort feeling" (Hochschild, 1983: 39) for their patients. Hochschild, as did Berger and Luckmann (1966) earlier, would argue that these are institutional feelings. In other words, one has to be caring to be a good patient-attendant. Hochschild states that: "some institutions have become very sophisticated in the techniques of 'deep acting'; they suggest how to imagine and thus how to feel" (Hochschild, 1983: 49). Patient-attendants' emotional bond with clients, and their sympathy or perception of sickness in patients, often lead them to forgive patients of aggression. Hence, in some cases, 'caring' for patients

influences workers' negotiation of risk.

Hochschild argues that 'deep acting' is a more successful and less strenuous way to manage emotional labour, because display is closely linked to emotional feelings. However, 'deep acting' is not successfully practiced by all patient-attendants. In fact, many of the patient-attendants who have difficulty connecting emotionally with their clients feel helpless and depressed, and do not discuss any coping strategies used to deal with emotional labour. We can not say for sure whether patient-attendants' feelings are the result of institutionalization or if their genuine emotions just happen to coincide with the norms of the hospital. However, we can see from patient-attendants' testimonies, that those who do not 'feel' for their patients often suffer emotional strain.

Due to the variety of coping methods employed by prostitutes to reconcile their feelings and display, it does appear that they have more freedom in deciding how to manage their emotions than do patient-attendants. Future research on emotional labour should explore the different coping mechanisms used in institutional versus non-institutional occupations, and assess the effectiveness of various coping strategies in minimizing emotional strain to workers.

2. Body work

Body work yields many risks to patient-attendants and prostitutes, physical barriers, personal rules, intuition, and teamwork, are all used in both occupational settings to manage these risks. Body work is often 'intimate' work, so the management of body work can be influenced by the emotional engagement of workers with clients.

When workers want to maintain emotional distance between themselves and their clients, as is the case for most female prostitutes, they will be more likely to use physical barriers. On the other hand, when workers feel close to their clients or patients, they will forego the use of barriers when performing intimate tasks. This is one possible rationale to explain the difference in barrier use between patient-attendants and prostitutes.

Body work is often negotiated and managed through routines and departmental policies in the hospital. For example, patient-attendants must follow departmental decisions regarding hygiene care, and aggression is also dealt with via protocol in the hospital setting. This has been shown to ensure safety for attendants, however in some instances it also limits the amount of decision making power they have in dealing with risk.

Prostitutes usually employ personal rules to manage body work, and to prevent the risks associated with it. Personal control and decision making is evident in prostitutes' descriptions of physical interactions with clients: men and women prostitutes usually set their own limits, decide what services they will offer, and refuse to be with clients who give them a 'bad feeling'. Meanwhile, stigma and the illegal nature of prostitution has the effect of limiting prostitutes' options when dealing with risk, and can increase certain risks.

3. Other occupational risks

It has been shown that physical labour is a source of risk for prostitutes and patient-attendants. In the hospital, the problem of physical labour is often exacerbated by

budget cuts, forcing patient-attendants to perform strenuous tasks with faulty equipment, alone. Sexual acts performed by prostitutes, along with the numerous hours spent walking and running during their shift, make prostitution physically demanding work. To cope, prostitutes use a variety of personal tactics.

4. Conclusion

This thesis has shown many areas for development of future research on occupational risk. First, further research examining the use of safety precautions by workers is needed. It was found that a large proportion of patient-attendants do not adhere to universal precautions. It would be interesting to determine whether workers in other high risk occupations such as police officers, construction workers and miners for example, follow precautionary measures.

On the management of emotional labour, future research should look into the effectiveness of 'deep acting' versus 'surface acting' to reduce strain on workers. This research suggests that aside from 'deep acting' there are not many options available for service workers in institutions to cope with emotionally difficult work.

More research on experiences and management of occupational violence is needed. This thesis has shown that violence is present in both work settings, and has offered some coping strategies employed by workers. However, data on the degree or dangerousness of violence in each setting was not available. Future research on this subject is needed to determine how dangerousness of potential occupational violence, influences prevention and coping strategies used.

Future research on the relationship between training received and risk management is also needed. The training of employees in various job settings should teach workers how to deal with emotional labour, physical labour and body work.

On a micro level, it would also be interesting to explore how motivations for entering into a particular occupation shapes the negotiation of risk. Perhaps, those in dire financial need will be more likely to accept risk and focus on the monetary rewards of employment. These are all examples of further questions that can be raised by this research.

In conclusion, this thesis expands the sociological study of occupations in various ways. First, by showing that occupational legitimacy provides more structural tools to cope with risk, while illegitimacy limits workers' resources. Second, it indicates that stigma can increase risk to workers. Third, the importance of co-worker support to manage occupational hazards is highlighted. Fourth, by illustrating that workers' understanding of risk is often mediated by their perceptions of clients. Finally, by demonstrating that the management of work-related risk does not always proceed along gender segregated lines.

The findings presented in this thesis can not be generalized to the larger population of hospital workers and sex workers. However, they do respond to the goals of the research; most importantly to integrate prostitution within the sociological study of occupations and to provide many suggestions for future studies on the topic of work-related risk. This thesis implies that we must reconsider work experiences keeping in mind varying degrees of organization, stigmatization, and legitimacy of occupations.

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APPENDIX A

Interview Guide

Note: Questions in this interview guide were asked of patient-attendants and prostitutes in the sample of workers. However, question #39, regarding arrest, was asked only of prostitutes.

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 street prostitute in the sex trade.

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

/___/___/___/___/
Respondent Number

CURRENT DEMOGRAPHICS

1. What is your birth date? ____ ____ /___/___/
day month year

2. Sex/gender?
female 1
male 2

3. In what country or province were you born? _____

(IF BORN OUTSIDE CANADA) Did you go to elementary school in Canada?
no . . 1
yes . . 2

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

_____

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

less than high school 1
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

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

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

7. Are you ...

single 1
cohabiting . . 2
married 3

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

no 1
yes, girlfriend 2
yes, boyfriend 3

8. Do you consider yourself to be ...

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
	/	/	
	/	/	
	/	/	
	/	/	
	/	/	
	/	/	
	/	/	
	/	/	

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
/___/	/___/	_____
/___/	/___/	_____
/___/	/___/	_____
/___/	/___/	_____

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

Single detached	1
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

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

no	1
yes	2

(IF YES) Is there a mortgage on it?

no	1
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?
_____	/___/	/___/___/	/___/
_____	/___/	/___/___/	/___/
_____	/___/	/___/___/	/___/
_____	/___/	/___/___/	/___/

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 _____

Mother _____

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

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 . . . _____
freezer (stand alone) . . . . _____
clothes dryer . . . . . _____
two or more cars . . . . . _____
VCR (video recorder) . . . _____
gas barbecue . . . . . _____

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

very poor 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 prostitute.

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

street 1
massage parlour 2
bar/hotel 3
escort 4

19. How long have you worked in this particular job?_____

20. Is it your primary occupation or activity?

no 1
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.]

21. How many years in total have you worked as a prostitute?

_____

22. When you first started working as a prostitute how old were you?

/___/___/

23. Describe the circumstances surrounding your decision to begin working as a prostitute.

Probe:
how find out about it

where learn the skills

whether had other alternatives

JOB DESCRIPTION

24. Do you work for yourself or do you consider that you work for someone else?

Work for self 1
Work for other 2

(IF OTHER) Who do you work for? _____
relationship to respondent

How many other people work for him/her? /___/___/

Describe your relationship with this person? [Probe for services provided, proportion of money turned over, etc...]

(IF FOR SELF) Are you involved with someone others could consider a pimp?

no 1
yes 2

(IF YES) Who? _____
relationship to respondent

Why do you NOT think of him/her as a pimp?

25. For how many weeks during the past 12 months did you work as a prostitute?

full time weeks /___/___/
part time weeks /___/___/

26. During those weeks, how many days per week did you usually work?

days/week when full time _____

days/week when part time _____

27. During those weeks, how many hours per week did you usually work?

hrs/week when full time_____

hrs/week when part time _____

28. What hours do you usually work? [Specify am/pm] _____

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:
Connecting with customer
Deciding on service/price/location
Preparation for service
Performing service
Safety precautions
Termination
Time between clients

WORKPLACE ENVIRONMENT AND INTERPERSONAL RELATIONSHIPS

30. During your job you come into contact with substances such as bad breath, sweat and sexual fluids and perform tasks such as washing clients and performing sex acts with strangers. How do you feel about this? [If they are unhappy about it, probe for how they deal with it.]

31. On average in a night's work how much time do you spend with each date?

_____hr/min

32. On average, how many dates do you have in a night?

_____

33. Have you ever refused a potential date?

no 1
yes 2

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

34. In the past month, how many potential dates have you refused?

_____

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

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? . . . ____
Risks of infection or disease? . . . . . ____
Risks of accident or injury? . . . . . ____
Poor relations with other people ? . . . . . ____
Sexual harassment? . . . . . ____
Other harassment? . . . . . ____
Discrimination of any kind [age, sex, race, ethnicity, disability, sexual orientation]? . . . . . ____
Threat of job loss? . . . . . ____
Threat of arrest? . . . . . ____

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

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

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 ...		
clients	/___/___/	_____
co-workers	/___/___/	_____
pimps	/___/___/	_____
others _____ (specify)	/___/___/	_____
In the past month, how often were you insulted, threatened, or yelled at by ...		
clients	/___/___/	_____
co-workers	/___/___/	_____
pimps	/___/___/	_____
others _____ (specify)	/___/___/	_____

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 ...		
clients	/___/___/	_____
co-workers	/___/___/	_____
pimps	/___/___/	_____
others _____ (specify)	/___/___/	_____
In the past year, how often were you physically assaulted (pushed, slapped struck, choked, etc...) by ...		
clients	/___/___/	_____
co-workers	/___/___/	_____
pimps	/___/___/	_____
others _____ (specify)	/___/___/	_____
In the past year, how often were you robbed by ...		
clients	/___/___/	_____
co-workers	/___/___/	_____
pimps	/___/___/	_____
others _____ (specify)	/___/___/	_____

38. Con't

In the past year, how often were you sexually assaulted or raped by ...	# times	What did you usually do?
clients	/___/___/	_____
co-workers	/___/___/	_____
pimps	/___/___/	_____
others _____ (specify)	/___/___/	_____

39. Have you been arrested or received a warrant in the past twelve months?

no 1
yes 2

(IF YES) For what crime(s) and what was (were) the outcome(s)?

Crime(s)	Outcome(s)
_____	_____
_____	_____
_____	_____
_____	_____

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 (e.g., loitering and jay walking tickets).]

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

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

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
sex acts
client relations
co-worker relations
pimp relations
workload
discretion/autonomy
salary
physical labour
emotional labour

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

Probe:
physical surroundings
sex acts
client relations
co-worker relations
pimp relations
workload
discretion/autonomy
salary
physical labour
emotional labour

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

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

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

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

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

no 1
yes 2

(IF NO) Why not?

(IF YES) Why?

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

(b) There is a lot of freedom to decide how to do your work 1 2 3 4

(c) You do the same things over and over 1 2 3 4

(d) Your job requires a high level of skill 1 2 3 4

(e) The pay is good 1 2 3 4

(f) Your chances for promotion/career development are good 1 2 3 4

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

(b) Do you find your work boring?

Not at all				Very Much
1	2	3	4	5

(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

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

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

No Importance				Very Important
1	2	3	4	5

INCOME/SAVINGS

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

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

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] /___/___/

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] /___/___/

54. Have you any savings?

no 1
yes 2

(IF YES) Approximately how much do you have? $_____

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

56. How many people lived with you at the time you left? _____

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

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

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

negative	1
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
_____	/__/	_____	_____
_____	/__/	_____	_____
_____	/__/	_____	_____
_____	/__/	_____	_____

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

no 1
yes 2

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

Single detached 1
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

62. Were there periods before you left home 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

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 . . . _____
freezer (stand alone) . . . . _____
clothes dryer . . . . . _____
two or more cars . . . . . _____
VCR (video recorder) . . . _____
gas barbecue . . . . . _____

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

very poor 1
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?

1. no
2. yes
8. don't know
9. not apply

Mother	Father	Sibling	Other relative
/___/	/___/	/___/	/___/

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

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
/___/	/___/	/___/	/___/

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

Mother	Father	Sibling	Other relative
/___/___/	/___/___/	/___/___/	/___/___/

67. Do you see .....

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

Mother	Father	Sibling	Other relative
/___/	/___/	/___/	/___/

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

mother _____

father _____

sibling _____

other relative _____

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
/___/	/___/	/___/	/___/

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	/___/___/	/___/
Go to meetings or do volunteer work	/___/___/	/___/
Go to restaurants or bars	/___/___/	/___/
Go to movies, theatres or play bingo	/___/___/	/___/
Go out for sports, exercise or recreational activities	/___/___/	/___/
Shop (not groceries)	/___/___/	/___/
Visit with relatives in either of your homes	/___/___/	/___/
Visit with friends in either of your homes	/___/___/	/___/
Other activities not already mentioned	/___/___/	/___/

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 . .	/___/	/___/
magazine . . .	/___/	/___/
book	/___/	/___/

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
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
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
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	/___/	
Heroin	/___/	/___/
Crack	/___/	
Other forms of cocaine	/___/	/___/
Speed	/___/	/___/
Acid/LSD	/___/	/___/
Other	/___/	/___/

(Specify other) _____

_____

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

$ _____

(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

(IF HIGH) Is this usually ...

when you are working 1
when not working 2
both 3

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 past few weeks, how often have you felt ...

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

75. How often, if at all, in the past year 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 . . . . . /___/
upset stomach . . . . . /___/
cramps (legs, period) . . . . . /___/
headaches . . . . . /___/
sore feet . . . . . /___/
shortness of breath . . . . . /___/
difficulty sleeping . . . . . /___/
diarrhea/constipation . . . . . /___/
fatigue/general weakness . . . /___/
difficulty in concentration . . . /___/

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

/___/___/ times

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

no 1
yes 2

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

78. Has the AIDS situation affected your work?

no 1
yes 2

(IF YES) In what way?

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) . . . . . _____
labour union . . . . . _____
media (t.v., radio, newspaper) . . . . . _____
co-workers . . . . . _____
prostitutes rights organizations . . . . . _____
other (specify) . . . . . _____

_____

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

no . . 1
yes . . 2

(IF YES) Why did you take the test?

Were the results good or bad?

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

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

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)
_____	_____	/__/
_____	_____	/__/
_____	_____	/__/
_____	_____	/__/
_____	_____	/__/

(IF ONLY SEX WORK OVER ALL 5 PERIODS) What jobs, if any, have you had other than prostitution?

FUTURE JOB PLANS

83. How much longer would you like to work as a prostitute?

_____

84. How much longer do you think you will actually work as a prostitute?

_____

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

no 1
yes 2

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

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

Description of respondent:

To which visible minority does respondent belong?

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

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

Interviewer: _____

Location of interview: _____

Date of interview: _____
Day / Month / Year

Time of interview: _____

Language of interview: _____