Invisible and Undervalued: Understanding the Work Experiences of Women Clerical Workers in a British Columbia Cancer Centre

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Abstract

The purpose of this qualitative study is to understand the experiences of oncology support staff through an examination of workplace organization, patient and team relationships, and emotional impact. In-depth interviews were conducted with seven medical secretaries and five nursing unit clerks. A critical-interpretive feminist lens is adopted to facilitate focus on subjective perceptions and meanings of these work experiences. This approach allows exploration of how social identities in particular workplace settings are shaped by gender, social class, ethnocultural background, age, sex, (dis) ability, and geography. It also directs our attention to dominant discourses and inequities in the workplace that render women's work invisible and undervalued. Indeed, key findings identify issues of powerlessness, lack of control and decision-making, self-reported stress and burnout, and the perception that the work performed is not recognized or valued. Implications for managers and those working with support staff in oncology settings are briefly highlighted.

Keywords: Clerical; gender; power; invisible; stress; oncology

Dedication

This thesis is dedicated to the memory of my grandmothers, Nora Brown and Teodora Soltys, who passed away during the course of my studies. They were significant in my life, and they live on in my heart as love and inspiration.

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1. Introduction

1.1. Setting the Scene

The inspiration for this study comes from my interest in health, health care, inequities, and social justice. I have worked as a medical secretary at a Cancer Centre for several years and the experiences and insights that I have gained have been the motivation for this research. When I first started working in cancer care, I had no previous medical experience, except for the Medical Secretary Certificate that I attained at a college. Prior to my entrance to health care, I did not have knowledge or experience of cancer, and I did not know anyone with the disease. I was also not familiar with unionized environments, but after signing on to the Hospital Employees Union (HEU) as a member, it did not take long to learn the culture of a unionized workplace. I started to learn about larger political issues that have a direct impact on workers. This was especially true after the passing of Bill 29 in January 2002. This Bill unilaterally altered collective agreements between employers and unions representing approximately 100,000 workers in the health and social service sectors. It cleared the path for private corporations to take over the management and delivery of health care support services in hospitals and long-term facilities by privatizing and restructuring them (Creese & Strong-Boag, 2005; Lee & Cohen, 2005). Fuller, Fuller, and Cohen (2003) argue that the BC health care system has entered a period of profound upheaval where changes are being made to services that are not beneficial. According to these authors, at the most basic level, health care reorganization in BC involves two main trends: reductions in service and privatization. The final report of the Romanow Commission, based on extensive research and consultations with Canadians, sets out a proposed first step for improving health care services in Canada. This includes less for-profit involvement in health care, services that are more comprehensive, and more funds. The approach taken by the BC government, however, is very different from that of the Romanow Commission. It is an approach that emphasizes a for-profit health care system along

with service cuts which, some argue, will not improve the health care system in BC (Camfield, 2006; Fuller et al., 2003).

According to Cohen (2003), the BC government's actions to facilitate health care privatization have reversed more than thirty years of pay equity gains for women in health support occupations. This directly affects Cancer Centre support staff, including the women interviewed for this study. These workers are members of HEU, which consists of over 40,000 hospital and long-term care facility workers. HEU is a predominantly female workforce, and it has played a significant role in ensuring that work performed by women in the health care sector are paid wages that are equal to comparable work that is performed by male health care workers, as well as other employees working directly for the provincial government (Cohen, 2003). But *Bill 29* set back the clock for women, and Health Authorities laid off over 7,000 health care support workers, mostly women, in an unprecedented privatization of health care services. Employers were free to restructure the workplace with an entirely new workforce paid at much lower rates and with fewer benefits (Lee & Cohen, 2005). Then, in April 2004, HEU members took strike action that mobilized sections of BC's working class to the brink of a province wide general strike. Public sector unionists struggled to defend themselves and the services they deliver from employers and a government intent on reorganizing the public sector along neo-liberal lines (Camfield, 2006; Gillespie, 2007; Isitt & Moroz, 2007). The strike was "influenced by BC's class-polarized political culture and HEU's distinct history ... [representing] a key moment of working-class resistance to neoliberal privatization" (Isitt & Moroz, 2007, p. 1). Unfortunately, the outcome of that strike saw the Liberal government arbitrarily impose a fifteen per cent wage cut through *Bill 37* – the Health Sector Collective Agreement Act. The provincial government justified its actions by claiming that hospital support workers were overpaid (Cohen, 2003). Along with many other workers, I was personally affected by this wage cut, which reduced my hourly rate of pay by almost $4.00 an hour. This was a crucial turning point in how I viewed the political and economic environment in this province and my work situation.

These actions have had profound implications for health support workers, the value of women's work, pay equity achievements, and the quality of work performed in BC's health care facilities (Cohen, 2003). Based on studies that have examined the

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after-effects of these cuts on employees, Lee & Cohen (2005) argue that the hidden costs of health care wage cuts to the BC health care system are substantial. These authors state that the impacts of the wage cuts and contracting out on health support services have caused low morale among employees, lack of loyalty and commitment, the resulting negative effects on quality of care to patients, low recruitment and retention rates, negative effects on personal finances, and negative effects on the family life of health care workers. And according to Creese & Strong-Boag (2005), the Liberal government not only cut women's jobs in the public sector that were unionized and secure, but they "weakened employment standards, eliminated pro-active measures such as pay equity and employment equity, cut childcare and impaired access to education" (p. 2). By eliminating thousands of jobs that were secure and that paid well, the move toward gender parity has been undermined (Creese & Strong-Boag, 2005, p. 24).

In an attempt to recover lost wages for HEU members, negotiations between health unions and the government were carried out in June 2007. The Supreme Court of Canada ruled that parts of *Bill 29* violated the *Charter of Rights and Freedoms* and established that collective bargaining is a constitutional right. HEU members received gross payments in lieu of their cut wages; however, workers still talk about how this violated them and how they have not recovered financially. HEU secretary-business manager Judy Darcy (2008) explains:

> ... the compensation payouts will never make up for the damage *Bill 29* caused to health care workers [which was] devastating to so many families and continues to undermine the wages and working conditions of the thousands of workers employed by private contractors in our public health care facilities ... workers are still paying for *Bill 29* (p. 3).

In fact, health care organizations are also still paying for the actions of the government due to low morale, worker resistance, and so forth. Privatizing healthcare sets a precedent for the private sector, sending the message that they too can set aside arguments about the necessity for a fair wage for women's work (Cohen, 2003). Canadians value health care and expect governments to ensure that everyone has access to the best health care possible. Unfortunately, the reforms that have taken place and that will continue to take place are not improvements at all. Rather, they are creating a less efficient and accessible health care system rooted in neoliberal global forces (Camfield, 2006). These forces are at the root of inequities for women and their

everyday lives. I have used the political economic events outlined above to contextualize my interest in the subject matter of this thesis. They are also useful in understanding the work worlds of health care workers, particularly in British Columbia.

1.2. Statement of Purpose

The purpose of this qualitative study is to gain a deep understanding of clerical workers' lived experiences working in a Cancer Centre by seeking the viewpoint of oncology support staff. This is inherently a subjective study, understanding that each individual has their own socially constructed reality. Using data from in-depth interviews with support staff, it examines work organization, team relationships, patient relationships, and emotional impact. Oncology support staff are clerical workers who are mainly women and who are defined here as medical secretaries (MSs) and nursing unit clerks (NUCs). These health care workers play an important role wherein the work that they do has a direct impact on their health and patient care. There are costs to caring that can affect support staff physically, emotionally, and psychologically. Understanding the experiences and needs of support staff may inform the future development of workplace organization and education initiatives targeted at improving the sense of community and degree of coping skills in this population. Staff that have power to make decisions about their work, whose skills and knowledge are valued and fully utilized, who have better training and education, and better support are empowered (HEU, 2000). By improving workplace organization and providing resources for staff the health care system will potentially improve patient outcomes, notably patient satisfaction (Cashavelly et al., 2008).

The experience of working in an oncology environment for health care professionals has drawn much attention (Cohen et al., 1994; Creagan, 1993; Kovacs, Kovacs, & Hegedus, 2009; Lewis, 1999; Lyckholm, 2001; Stearns, 2001). Oncology support staff, however, have rarely been researched, acknowledged, or described in the literature (Cashavelly et al., 2008; Grunfeld et al., 2000; Mack et al., 2003). These personnel are frontline staff and are often the first link a patient has to the team of oncology professionals, providing a range of critical services that can shape the patient and professional experience of cancer care (Cashavelly et al., 2008). Similarly, few

studies have addressed the development of workplace organization, training, support, and education initiatives targeted at support staff. This is important given the fact that poor health outcomes are prevalent among oncology staff (Jones et al., 2011). A study conducted at an Ontario Cancer Centre found that oncology staff experience high levels of stress and burnout and that large numbers are considering leaving or decreasing their work hours, for example. This is an important finding for the cancer care system, where experienced health care workers are already in short supply (Grunfeld et al., 2005).

Overall, research that focuses on oncology support staff's experiences from a sociological perspective is at an early stage. Studies to date are lacking in the examination of patterns of support work associated with key sociological factors such as gender, sex, class, age, ethnocultural background, (dis) ability, geography, and immigration status. Sociologically informed research can contribute to the development of a sociology of cancer caring, offering an important counterweight, for example, to the psycho-oncological focus on psychological distress among cancer care workers that dominates the literature (Thomas & Morris, 2002). Furthermore, although there are non-sociological quantitative studies of stress and burnout in oncology health professionals, there is little qualitative research aimed specifically at oncology support staff. Qualitative research from a sociological perspective can tease out more detailed and nuanced information about women's subjective experiences, shedding light on the experience of power and control. A comprehensive look at the experiences of oncology staff must include support staff, be multidisciplinary, and use qualitative measures (Rohan & Baush, 2009). This study is a fundamental step in filling these gaps.

In further understanding support staff, it is essential to understand gender and power structures that exist both explicitly and implicitly in their working lives (Sebrant, 1998). As is evident in the BC government's actions in restructuring and privatizing healthcare, larger political and economic forces are at play that affect both health care and health care workers. Coburn and Eakin (1998) articulate how both micro and macro forces are intricately connected:

> Much of what sociology is all about as an intellectual enterprise concerns the tension
> between human actions and social structural constraints and opportunities. The discipline
> is thus characterized by dichotomy: human agency versus social structure ... 'micro'
> versus 'macro' level phenomena. Yet common to all of these positions is the view that

phenomena involving human action, including that regarding health and health care; is the product of social interrelationships (p. 84).

The consideration of micro and macro levels in this study helps to understand the processes at play that contribute to the invisible work that oncology support staff do, why the work is gendered, and not valued. In their discussion on determining who counts as a health care worker, Armstrong, Armstrong, & Scott-Dixon (2008) state that:

> The very term *ancillary* implies a particular understanding of health care. It invokes a notion of clearly defined activities with definite boundaries between work that is central and work that is peripheral or not even part of health care. The notion of support work fits best with a medical model of health care focused on the scientifically based treatment of body parts, with doctors as the central authority. Diagnosis and cure are directed by a physician whose expertise and authority are based on a command of scientific research that establishes causes and corrective treatments. Thus, the physician is at the centre, directing the treatment that is understood to be the purpose of health care. In such a model, health care workers are those who have acquired formal, advanced training and who are focused primarily on interventions, treatment, and cure, or on carrying out the directions of those who have such a focus. It is not surprising, then, that it is doctors and nurses who are the subjects of research and statistics on health care work, given the dominance of allopathic medicine that puts them at the centre of diagnosis and cure (p. 62).

In addition to the medical model and medical dominance, there are other interests and other ideas that play a powerful role in defining support workers as ancillary or outside of health care (Armstrong et al., 2008). Smith (1987) locates lived experiences of oppression within the social contexts that produce those experiences. Ruling relations identifies the institutional complexes (emerging from the development and elaboration of capitalist economies) that coordinate the everyday work of administration and the lives of those subject to administrative regimes, such as health care. Health care is an interesting arena for the examination of social life because it is a microcosm of stratified layers of hierarchical relations intertwined with and affected by the political economy. In fact, the present structure of the health industry is both a product of contemporary capitalism - it facilitates the reproduction of the status quo and key forms of societal power relations, namely, interactions that are hierarchical, authoritarian, unequal, patriarchal, and professionally and bureaucratically indifferent (Teeple, G. in Raphael et al., 2006, p. 2). Fisher (2010) refers to *gendered hierarchies* that she says are entrenched in the workforce, especially in the institution of medicine. Despite the "significant progress that women have made toward equity in the workplace, feminized professional identities and the subordinated role that goes along with these identities continue to be rewarded by most industries, the healthcare sector in particular"

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(Bolton, 2005 as cited in Fisher, 2010, p. 169). Support staff, like many women in feminized jobs must, "perform in accordance with a particular gender identity to be accepted in the workplace; however, this same gender identity traps them in a subordinated position" (Fisher, 2010, p. 169). Gender in these cases operates as "both a powerful and constraining social structure because women must perform feminized roles to be accepted in the workplace but these same roles do not allow the recognition of their skills and expertise that could bring about institutional change" (Fisher, 2010, p. 169).

In examining gendered hierarchies, it is essential that an intersectional approach be adopted. This facilitates an examination of key sociological factors that intersect with gender to create gender inequities. Structural systems such as class, ethnocultural background, age, sex, (dis) ability, geography, and immigration status are taken into consideration in this study. Also factored in are the impact of systems and processes of oppression and domination such as racism, classism, sexism, ableism, etc. (Hankivsky & Cormier, 2009, p. 3). This is because the intersections of these systems create individual's varied social positions (Gu, 2006). Oncology support staff are a diverse group of women, and they experience an internal hierarchy at diverse intersections. Inequity regimes or interlocked practices and processes (Acker, 2006, p. 441) around diverse intersections maintain interlocking systems of oppression and privilege among workers (Landry, 2006). Inequities in organizations leads to systematic disparities in power and control, decision making, resources, work organization, goals, work relations, and respect (Landry, 2006; Rakovski & Price-Glynn, 2010). Indeed, there are many forces at play that contribute to the oppression of women, particularly those who occupy subordinate roles. In exploring the experiences of oncology support staff, I use a feminist-interpretive lens, an approach that is conducive to analyzing women's subjective experiences and structural forces that lead to inequities. In this thesis, I argue that unequal social power relations contribute to gender inequality among oncology support staff, that the work that they do is significant and crucial to care, and that if a comprehensive understanding is to be attained, structural forces must be taken into account.

1.3. Outline of Thesis

In this chapter, I introduce the topic of research and lay out the purpose and rationale for doing the study. In the second chapter, I review the existing literature on the research topic. The literature is divided into five thematic sections in order to contextualize the multiple factors that affect support staff: 1) Professionalization 2) Occupational sex segregation 3) Emotional labour 4) Work stress and 5) Burnout. The third chapter describes the methodological approach utilized in this research, as well as the design of the study, selection and recruitment of participants, data analysis process, validation of the data, and ethical considerations. In the fourth chapter, selected emergent themes from the interviews are presented in four major domains. The fifth chapter presents implications drawn from the selected themes, recommendations, and future research.

2.   Literature Review

Much of the social and economic inequality that exists in society is created in organizations in the daily activities of working and organizing work. All organizations have inequality regimes, a term that Acker (2006) defines as, "loosely interrelated practices, processes, actions, and meanings that result in and maintain class, gender, and racial inequalities" (p. 443). This inequality is obvious; for example, department heads, managers, and physicians have much more power and higher pay than MSs or NUCs. Medical institutions are traditionally bureaucratic which allows them to have steep hierarchies wherein health care workers are ranked according to their occupational position:

> By virtue of its traditional organizational position, its job content, and the status of those usually occupying it, the role of the clerk in patient care delivery represents a model case among examples of women's work. The clerk position is located structurally at the apex of an inverted pyramid. That is to say, unit and clinic clerks answer to many workers of higher status and authority, such as physicians, nurse managers, and staff nurses, and have virtually no one over whom they exert direct authority. In many cases, they have no peers available in their work areas, because one clerk working alone often handles the clerical responsibilities of a unit or a clinic. These organizational features of the clerk position make it a potential reservoir for displaced aggression, providing virtually no outlet for dissipating pressures created by such power dynamics (Hall, Stevens, & Meleis, 1992, p. 11).

Oncology support staff, for example, are situated at the lower end of the hierarchy and have low status. Their work is demanding and they have little control. In fact, as will be discussed, clerical workers generally have low control but high demand in their work. Research shows that jobs with low control are often associated with low status in an organization's hierarchical structure (Karasek & Theorell, 1990). Workers who rank low in the organizational hierarchy, who have highly demanding jobs and low control are at risk for stress, burnout, and negative health outcomes (Karasek & Theorell, 1990). The focus of this review is to synthesize the key elements of the topic in order to contextualize the research problem. In keeping with a critical-interpretive feminist approach, I have included literature on issues of power, control, and gender inequity.

Work stress and burnout in medical organizations is a serious issue costing institutions hundreds of thousands of dollars and causes poor health in women. In order fully understand the experiences of support staff; it is necessary to draw on several domains of knowledge. The incorporation of multi-disciplinary literature provides depth to the study of this topic. I consulted relevant literature from the following areas: sociology, gender studies, psychology, physiology, epidemiology, and social work. These domains contribute to the existing body of literature related to this subject and provide the background for a sociological analysis of oncology support staff. The literature is organized into five thematic sections that contextualize the study: *Professionalization; Occupational sex segregation; Emotional labour; Work stress; and Burnout.*

2.1. Role of Medical Secretaries and Nursing Unit Clerks

MSs and NUCs are an integral part of the oncology health care team. A predominantly female occupation, these individuals incorporate responsibilities and functions that are multiple, vital, and require organization, concentration, and an ability to adapt to stressful situations. A key aspect of their work involves social interaction: they are the communication hub for staff, patients, and families. Their role is crucial and physicians, nurses, and other hospital workers rely on them. A breakdown at this level disrupts the work patterns of all other facets of the health care team and ultimately threatens patient care and safety. Therefore, efficiency and accuracy are paramount, as is the ability to work under pressure and multitask in a demanding and challenging high-paced environment. Both MSs and NUCs triage calls and must have excellent medical knowledge and experience in order to do this. They organize patient care in the form of booking chemotherapy, radiation therapy, diagnostic imaging tests, lab work, and several other procedures. They are required to interact with patients and families, and they spend a considerable amount of time problem solving, investigating, and listening to patients articulate their pain, sickness, sadness, fear, and much more. Although there is some overlap in job functions, the actual work performed by MSs and NUCs is quite different and that is why the job requirements and qualifications differ. For example, MSs are physically located in the administrative area of the Centre alongside doctor's

and their offices. They provide clinical and administrative support to a group of oncologists (usually 2-7 doctors) and usually work with that doctor group for years. This puts them in close proximity with physicians wherein they are relied upon for a variety of tasks. MSs often act as the organizational glue or connecting thread between staff in the Centre. NUCs are mainly involved in clinical work wherein they book and coordinate cancer patients' treatments. For example, in the oncology setting, depending on whether staff work in Radiation Therapy or Systemic Therapy, they process physicians' orders such as chemotherapy treatments and/or radiation therapy treatments. These physicians' orders are complex and require knowledge of the treatments and attention to detail. NUCs also order supplies needed for the clinics, and, similar to MSs, are required to communicate effectively within the Centre between departments as well as with external agencies. Their work puts them in daily and regular contact with clinic staff, patients and their families.

Although the roles are intrinsically different, there are indeed many similarities. For example, both are front-line workers who are an integral part of the oncology team and who provide patient care. They are required to promote and maintain good public relations between the Centre, patients, families, and visitors. Moreover, they are regularly exposed to intimate and confidential medical information. They must be able to problem solve and think quickly while interacting with patients and their families, especially with respect to medical emergencies, guarding confidentiality, and so forth. Many support staff develop relationships with patients and their families during the course of treatment and care in the oncology setting. In an oncology setting, all staff members work with patients and families dealing with a life-threatening disease every day (Cashavelly et al., 2008). Thus, the work that they do, and the environment that they find themselves in, puts them in a precarious work situation. This, along with forces at play such as social structures of power, is domineering and oppressive.

2.2. Professionalization

Physicians hold a great deal of power in society due to their knowledge and social class; and they are at the top of the medical hierarchy in terms of authority, prestige, and status. The misuse of power and authority by physicians can negatively

affect members of the healthcare team such as nurses and support staff. The goal of a healthcare team is to deliver quality patient care and to create a healthy work environment. This is accomplished by means of clear communication, respect, and collaboration. That conflict and power struggles exist in healthcare is well documented in the research literature and all too commonly experienced by health care staff. In order to understand the authority that physicians command, it is helpful to outline the professionalization of their profession. A profession is a particular form of occupation that is distinguished by its organization, social status, and educational/knowledge requirements. Defining "professions" has been the source of considerable debate. Many definitions:

> ... of professions emphasize power. The work of a doctor can have life or death consequences and can fundamentally shape people's life experiences. Doctors have a great deal of influence over their own work and over others who interact with them. Thus, for Friedson (1970), Johnson (1982), and others, professions are best defined not according to a set of characteristics, but through the ability of practitioners to control their occupation, their work, and the labour of those who work with them. Similarly, Larson (1977) emphasizes that professions also have the ability to shape the market for their expert services. For Foucault (1977), professional knowledge and expertise are both a source and a product of power in modern society. Professionals can use their positions to obtain knowledge about us, which they can use to exert power over us – hospitalize or incarcerate us, or declare us a poor risk for a loan, a passport, or a job (Adams & Welsh, 2008, p. 253-254).

The social privileges and influence that physicians can exert that potentially confers upon them power over individuals and society is known in sociology as *medical dominance*. Although doctors are only one group of trained professionals on a health care team, the entire health care industry is usually subordinate to their professional authority in clinical matters. This dominance is exhibited in a number of ways that include control over patients, clinical work, and the efforts of most other people who provide health care directly to patients. Nurses have direct interaction with patients and doctors, and there have been many studies conducted by nurses that examine their perceptions of dominance by physicians. Findings have shown that nurses are aware of dominance, that they have little decision-making capacity (though this is changing), and they are recipients of negative criticism. Some nurses also negatively evaluate their lower status and lack of autonomy relative to doctors (Gair & Hartery, 2001; Nugus et al., 2010; Reeves et al., 2010; Tabak & Koprak, 2007). Tabak & Koprak (2007), for example, found that there was interprofessional conflict among healthcare workers with respect to gender, age, ethnocultural differences as well as gaps in education and socio-

economic status. They also found that physicians often do not consider nurses' opinions and they are apprehensive about challenging a physician's greater power and authority. In their study, nurses who felt intimidated by physicians' prestige and authority hesitated to report changes in a patient's condition. Dimitriadou et al., (2008) say that tension among physicians and nurses is a significant factor in nursing stress in the workplace. The tense environment and verbally abusive behaviour by some physicians towards nurses can contribute to less power at work and poor working conditions for nurses and therefore increases the risk of accidents and mistakes (Dimitriadou et al., 2008; MacDonald et al., 2011).

The tense environment has a trickle-down effect, and MSs and NUCs often find themselves being verbally abused as well. For example, NUCs have reported being verbally abused and bullied by nurses. Likewise, they also verbally abuse MSs, who interact regularly with doctors. Overall, support staff are often recipients of criticism, condescending remarks, and angry outbursts. Like nurses, they are also mainly women in subordinate roles; and unlike other jobs that are dominated numerically by women (e.g. teachers, librarians), they work in the context of a powerful male-dominated profession. This places them in a precarious position wherein physicians often convey a strong paternalistic attitude toward them, drawing lines between their own expertise and the women who they view as suited by nature to the tasks of caring and assisting (Riska, 2010). Of course, there are physicians who follow the highest professional standards in the workplace and show courtesy and respect to those they work with. However, poor behaviour is enough of a problem that several studies address the issue (Dimitriadou et al., 2008; Gair & Hartery, 2001; Leape & Fromson, 2006; MacDonald et al., 2011; Nugus et al., 2010; Pfifferling, 1999; Reeves et al., 2010; Rosenstein & O'Daniel, 2008; Shamian & El Jardali, 2007; Tabak & Koprak, 2007). In North America, such "disruptive behaviour" has become an issue that is receiving increased attention from regulators (Rosenstein, 2011).

Pfifferling (1999) defined the disruptive physician as one who occasionally or repeatedly shows disrespect for others, especially those with less power. Disruptive physician behaviour takes many forms including verbal (insults, yelling), physical (touching), environmental (gossip, emails), systemic (hijacking meetings, inappropriate demands/complaints), racial/ethnic slurs, sexual harassment, failure to respond to phone

calls/pages, and angry outbursts (MacDonald et al., 2011; Rosenstein & O'Daniel, 2008). Disruptive behaviour causes stress, anxiety, frustration, and anger and can cause breakdowns in communication and collaboration among physicians as well as other healthcare workers. This can lead to medical errors, adverse events, and near misses that compromise the quality of patient care (Dimitriadou et al., 2008; Leape & Fromson, 2006; MacDonald et al., 2011). It can also lead to recruitment and retention issues, impact workers health and well-being, jeopardize patient safety, and have negative organizational and societal outcomes (Shamian & El Jardali, 2007).

In conclusion, the professionalization of physicians gives them great autonomy, power, and control, referred to as medical dominance. Medical dominance asserts itself in the healthcare setting by giving physicians authority to guide and control the work of other healthcare workers, especially those with lower status and a lack of power and control. Although there are physicians who are ethical and practice to the highest professional standards, it is unfortunately common for them to behave disruptively in the workplace. This causes problems for staff, patients, and the organization. In multi-professional health care settings, interprofessional collaboration is essential for effective functioning (Dimitriadou et al., 2008). It is therefore important to understand what contributes to, incites, or provokes disruptive behaviours. By understanding the cause's organizations can provide appropriate educational and training programs that can decrease the likelihood of occurrence, thereby improving the overall effectiveness of communication among the health care team. In addition, appropriate policies should be developed and implemented in order to effectively deal with this serious issue (Rosenstein & O'Daniel, 2008).

2.3. Occupational Sex Segregation

A sexual division of labour, wherein men and women have different responsibilities, has characterized most societies throughout history. Occupational sex segregation, also known as the *gender division of labour*, is a process where society divides work among women and men according to what is considered suitable or appropriate to each gender. This is discrimination against women because women assume most of the burden of labour, both in unpaid domestic work and paid work.

England & Boyer (2009) have found that, for nearly a century, clerical work, which they refer to as "women's work," has been the most gender-segregated of all jobs. Although women have moved into the paid work force, they are still primarily responsible for domestic labour, which some researchers refer to as the *unequal division of domestic labour*. This is an important issue because inequity in this area contributes to gender inequity on a broader social level (Adams & Welsh, 2009). Moreover, although women have made considerable advances in opportunities, feminist and gender scholarship continues to show and challenge the modes that men use to subordinate women (Tichenor, 2005). For example, in the workplace, gender inequities can manifest in well-known institutional forms, like the glass ceiling (Padavic & Reskin, 2002; Rosser, 2004). It can also manifest in regimes of flexible work that often lead to less secure employment and lower wages (Smith, 1990), as previously illustrated by the privatization of healthcare services in BC and the resultant wage cuts impacting a predominantly female workforce (Isitt & Moroz, 2007).

Smith (1987) explains these and other workplace inequities as being rooted in the *gender subtext of organizations*, or as the rules and relations that are structured to appear neutral but nonetheless disadvantage women and minorities. Formal and informal mechanisms make up the gender subtext of organizations including how successful management is defined and how promotion schedules are filtered through certain requirements (Rees, 2004; Fisher, 2010). Sociologist Joan Acker's theory of gendered organizations critiques writings on bureaucracies that assume that organizations are gender neutral. Acker argues that, "... in organizations men and women do different work and gender differences are reinforced through social interactions and social ideologies" (1990 as cited in Adams & Welsh, 2008, p. 26). Acker has explored the gendering of organizations by examining job evaluations. These tools are used by management to describe and evaluate the content of jobs. Acker argues that job evaluations only consider jobs and not those who fill them. This makes individuals into abstract disembodied workers that exist only for work, and assumes that they do not have a life outside of work. Evaluation schemes describe and justify organizational hierarchies and are generally used to set income levels and paths of promotion (Adams & Welsh, 2008, p. 26). Gillian Creese's (1999) study of BC Hydro from 1944 to 1994 illustrates gendered and racialized processes that are hidden that

perpetuate inequality in job evaluations and organizational structure and culture. She found that the job evaluations appeared to be gender-neutral; however, upon closer examination they characterized women's jobs as requiring basic and general skills, whereas men's jobs required technical and specialized skills (Adams & Welsh, 2008).

A structural view of organizations enables analyses that illustrate how power operates to maintain and reproduce persistent gender inequities (Fisher, 2010). Armstrong et al., (2008) state that:

> Health care is women's work. This statement refers to what women do, what we say they do, and what we think they should do. In other words, it has material and ideological roots as well as discursive ones. The boundaries between male and female labour vary historically and with class, physical location, racialization, immigration status, and age, among other social locations. Although the boundaries change, what persists is a division of labour between men and women. This division is not simply about difference but also about power and assigned worth. In general, to call something 'women's work' means it is less valued work, in terms of both prestige and pay. It also usually means fewer resources of the kind that would provide the basis for allowing women's views to prevail, or at least to have a significant influence (p. 88-89).

This is especially evident in healthcare organizations with respect to support staff who are predominately women. According to Armstrong et al., (2008), female dominated jobs are associated with women's work in the home. These authors argue that the skills, responsibilities, effort, and working conditions involved in supportive work remain invisible and undervalued. They say that this invisibility and undervaluing contributes to the phenomena of defining support work as not part of care, and equating it to hotel services that require little effort or responsibility and few skills. Furthermore, women's lack of power contributes to this process (Armstrong et al., 2008, p. 5).

MSs and NUCs are an example of healthcare workers whose work is largely undervalued and invisible, and this is evident in the scant research done on them, as well as their lack of decision-making and control in their work (Armstrong et al., 2008; Cashavelly et al., 2008). Support staff require skills (including but not limited to) the ability to communicate effectively, interact with a variety of people, coordinate, prioritize, problem solve, think critically, make decisions quickly, triage, liaise, and much more. Moreover, as will be discussed, they perform emotional labour, which involves being empathetic, compassionate, sympathetic, caring, and nurturing to others.

2.4. Emotional Labour

Research on work that women perform has revealed that many of the expectations on the job are gender-based, yet these expectations are neither formally outlined or categorized by the organizations that require them, rendering them invisible (Armstrong et al., 2008; Smith & Cowie, 2010). Women are disproportionately found in caring work that requires emotive tasks wherein there are assumptions about proper gendered behaviour that are interwoven into the roles being played and are not necessarily articulated. These behaviours are expected to come naturally and therefore do not require explanation or compensation (Smith & Cowie, 2010; Wichroski, 1994). The concept of emotion work developed by Hochschild (1983) recognizes the manipulation of feeling in the self in order to meet the demands of the situation. This involves the induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a safe place (Gray, 2010). When this emotion work is transferred to the workplace for a wage, it becomes emotional labour (Hochschild, 1983). Emotional labour involves face-to-face or voice contact with the public, the ability to produce an emotional state in another person, and it allows an employer to regulate a degree of control over the emotional activities of workers through training and supervision (Hochschild, 1983; Smith & Lorentzon, 2007). The term emotional labour highlights the similarities as well as differences of emotional and physical labour. Emotional labour requires an individualized but trained response that assists in the management of patients' emotions in the everyday working life of health organizations (Gray, 2010, p. 349). It has traditionally been identified with women's work and the role of the mother in the family. The portrayal of emotional care as an entirely natural activity relates to the devaluation of emotional labour in cultural, gender and economic terms (Oakley, 1981). According to Parkin (1993):

> The public/private divide can be regarded as a useful way to explore gender divisions ...
> Women are consigned to the private sphere – the apolitical, the sexual, the emotional.
> Women have the 'expressive role,' men the 'instrumental.' The expressive role
> encompasses physical care of dependent people and of men. In sum, a gendered
> division of labour divides emotions and the way they are expressed, by whom and where
> (p. 168).

This is clearly the case in healthcare where physicians examine, diagnose, and treat patients; and more subordinate staff provide emotional comfort to patients and their families. The notion of care work being women's work extends far beyond care in the

private sphere. Despite significant changes in attitudes, care is still primarily understood as women's work, and it is still the case in practice (Armstrong et al., 2008, p. 90).

In caring for others, healthcare workers learn what is expected of them and how to manage their emotions on the job as well as those of others (Hochschild, 1983). While studies have argued that clerical workers' technical skills are frequently undervalued, the additional labour involved in projecting the 'appropriate' manner has generally remained hidden (Adams & Welsh, 2008). For example, support staff are expected to be polite, pleasant, and positive with patients and other members of the team, even when they are unhappy, angry, or feeling negative themselves. They must control their own emotions and portray those expected of them. Hochschild (1983) discusses *collective emotional labour*, a group process of managing emotions that is common in healthcare workers. Some organizations teach emotional display rules that they expect their employees to project. However, in circumstances where the situation is ambiguous and there are no rules, employees make their own judgements of how to manage and cope. For example, research has shown that employees engage in a phenomenon referred to as *informal communities* where they form into groups to vent, providing each other with emotional support in order to deal with pressures or abuse from customers or service users (Smith & Cowie, 2010, p. 231). These communities are common among MSs and NUCs who work with cancer patients and their families.

Adams & Welsh (2008) state that studies have found emotional labour to be the case for clerical workers in general, and that these workers must manage the emotions of others, "soothing them when unhappy or upset, and doing their best to make them feel positive about their interactions with the company as a whole" (p. 220-221). MSs and NUCs engage in such emotional work daily, especially with doctors and patients. They are expected to portray the stereotypical personality in their dealings with others, as C. Wright Mills says, and be "friendly, helpful, tactful and courteous at all times" as well as "alert yet obsequious" (1956, p. 183-184). Controlling appearance and mannerisms throughout the day can be exhausting. Additionally, according to Adams & Welsh (2008), clerical workers usually support many people in an organization, increasing the amount of emotional labour and personality management they must perform.

It is in this way that jobs are segregated and organized by gender, which has to do with existing assumptions about men's and women's emotionality. Erickson & Ritter (2001) state that women excel in emotional labour wherein negative emotional displays are suppressed and the presentation of positive emotions are projected - while men are better suited to the opposite. Also, individuals occupying more powerful statuses tend to have more control over their emotional labour and are therefore empowered to express more negative emotions, particularly anger (as illustrated in "disruptive physicians"). And, those who occupy more disadvantaged statuses tend to have less control over how their emotions are managed and are expected to display positive emotions towards higher-status others. This is seen particularly in support staff who are situated at the bottom of the medical hierarchy. The implications of suppressed emotions over a long period can result in stress, burnout, and poor health (Erickson & Ritter, 2001). The gendered division of emotional expression is socially constructed to reflect masculine and feminine roles. Gender acts as a power relation with associated meanings and social legitimacy and gender issues account for patterns in forms of meaning and experience in the workplace. A feminist analysis can help to address questions pertaining to the different patterns of domination and marginalization in the conceptualizations of the gender division of labour across disciplinary boundaries on healthcare teams.

Up to this point, the review of the literature has discussed how professionalization of physicians, occupational sex segregation, and emotional labour manifest themselves in social contexts. These points of discussion provide a backdrop that allows us to understand the circumstances of oncology support staff. These social forces not only create and sustain gender inequity; they also contribute to stress and burnout in healthcare workers. In order to understand stress and burnout in oncology workers, the review of the literature will now highlight some of the biomedical literature that identifies stress and burnout in oncology workers, turning first to stress.

2.5. Stress

Much of the literature on clerical workers discusses how poor work organization leads to stress, burnout, and poor health outcomes. In fact, stress is one of the most

widespread complaints in the workplace today and has become a major public health problem. Work stress is defined as the harmful physical and emotional responses that occur when job requirements do not match the worker's capabilities, resources, and needs (Dolan, 2007). Stress is increasingly recognized as one of the most serious occupational health hazards reducing workers satisfaction and productivity, and increasing absenteeism and turnover (Gianakos, 2001). It is recognized worldwide as a major challenge to individual mental and physical health, and organizational health. Stressed workers are also more likely to be unhealthy, poorly motivated, less productive and less safe at work. By some estimates, work-related stress costs the national economy a staggering amount in sick pay, lost productivity, health care and litigation costs (Palmer et al., 2004).

While industries in developed countries have addressed chemical and physical sources of risks, they are faced with the threat to the quality of life of their employees (Dolan, 2007). According to research done by Hospital Employees Union, physical hazards are no longer the leading cause of workplace injury and illness - today, healthcare workers are more likely to be hurt by jobs that are designed poorly, have poor management practices, and top-down power structures (HEU, 2000, p. 7.). Researchers have demonstrated conclusively that stress levels vary depending on the organization of work, the physical and social environment in the office and the economic status of the worker (Cohen et al., 1989; Wilkinson, 2000). Clerical workers employed in the public and private sectors make up one of the largest segments (24.3%) of the female workforce in Canada (Statistics Canada, 2005). Female clerical workers face work-related demands that are similar to those of other employed women; however, they also experience organizational conditions that are unique, given the gendered division of their labour and the lack of value and power afforded them in society (Ames, 1996; Harkness et al., 2005; Long et al., 2008).

Stress is more common in employees at lower levels of workplace hierarchies (Wilkinson, 2000). Clerical workers generally rank low in a hierarchy and although the work that they perform is essential, it is not always recognized. Bureaucratic workplace characteristics, such as inadequate rewards, lack of decision-making control, and depersonalized work have been associated with clerical workers' depressed mood and somatic symptoms (Karasek, Gardell, & Lindell, 1987). In addition, negative health

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outcomes have been attributed to poor supervisor support and gender harassment (Balshem, 1988; Piortrkowski, 1998). Moreover, multiple health outcomes have been linked to female clerical workers' work-related stress appraisals and coping strategies (Long, 1998; Long et al., 2008; Morris & Long, 2002). The structure of the work environment has an effect on both physical and mental health. Subjective experiences and emotions can produce acute and chronic stress which affect biology, and, hence, physical and mental illness. Psychological factors in an individual point to ways that the social environment can have a powerful influence on health (Sapolsky, 2005; Wilkinson, 2000). For example, health is correlated with income, and those at the lower end of the social hierarchy experience income inequality, which can create negative emotions. These emotions cause ill health through psycho-neuro-endocrine mechanisms (the fight-or-flight response) and health-destroying forms of behaviour – for example, overeating, smoking, or using alcohol (Raphael et al., 2006). Low status, limited social support, lack of adequate control over work, among other factors, are also psychosocial risk factors that can predict ill-health and premature death (Krieger, 1990, 2005; Raphael et al., 2006; Sapolsky, 2005; Wilkinson, 2000).

Research suggests that psychosocial influences on health are sources of stress that cause physiological arousal. At the individual level, the perception and experience of personal status or situation can lead to stress and poor health. An individual's interpretation of their standing in the social hierarchy can produce feelings of shame, worthlessness, and envy that have psychobiological effects upon health (Krieger, 1990; Sapolsky, 2005; Wilkinson, 2000). The link between social hierarchy, stress and health outcomes were made evident in the well-known Whitehall Study, a research project that tracked over 18,000 female and male civil servants in occupations ranging from filing clerks to upper level management for nearly twenty years. The study found that those who worked lower in the hierarchy had a greater likelihood of suffering from angina, heart and circulatory problems, chronic bronchitis, and other stress-related conditions. In addition, those in low status jobs felt that they had little control due to their rank and to the demands of the job (HEU, 2000; Marmot et al., 1991; Wainwright & Calnan, 2002). Clerical workers were almost twice as likely to develop heart disease as women in managerial, professional, service, or blue-collar positions in the well-known Framingham Study (Cohen & White, 1986; HEU, 2000). Furthermore, studies have shown that

organizational structures are also implicated in physiological illnesses in clerical workers such as depression, headaches, fatigue, muscular-skeletal injuries, gastrointestinal disorders, weakening of the immune system, high blood pressure, and coronary heart disease (Alfredsson, Spetz, & Theorell, 1985; Gallo et al., 2003; HEU, 2000; Long et al., 2008; Steptoe et al., 2003).

Moreover, a worker's lack of control is the most important cause of stress related health problems (Wainwright & Calnan, 2002). Studies that have examined work stress looking at the interactions between job demands and job control have found that high job demands along with low job control precipitates psychological and physical strain, whereas jobs in which both demands and control are high lead to well-being, learning and personal growth (Karasek, 1990; Landsbergis, 1989; Marmot et al., 1991; Perrewe & Ganster, 1989). This is important and relevant to oncology support workers who rank low in the organizational hierarchy and have little or no control in their work. The literature on stress highlighted here demonstrates that poor work organization, jobs with low control and high demand, and low status lead to stress and poor health outcomes in clerical workers. When stress is experienced at high levels over a prolonged period, it results in burnout, a condition that is common to those who work in cancer care.

2.6. Burnout in Oncology Work

Burnout is a syndrome of emotional exhaustion, depersonalization, and low personal accomplishment that can occur among individuals who work with people on a daily basis. It has important consequences both for the workers involved and for the organizations that employ them (Cordes & Dougherty 1993; Grunfeld et al., 2000). At the individual level, literature on burnout of health care personnel has linked the components of burnout with mental and physical health problems (Cordes & Dougherty, 1993; Felton, 1998; Woodward et al., 1999). Researchers have found that oncology health care workers are particularly susceptible to emotional distress, including burnout, because providing support to cancer patients and their families necessitates a great expenditure of energy and intense patient relationships (Cashavelly et al., 2008; Glasberg et al., 2007; Grunfeld et al., 2000; Mack et al., 2003; & Rohan & Bausch, 2009). When these relationships repeatedly end with the death of the patient, staff may

experience disturbing symptoms, such as helplessness, depression, boredom, apathy, guilt, displaced anger, work-related dreams, withdrawal from dying patients, and questioning of the value of the work (Valent, 2002; Stearns, 2001). According to Stearns (2001), in oncology work grief is cumulative over time, as "oncology health care providers see more death in a year than most others see in an entire career or even in their lifetime" (p. 224). In her discussion of oncology social work, Stearns (2001) labelled oncology social workers' reaction to recurrent loss as professional grief, a term that also applies to oncology physicians and nurses (Rohan & Bausch, 2009). I propose that this term also applies to MSs and NUCs, who also experience feelings of grief and loss when patients that they have been working with pass away.

Recognizing the importance of the health care team and its impact on patient-centred care is essential for quality care. Cancer care patients have complex medical and psychosocial needs and caring for these patients presents challenges and rewards for the entire oncology team (Cashavelly et al., 2008). It is now widely accepted that a serious disease such as cancer carries with it considerable psychological and social consequences for family carers as well as for health care workers. Key cancer service policy documents state that patients, families, and carers need access to support from the time that the cancer is first suspected through to death and into bereavement (Thomas & Morris, 2002). Staff that are stressed, burnt out, and who develop physical and mental illness, however, are prone to sick days and long-term disability claims. This leaves the health care system facing staff shortages and overworked employees, which is not conducive to quality patient care.

2.7. Summary

This review has touched on some of the issues in the literature regarding clerical workers in general: power in the workplace, the gendered nature of work, emotional labour, stress, and burnout. It is clear that much of the social and economic inequality that exists in society is created in organizations in the daily activities of working and organizing work. Clerical workers in health care organizations are situated at the bottom of the medical hierarchy and have little status. The organizational features of the clerk position render the work done invisible and a potential reservoir for displaced

aggression. Physicians hold a great deal of power in society due to their knowledge and social class; and they are at the top of the medical hierarchy in terms of authority, prestige, and status. The misuse of power and authority by physicians can negatively affect members of the healthcare team such as nurses and support staff. The "disruptive physician" is an example of a physician who occasionally or repeatedly shows disrespect for others, especially those with less power. Clerical workers are an example of those with less power, and they have little control but high demand in their work. Occupational sex segregation contributes to inequities and subordination of clerical workers. By dividing work among women and men according to what is considered appropriate to each gender, women inevitably end up with more work and less rewards. This is discrimination against women because women assume most of the burden of labour, both in unpaid domestic work and paid work. Jobs that women find themselves in are largely segregated and organized by gender, which has to do with existing assumptions about women's and men's emotionality. Emotional labour, for example, is largely seen as work that women do, and health care work is a good example. Workplace inequities are rooted in what Smith (1987) refers to as *rules and relations* that are structured to appear neutral but nonetheless disadvantage women and minorities. Workers who rank low in the organizational hierarchy, who have highly demanding jobs and low control are at risk for stress, burnout, and negative health outcomes.

Stress and burnout are key findings in the *biomedical literature* with respect to clerical workers and research on this topic has mainly been done by those working within the disciplines of psychology, physiology, and epidemiology. These disciplines offer a framework for making sense of and responding to adverse experiences at work along with their emotional and physiological correlates. However, it should be kept in mind that like all interesting social phenomena, work stress does not fall neatly within disciplinary boundaries (Wainwright & Calnan, 2002). For example, it does not reside exclusively in the objective characteristics of work, or in the personal attributes of the individual, but in the relationship between the two – a relationship that is mediated by subjective interpretations and appraisal. One of the weaknesses in objective measures of job stress is that they cannot explain the characteristics that one worker may interpret as an unbearable burden and another a stimulating challenge. This is an important

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distinction, because it can affect an individual's beliefs about whether stress is a positive or negative experience (Wainwright & Calnan, 2002). In conclusion, by including multidisciplinary literature in this review, a framework is adopted that is sufficiently broad enough to incorporate the insights of sociology, gender studies, psychology, physiology, epidemiology, and social work, facilitating their synthesis within a broader social context.

3. The Research Process

3.1. Methodology

In researching women's lives, women's experiences need to be integrated with theoretical perspectives - an interpretive and synthesizing process that connects experience to understanding (Maynard, 2002). I have attempted to do this using a critical interpretive feminist approach. A critical interpretive approach aims at understanding how individuals construct their worlds and how relations of power constrain their choices (Koehn, 1999, p. 15). It emphasizes the meaning that social actions and structures have for individuals, focusing on individuals' understandings and how they attain a sense of order in their lives in a particular social context and through interaction within that social context (Schwandt, 1998). Through this lens, I seek to understand participants' subjective accounts of their experience, the dominant discourses shaping their experience, and their (in) ability to act. In this study, a feminist lens directs our gaze to accounts of women's position in the work force, in the medical sector, paying particular attention to the intersection between gender, class, ethnocultural background, age, (dis) ability, sex, geography, and immigration status.

3.1.1. Critical Interpretive Paradigm

The methodology of interpretivists is hermeneutical (Travers, 2007, p. 23). Hermeneutics is identified as "a process and method for bringing out and making manifest what is normally hidden in human experience and human relations" (Lopez & Willis, 2004, p. 728) and looks for meanings embedded in common life practices. A central tenet of hermeneutics is that the focus of inquiry should be on the relation of an individual to their life experiences, that is, an individual's realities are invariably influenced by the world in which they live (Lopez & Willis, 2004). For example, in this study, I obtained participants' descriptions of a typical day as support workers and encouraged them to describe interactions, workload, relations with others, experiences

of the body, and experiences of time in order to place lived experiences in the context of daily work practices and socialization (Smith, 1987). The focus of an interpretive inquiry is what an individual's narrative implies about what is experienced every day; the essence being the interpretation of the narratives provided by participants in relation to various contexts (Lopez & Willis, 2004; Schwandt, 1998). To understand the experiences and meanings of interviewees, interpretive researchers look for thick and rich descriptions of the issues being studied and try to develop an empathetic understanding of the world of others (Rubin & Rubin, 1995). Reality is viewed as constructed and contextual wherein both the researched and the researcher create meaning and portray a rich account of social reality through their interaction (Travers, 2007, p. 23). The advantage of interpretive research is to make sense of the world, thereby creating or constructing understanding and knowledge through interaction, by drawing on what is already known and believed. In order to incorporate social critique, which intertwines politics with inquiry, Denzin & Lincoln (1998) propose *critical interpretivism*. The purpose of adopting a critical position is that it helps to uncover inequities such as gender, class, race, age, etc. in the workplace, thereby creating the potential for change. Critical social science concerns itself with the subjectivity of individuals and focuses on their lived experience. It has a dialectical concern with the social construction of experience and it can reveal power relations involved in constructing inequity, thereby making it an emancipatory tool (Kincheloe & Mclaren, 2000, p. 280 cited in Travers, 2007, p. 17). It is for this reason that I have incorporated a critical approach in this study.

3.1.2.   Feminist Paradigm

There is a vast range of feminist approaches to social science; however, the strain of feminism applied to this study is the critical-interpretive paradigm (Travers, 2007, p. 25). Although feminist approaches to social science differ widely, they all share a mutual focus on applying a critical lens to the unique experiences of women and the social structures that shape them (Harding, 1987; Olesen, 1998; Smith, 1987). Smith (1987, p. 6) states that "a sociology for women must be able to disclose for women how their own social situation, their everyday world is organized and determined by social processes which are not knowable through the ordinary means through which we find our everyday world." Feminist research is based on the lived experiences of women, on

gender as socially constructed and historically specific, and on a political commitment to the emancipation of women (Byrne & Lentin, 2000; Creese, McClaren, & Pulkingham, 2009). A key element to feminist work is that it is theoretically grounded and provides a framework concerned with gender divisions, diversity, and women's oppression (Maynard, 2002).

At the root of feminist research is the practice of critical self-reflexivity. This requires the researcher to critically reflect on power and how these relations influence methods, interpretations, and knowledge production. It is also implicated in how the researcher relates to research participants and what can or cannot be accomplished in the research within the context of institutional, social, and political realities (Kobayashi, 2003). As such, it is integral to conducting ethical research. The practice of self-reflection attempts to expose hidden assumptions and position the researcher in terms of their worldview and values. A researcher often picks a research topic with which they have subjective experience and about which they hold certain opinions. That is, the potential for bias enters the research process the moment a researcher chooses one topic or theory over another (Ogden as cited in Given, 2008, p. 61). However, feminist research assumes that the self of the researcher has an effect upon the subject and context of the study and accepts the assumption that there is no objective point of view (Ogden as cited in Given, 2008, p. 61). Positivist assumptions about objectivity and the distance and detachment of the researcher have been challenged by feminist research and are not recognized as a valid position (Olesen, 1998; Travers, 2007). Rather, researchers are enjoined to recognize subjectivity and compelled towards reflexivity (Ogden as cited in Given, 2008; Olesen, 2005; Pettinger, 2005; Smith, 1987). We should not strive to be neutral or objective to women's experiences, rather, we should embrace our experiences and insights and be fully involved in the practice and process of research (Olesen, 1998; Smith, 1987). Scheper-Hughes (as cited in Denzin & Lincoln, 1994, p. 250) says, "the self of a researcher is a set of resources rather than something that is problematic or to be controlled." What is important is the direction that the bias takes and that it is transparent so that the research can be judged accordingly. In being transparent I mean being accountable, which I have strived for by engaging in critical self-examination, and interrogating my assumptions and values that are imposed on the interpretation of participant's knowledge. My social location has clearly

influenced both topic choice and methodology, and I will discuss this in the next section so that the direction of my biases can be adequately judged.

3.1.3.   Researcher Reflexivity

As mentioned in the introduction to this thesis, I have spent several years working in health care as a medical secretary in cancer care. During this time, I have developed an interest in the relationship of health and disease to culture, society, and politics. Many of the sociology courses that I have taken throughout my education have examined health and health care from micro and macro levels, addressing power, control, and inequities. My sociological theory courses were particularly influential in my thinking about social processes, particularly topics that touched on critical theory and feminism. It is with these tools that I have entered into my analysis of oncology support staff who work in an environment where there is a variety of class backgrounds and levels of education. This social stratification, or hierarchy, is especially salient in medical institutions. Over time I found myself questioning what the processes are that create hierarchies and why inequality is so prevalent, especially with respect to women. My experience as a support worker links me to other women similarly situated, and I can share in an understanding of what it is like to work in a Cancer Centre, a unique opportunity that provides one with a range of experiences.

Although the participants in this research and I vary in terms of our ages, ethnocultural backgrounds, and education, we all share in the fact that we are women employed in support roles in a health care setting. I have heard many staff members talk about how rewarding and gratifying it is to be a part of cancer care, that it is important and worthwhile. I agree with this, and have many inspiring stories and memories of patients that I have interacted with over the years. At the same time, working in a Cancer Centre can be stressful due to a variety of reasons. For example, some staff have expressed their frustrations and difficulties on the job, the lack of control in making positive and healthy workplace changes, understaffing, unmanageable workloads, and so on. These events occur regularly in health care, often over long periods. I have experienced these situations in my role as a medical secretary, and this no doubt influences my thoughts about working in a Cancer Centre. Additionally, I have strong opinions about how support staff are treated at times by professional staff and

management. The impact of budget cuts in staffing that I referred to earlier have affected my attitude about leadership and government, and this too influences my perception of what I perceive to be inequitable and unfair practices that affect workers' health and morale, and inevitably patient care.

My social location has clearly influenced the topic of this research, its methodology, and its implications. Throughout the research process I have engaged in self-reflexivity and have scrutinized the issue of value-laden research. I have become comfortable with the notion of researcher bias and I agree with Harding (1987) who states that it is impossible to be completely neutral. Rather, personal biases and agendas should be made explicit in order to avoid deception. I believe that being reflexive is a central component of an ethical research framework and in designing this research project I have tried to develop an ethical, reflexive, and principled methodology that ensures the relevancy of this project to women who work in support roles in health care.

3.1.4.   *Summary*

In this section, I have discussed some of the epistemological principles underlying critical interpretive and feminist paradigms in social research. Critical theory functions as an emancipatory tool and occurs in a dialogic and dialectic relationship between the researcher and researched (Travers, 2007, p. 18). This paradigmatic approach is suitable for the research topic in this study because it allows for the exploration of how participants construct and interpret their experiences at work. At the same time, it is capable of revealing powerful forces in society that cause oppression and inequity.

3.2. Methods

3.2.1.   *Research Questions*

This research project explores the life worlds of oncology support staff. My main research question asks, "How do oncology support staff experience their work environment?" This question is split into the following sub-questions in order to establish

a range of experiences that can be examined to answer the research question: a) How would you describe the organization of your work? b) What are working relationships like with other members of the oncology team? c) What are relationships like with patients and families? d) What is the emotional impact of working in a cancer centre? e) What kinds of experiences do you consider stressful?

A key feature of this inquiry is the centrality of women's voices and women's experiences and the explication of social processes of everyday life in working in a health care institution. This research aims to raise awareness of the important role that support staff play wherein the work that they do has a direct impact on their health as well as patient care.

3.2.2.   Data Generation and Sampling

The method used in this study to generate data is qualitative semi-structured open-ended interviewing. This method is conducive to understanding and capturing the subjective work experiences of oncology support staff. This approach is appropriate when working with small numbers of participants specific to one context, the goal being to understand rather than to compare. In contrast to quantitative sampling techniques that rely on statistical probability theory, qualitative sampling is based on purposeful or theoretical sampling principles. The aim is to identify information-rich participants who have certain characteristics, detailed knowledge, or direct experience relevant to the phenomenon of interest (Charmaz, 2006). Denzin and Lincoln (1998, p. 370) state that "... qualitative researchers employ ... purposive, and not random, sampling methods. They seek out groups, settings and individuals where ... the processes being studied are most likely to occur." The primary feature of this method of sampling is that the situation of the sample is determined according to the needs of the study, and not according to external criteria, such as random selection. Participants were selected because of the same experience or knowledge, not because of their demographic reflection of the general population (Charmaz, 2006). Therefore, purposeful sampling was used to recruit oncology support staff who work in a Cancer Centre. These individuals have detailed knowledge, direct experience, and are rich in information in the topic that I am studying. The information they provided was relevant to my research questions,

theoretical position, and importantly the account that I develop (Silverman and Marvasti, 2008), which is to locate some of the axes of inequity in the workplace.

3.2.3. Snapshot of Participants

The data source for this study includes twelve participants. Of the twelve women, seven are MSs and five are NUCs. Their ages range from late thirties to early sixties; seven participants are married/common law; five are single/widowed; and all but two of the participants have children ranging from 1-4 in total. Participants identified with several different ethnocultural backgrounds; however, I have not listed their ethnicities in an attempt to protect confidentiality. Their length of employment at the Cancer Centre ranges from 1-25 years; six having worked for more than 15 years and seven less than 15 years. MSs and NUCs in this study work in five (of six) departments at the Centre. Some participants have worked in several different departments in other clerical roles over the years. All participants are members of the Hospital Employees Union, a collective bargaining union and have a college certificate or diploma, and three have a Bachelor of Arts degree.

3.2.4. Recruitment

Participants were recruited from a Cancer Centre in British Columbia. In order to explore diversity I attempted to recruit individuals from a range of ethno cultural backgrounds, ages, sex, (dis) ability, and geography. Participants were required to have worked for a minimum of one year as a MS or NUC in order to gain sufficient experience in their role in the Cancer Centre. After obtaining permission from Head's of Departments and Department Supervisor's, recruitment took place through the Cancer Centre's employee email distribution list. Based on instructions from the Cancer Centre Research Ethics Board, respective supervisors initially sent out introductory emails to MSs and NUCs informing them that they would be receiving an invitation to participate in a study by a graduate student at a university. Following these notices, I sent an introductory email introducing myself letting employees know that I was conducting a study and that I would be sending them an invitation to participate in the near future. A week later, I sent the advertisement containing the invitation to participate in the study to potential participants. This was sent to 72 staff members that included 24 MSs and 49

NUCs from 6 departments. Fourteen women were recruited over a period of two months – 9 MSs and 5 NUCs. An interview with two MSs was done together per their request. This was done at a Starbuck's coffee shop at a busy time of the day when it was quite noisy. As a result, the audiofile from the interview was mostly inaudible, except for the music and outside traffic. After informing both of the women of this, and after they declined the invitation for another interview, I let them know that I unfortunately had to exclude their interview from the study.

3.2.5.   Feminist Interviews

The selection of a data collection strategy for this research project is based on the critical interpretivist position that I take and my research objectives, which are to understand the experiences, knowledge, views, interpretations, and interactions of oncology support staff. Qualitative semi-structured in-depth interviews drawing on feminist interview techniques is used as they ensure that relevant contexts are brought into focus so that situated knowledge can be produced (Mason, 2007). Data and knowledge are constructed through interaction during an interview, and the knowledge is reconstructed where meanings and understandings are created, or co-produced, between the researcher and participants (Oakley, 1981; Mason, 2007, p. 62). In viewing knowledge as situational and in striving for depth, nuance, and complexity, in-depth interviews are conducive to understanding the social experiences and processes of participants. This is because they allow interactive talk, questions, listening, and they can give access to participants' articulations and accounts that can be deep and rich. Although structured interviews or questionnaires allow for large sample sizes and have the potential for generalization to the wider population, they cannot access knowledge that is situational (Mason, 2007). Qualitative interview techniques are better suited to deriving detailed accounts of the oncology support worker's average day at work and how that is experienced and interpreted (Armstrong & Armstrong, 1983). How knowledge is produced has been an ongoing debate between quantitative and qualitative researchers. For example, quantitative research relies on rules of objectivity, reliability, and validity in order to discover truth. If research does not follow the rules it is often criticized and dismissed as methodologically flawed and untrue (Westmarland, 2001). Researchers who work from the positivist and post-positivist traditions standardize their participation in interviews by being objective and detached so that the

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data will not be biased. In these interviews, researchers ask standardized or semi-standardized questions based on a specific agenda. Although there is communication that flows back and forth, the researcher does not share or consciously reveal their standpoint or feelings (Hesse-Biber-Leavy, 2006; Oakley, 1981; Reinharz, 1992; Westmarland, 2001). Feminist researchers consider such interviews as a site for the possible exploitation and subordination of women because they do not validate women's subjective experiences or legitimize their knowledge in their own terms (Oakley, 1981; Reinharz, 1992). One of the many aspects of feminist research techniques is to encourage and promote a reflexive and reciprocal approach (Oakley, 1981).

Recognizing the inter-relationship between subjectivities of both the researcher and the participant in the social construction of knowledge and treating the interview as co-constructive is one way in which such problems have been addressed (Hesse-Biber & Levy, 2006; Mason, 2007). This type of interviewing is reciprocal, serving as a guide to participants' account of their experiences in the social context(s) in which they are constructed and embedded rather than explicitly directing questions as in a positivist interview. Interviews that are conversational in nature, that include the subjectivity of both the researcher and participants, and that strive for a friendly and equal relationship help to reduce power inequities, and can lead to a more fruitful understanding of participants' experiences (Oakley, 1981; Reinharz, 1992). Interviews are a collaborative and consensual enterprise among women, however, in order for reciprocity and shared authority to be possible in an interview there must be rapport and trust wherein participants feel safe, comfortable, and valued (Hesse-Biber & Leavy, 2006). It is also important to take issues of difference (gender, ethnicity, class, etc.) between the researcher and participant into consideration in the interview situation. Positivist researchers usually pay very little attention to differences in the interview situation and try to minimize their effect through the standardization of questions. Qualitative researchers, on the other hand, acknowledge differences and rather than trying to minimize them, try to understand how differences affect the interview situation (Hesse-Biber & Leavy, 2006, p. 132). The traditional idea of objectivity as a viable means of measuring social knowledge is widely rejected or redefined by feminist researchers. In its place, such researchers propose the idea of situated knowledge, in which the researcher recognizes that knowledge can never be universal (Haraway 1991 as cited in

Westmarland, 2001, p. 2). Qualitative in-depth interviews that use feminist interview techniques are a valuable tool for placing women and their understanding of their experiences at the centre of inquiry; they have the ability to give presence to women's voices and experiences in their own words, facilitating the understanding of women's lives from their own standpoint. Thus, importantly, women are recognized as experts of their experience (Hesse-Biber & Leavy, 2006; Oakley, 1981; Reinharz, 1992).

3.2.6.   *Interviewing Participants*

In keeping with the principles discussed in the previous discussion, I conducted fourteen qualitative semi-structured in-depth interviews with oncology support staff. I went over the consent form with participants prior to the interview and they all signed it and received a copy for their records. All of the participants consented to the interviews being audio-recorded and these recordings were later transcribed verbatim. The interviews were conducted during non-working hours at a time and location that was convenient for participants. These included the food court of a mall, coffee shops, the cafeteria of the Cancer Centre, a hotel lobby, and one in my home as per the request of the participant. The interviews lasted from one to three hours. I developed an interview guide that began with broad and abstract areas of inquiry from which I later developed more specific questions (Hesse-Biber & Leavy, 2006). The questions were developed in line with a feminist approach to interviewing that incorporates an individual's life experiences and that accounts for how the experiences are situated within various contexts. The initial interview guide was piloted with a support worker to test out its clarity, effectiveness, and to ensure relevancy, flow and comfort. Some of the initial questions in the guide were reworded, and some were removed and replaced by questions that were more relevant. This exercise was very valuable and gave much appreciated insight and feedback. In developing the interview guide, I paid attention to feminist interviewing principles of reflexivity, which meant that I left room for participants to share their stories in a fluid and holistic manner. The guide contained a general framework for the interview but gave the freedom to pursue the questions in an unstructured order and to allocate more time to some questions than to others depending on how the interview unfolded.

Each interview began with demographic questions pertaining to the participant's age, ethnocultural background, immigration status, marital status, if she had children, her job role, training, length of employment, and employment status (full/part-time/casual). Following this, I asked participants how they experienced a typical workday. This question inspired participants to speak eagerly about their work, as well as personal aspects of their lives, and their opinions and feelings on a variety of issues and life experiences. For the most part, however, I actively listened during the interviews. In almost all of the interviews, participants asked me my perspective on certain issues. I shared my views, opinions, and feelings with them, and made a concerted effort to create a balance wherein I opened up and shared but not in a way that interfered with the flow of their stories. There were times throughout the interviews when I used probes and markers to encourage further discussion on topics that were outlined in the interview guide in order to hear more of participants' views and experiences.

In using feminist interview techniques, I have attempted to document women's voices respectfully and in a way that is true to their experiences. The interviewing techniques used offer personal and interactive communication and aid in the development of building trust and rapport in an interview, which is important when trying to find out about personal and sensitive issues. Having said that, the development of rapport in an interview can be one of the most insidious forms of deception for the researcher in that the development of trust can make people vulnerable (Homans, 1991 as cited in Koehn, 1999). The researcher therefore needs to be aware of the implications for the knowledge produced and ethical issues associated with dealing responsibly with power asymmetries. Open-ended in-depth interviews can help to reduce power inequities by interviewing collaboratively where the researcher and participant approach equality in questioning, interpreting, and reporting (Kvale & Brinkman, 2009, p. 34). At the same time, regardless of how much the researcher aims to avoid objectifying participants, and however positive the rapport seems to be, there is nonetheless a power asymmetry wherein the process of research and the interview situation tends to benefit the researcher more than the interviewee that must be acknowledged (Kvale & Brinkmann, 2009). For example, although participants may value and consider interviews beneficial that simulate a conversation between the

interviewer and interviewee, one must be cautious and aware that the research interview is not necessarily an open every day conversation between equal partners. This is because the interviewer initiates and defines the interview situation, determines the interview topic, analyzes the interview transcripts, writes up the findings, and so forth.

Although I sought collaboration and equality in this project, there were times when I was concerned that I was exploiting participants' time and experiences for my own benefit and I questioned what benefit, if any, they received. I therefore asked participants after each interview how they felt about the interview. Some of the women said that they did not know what to expect at first; some said that they were suspicious of my motivation until after the interview started. Surprisingly, however, many of the participants said that it was the first time that anyone had shown an interest, cared, or asked them how they felt about their jobs. Many said that it was wonderful to hear themselves talk about their experiences and that it was amazing how it helped them to 'put it all together' or to 'think' about how they felt and viewed their work. Several said that it was a therapeutic and cathartic experience. Although I was positioned as a researcher asking the questions, the open-ended interviews gave participants the opportunity to express as little or as much about themselves as they chose. Therefore, although I benefitted from the interviews, many of the participants told me that they enjoyed the interview and felt that they had benefitted and were happy to be a part of what they felt to be important research. This was very rewarding for me, and it encouraged and motivated me to continue this project. By practicing reflexive, reciprocal, and collaborative research and making the research process as transparent as possible, I have thus attempted to reduce any power asymmetries.

Throughout the research process, I have moved between the role of researcher and medical secretary, which has given me a view from both perspectives. With respect to being an insider with the medical secretary view my biography (gender, class, ethnicity, and so forth) gave me a lived familiarity with the group being researched. It also allowed me to use my knowledge to navigate my way around the institution, understand the rules and norms for interaction, and be aware of the everyday workings of the clinic. My position as an insider shifted back and forth throughout the research process, and there were times when I was an outsider, this position stemming from my education and role as a researcher. There were times when I felt uncomfortable moving

between the role of medical secretary and that of researcher and there were moments when I questioned what right I had to be conducting this research. During the research process there were times when I was on site that I felt positioned outside of the group, particularly after I had sent out the letter of invitation inviting support staff to participate in an interview. My discomfort (i.e. insider/outsider) is not unique; for example, nurses often conduct research at their place of work (Carolan, 2003; Pellatt, 2003). This raises ethical issues that I will discuss later in the ethics section of this chapter. Despite these positional ambiguities, it is important to remember that researchers are a part of the social scene they are studying and must be acknowledged as such (Hammersley & Atkinson, 1995; Morse et al., 2002). Throughout the research process I came to understand that my own subjectivity is not only legitimate, it is essential to the process of analysis to facilitate making participants' voices heard and their experiences visible (Smith, 1987).

3.3. Data Analysis

Throughout this project I was engaged in simultaneously interviewing participants, analyzing the data, creating analytic codes and categories that I developed from the data, and writing memos. This is an iterative and cyclical approach that allows for flexibility in data collection and analysis, and this process allowed me to check, refine, and develop ideas and intuitions about the data (Charmaz, 2006; Mason, 2007). After the first interview with a medical secretary, I began a preliminary analysis that involved transcribing the interview, making notes during the transcription process on possible follow-up questions, reading the transcript to confirm the topics that needed to be explored further, and reading my interview notes. I made memos throughout the project about data categorizations in order to provide clues and direction for future analysis. This process helped to refine subsequent questions in the interviews as well as recognizing the similarities and differences in participants' experiences. I transcribed all of the interviews verbatim which, although time consuming, was beneficial as it allowed me to be intimately in touch with participants' words and note pauses, sighs, laughter, etc. During this process, participants were raising similar topics. If more than two participants brought up topics, I considered it a theme and noted its location in the transcripts.

After most of the interviews were conducted and the audiotapes transcribed, the transcripts were reread and the data were cross-indexed. This is a system for organizing and indexing the data according to a set of common principles and measures and allows researchers to identify themes (Mason, 2007). At this stage, major themes and sub-themes were decided on, based on the similarities and differences in the data, and they were then organized into thematic sections. Each stage of coding involved further decisions about which quotations fit with which theme. The themes of the interviews resulted from the application of my own interpretations of what was said by the participants. Interpreting the data also involved comparing experiences, identifying similarities and differences, and deciding if certain quotations were representative (Mason, 2007). In order to understand the interaction of social categories and how they manifest I used an intersectional approach to help to guide my analysis of the data. Of importance is how various intersections create a unique identity for each woman. In analyzing and interpreting the data, I attempted to make sense of participants' experiences focusing on emotional and cognitive factors looking for experiences that I interpreted to be thick, rich, contextual, and interactional (Denzin, 1989, p. 130 as cited in Koehn, 1999, p. 73). Throughout this process, I have reflexively made analytical decisions, and in describing participants' experiences, it has been my sincere intent to anchor my interpretation in their accounts and to represent their voices as true to their experiences. This process is, of course, my construction and inevitably introduces bias. Therefore, the theoretical stance that I have applied to this research problem and the reflexive accounts that I have provided throughout this thesis should be kept in mind (Koehn, 1999).

3.4. Validation of the Data

The criteria for determining credibility in qualitative research varies widely, but an important aspect is trustworthiness. In order to present findings that clearly represent participants' voices I used participants' quotes from the interviews verbatim. Although it was a time consuming process it is important to listen to the data when transcribing (Hesse-Biber & Leavy, 2006, p. 345) because apparently trivial information is crucial and a failure to transcribe it could weaken the reliability of the analysis (Silverman & Marvasti, 2008). Transcription is not a passive act, rather, it provided me with a valuable

opportunity to actively engage with the research material right from the beginning of data collection. It also made me aware of my impact on the data gathering process and allowed me to connect with the data in a manner that provides for the possibility of enhancing the trustworthiness of my data gathering techniques (Hesse-Biber & Leavy, 2006).

Member checking is another strategy that is sometimes used in qualitative research to help improve the credibility of a study and is an important way to verify the data. Participants are given adequate opportunity to review the findings and comment on whether they reflect their experiences, views, and feelings (Creswell, 2009; Doyle, 2007; Morse et al., 2002). This was accomplished in this study by summarizing the interviews, which I presented to participants giving them the opportunity to add, delete or reflect on their responses, in order to ensure that my interpretations were correct (Cresswell, 2009). Ten participants agreed to read the summary and two volunteered to meet with me in person offering further opinions, experiences, and updates regarding changes that were currently taking place at the Centre. Member checking was an important process at the time of analysis as there was the possibility that I ran the risk of over-interpreting participants' experiences – that is, interpreting through the lens of my own experience as an oncology support worker as if it were the same as theirs. Although this was a time consuming process, I feel that it was essential from both a methodological and an ethical standpoint for this type of research.

I also kept a reflexive journal as a tool to capture my thoughts, decision making, and to be able to identify factors that helped or constrained me along the way. It exposed my personal constructions of the world, my beliefs, values, and strengths and weaknesses that shaped the research process. Interpretive approaches lie on a continuum ranging from those that are more positivistic in their ontological and epistemological assumptions to those that take a more constructivist stance. Rather than assuming that I can stop my assumptions and values from having shaped the data collection process and data analysis phase as per a positivist approach, I have taken the position that my assumptions and values will inflect all that I do. My attempt to be aware of and explicate what my assumptions and values are is intended to help to ensure that participants are respected, that their identity and confidentiality are protected, and that the data is credible.

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There have and continue to be debates on how best to assess the credibility of qualitative research. According to Mason (2007), credibility in qualitative research can be assessed in two ways. The first of these is how credible one's data generation methods are. For example, were qualitative interviews an appropriate method to explore the experiences of oncology support staff? The objective of this study was to explore the experiences of support staff who work in a cancer setting in order to understand how they perceive their work and their interactions with others. Semi-structured open-ended interviews were suitable in this research because they gave access to participants' articulations and accounts that were deep and rich, helping to understand social experiences and processes. Therefore, given the objectives of this research, open-ended interviews are a valid method in exploring the experiences of oncology support staff.

The second way that qualitative research can be evaluated is to think about credibility, that is, credibility of interpretation. This process requires the researchers to ask themselves how credible their data analysis is, and the interpretation on which it is based (Mason, 2007, p. 191). The quality and rigour with which the data have been analyzed and interpreted is important in relation to the research questions and is contingent upon the findings and exactly how one's interpretation was reached (Mason, 2007). In this study, the analysis took place over a period of several months and involved reading and coding the data several times. The data was organized by theme in order to illustrate how oncology support staff experience and feel about their work environment. The intersectional approach that I used in analyzing the data took into consideration the simultaneous interactions that occur between different aspects of social identity such as gender, class, and ethnocultural background. Thus, interpretations were made based on the consideration of multiple possibilities, as well as their relation to research studies that I have consulted. Credibility of method and of interpretation must be demonstrated by giving an accurate account of the steps taken in the research process. This process requires a researcher to be reflexive, that is, recognizing that one's language is inevitably a part of the phenomenon being investigated, along with a sense of responsibility for the consequences of a particular way of representing the words and practices of others (Mason, 2007, p. 194).

3.5. Ethical Considerations

This section focuses on the measures taken to ensure that this study was performed ethically, which contributes to its credibility. Ethical approval to conduct this study was granted by both the Cancer Centre and SFU Research Ethics Boards (REB). The Cancer Centre REB required that I secure a supervisor who held a professional position at the Centre in order to oversee my research and that I gain permissions and approvals from Department Heads and Department Supervisors prior to reviewing my application. The REB approval process was lengthy; however, it contributed to my reflection as to what my ethical and moral obligations are. When undertaking research it is critical that a researcher consider ethical principles throughout in order to protect participants. Codes of ethics for professional and academic associations in the social sciences are the conventional format for moral principles and have an emphasis on four guidelines: informed consent, privacy, deception, and harm (Silverman & Marvasti, 2008).

According to van den Hoonaard (2002), ethical concerns in qualitative research often differ to those in biomedical or quantitative research; for example, with respect to issues of biomedical risk or harm. Professional codes of ethics are beneficial as guidelines to inform researchers of the ethical dimensions of their work, but some aspects of the review process may not be relevant (van den Hoonaard, 2002). Indeed, ethical guidelines are not sufficient to address or ensure good practice throughout the research process (Hesse-Biber & Leavy, 2006, Punch, 2005) as the very conduct of research is always contextual, relational, embodied, and politicized (Sultana, 2007, p. 1). Homan's (1991) distinction between ethical codes and ethical values is useful here. Take, for example, an informed consent form: by agreeing to comply with ethical codes as they are outlined in an informed consent form, the researcher is not free from moral obligation to follow underlying ethical values (Hesse-Biber & Leavy, 2006, p. 107). Homan (1991) reminds us that a researcher's moral obligation does not begin and end with the signing of a consent form. Rather, informed consent is a continuous process of review. Particularly salient are issues of consent and privacy, which Homan (1991) considers to be key moral obligations of a researcher. Indeed, it is a researcher's moral obligation to explain to participants the purpose and goals of the research, the methods

to be employed, potential harm, the voluntary and informed basis of participation, and issues of confidentiality. The privacy of participants is paramount and assurances of privacy were indicated in the consent form which I explained to participants just prior to the interview and which they all signed.

Interviews, especially in-depth interviews, are conducive to creating an atmosphere of openness and sharing which can lead to a participant openly discussing their thoughts and feelings. This opening up can make a participant vulnerable and put them at risk for experiencing emotional discomfort due to discussing sensitive work related issues, especially if they are characterized by a high degree of stress. This was a risk associated with this research, therefore participants were provided with contact information for the Employee Assistance Program which provides confidential counselling, should the need have arisen. I assured participants that they did not have to justify any questions they did not want to answer, that they could share freely as little or as much as they liked, and that they could end the interview at any time. I continued to check in with each participant throughout the course of the interview to make sure that they were comfortable with proceeding, particularly when discussing sensitive topics. They were informed that their participation in the study was voluntary and that should they decide not to participate it would have no effect on their employment. Included in the consent form were the names of persons to contact if questions or complaints were to arise (Cresswell, 2009, p. 89). Regarding the use of deception in research, I have avoided deception to the best of my ability by keeping participants well informed of the research aims and procedures throughout the interview and member checking process. And importantly, I explained to participants when they signed the consent form that ethical issues are processual rather than something that occur at one point in time (Punch, 2005).

In order to protect participants' identity and keep their interviews confidential, I have taken precautions such a using pseudonyms, changing details of the location, locking all audio-files and transcripts in a locked box in a locked cabinet, and password-protecting all computer files in order to guard against this. Codes are on interview audio-files, transcripts, and hard copy cover sheets that have the corresponding codes. Identifying information that is confidential such as participants' names, addresses, and

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phone/email are stored in a locked box in a locked filing cabinet and only I have access to these cover sheets.

In conclusion, research is not a straightforward endeavour and there are many opportunities for a researcher to face many ethical dilemmas during the research process. A researcher has the moral obligation of integrating ethics into the entire research process starting with the research problem, the research purpose and questions, during data collection, data analysis, and in writing up the results (Cresswell, 2009, p. 88).

4.   Findings and Interpretation

This chapter presents the findings from the interviews with twelve women. Each participant was given a pseudonym, as were all other individuals discussed in this thesis. The findings are organized into four major domains that are based on the interview schedule (see Appendix B). Each major domain has themes that emerged from the data and those are presented accordingly. The first domain focuses on the organization of work; the second domain identifies oncology team relationships; the third domain describes what relationships are like with patients and families; and the fourth domain highlights the emotional impact of working in an oncology setting. I conclude this domain with what participants said about their perspective on life. The findings described in this chapter serve as evidence that the work that these women do is multifaceted, stressful, that they perceive themselves to have little power and control, to engage in work that involves intense emotional labour, and that the work is undervalued and invisible.

4.1. Challenges in the Organization of Work

An overarching theme that emerged from the interviews is the challenge confronting participants in how work is organized, particularly with respect to understaffing issues and heavy workloads. Participants shared their issues and concerns demonstrating how power and authority operates in their everyday work lives. They spoke candidly about their workplace difficulties giving examples of social and organizational arrangements that are unequal and that cause low morale and poor health. The themes that constitute this domain include: *Working in the trenches: Heavy workloads; Heavy supervision and monitoring; Lack of control and decision-making; Physical health hazards; and Healthcare restructuring.*

4.1.1. Working in the Trenches: Heavy Workloads

During the interviews, both MSs and NUCs spoke of problems in their departments that were troublesome not only for those who work there, but for others in the Centre as well. They gave descriptions of departments being severely hampered by poor management, over-loaded with unfair and heavy workloads, and understaffed.

In all contexts, feelings of frustrations dominated the descriptions. Tara (MS) shares her experience of being overloaded:

> One of the biggest challenges for me in working at the [Centre] is keeping myself healthy... kind of funny isn't it? [laugh] ... that's really hard to do though when there's always someone away...We are always, pretty much on a daily basis short at least one secretary due to illness or vacation ... and though we do have really good casuals who are experienced, they're uh, not always available. When casuals aren't available ... we all take turns covering ... it's uh hard on us, on the patients, and on the doctors too ... I don't think there's enough staff to patient ratio ... the phone doesn't stop ringing, everything is urgent, and every call seems complicated ... it's really, we're dealing with people with cancer and their needs can't wait ... how do you put off a blood transfusion order, an urgent chemo order because someone is in chronic pain, or an urgent CT Scan? It is really stressful, the work just piles up ... I've gone into the bathroom many times for a cry.

The above excerpt highlights how being short staffed and overworked on a regular basis is stressful and has adverse health effects. Tara also spoke about how the stress at work does not end with her workday but spills over to her home life. Almost all of the women interviewed said that their jobs were stressful and that one of the most pressing issues for them is heavy workloads and inadequate levels of full-time permanent staff. Several also spoke about the increase in patient volume in recent years and how there just is not enough staff to accommodate the increase. Sophie (NUC) told me that her department does not have a problem with sick calls and absences, that what they really need is another unit clerk. In our interview, she questioned the fact that in any given clinic there are at least eight registered nurses and two licensed practical nurses and so many doctors, but few clerks to process all of the orders. She spoke about how NUCs have to multitask at the reception desk in the clinic, and about the difficulties, frustrations, and lack of organization:

> *I think we need actually a reception that's a reception* that can greet the patients and show them to the waiting room, instead of some ... *I had someone shouting at me once* and said that I was rude because I paged a doctor ... and the phone was ringing and of course I had to take it and said "I'll just be one minute" 'cause you can't page a doctor and then put them into voice mail right ... it was urgent too ... but they don't know that ... they just think you're rude and they shout at you and carry on and I don't blame them 'cause it is rude really... doing all that work at reception when really you should be focused on the

patient comin' in ... it's very demanding and on some days and I know not just for myself but for a lot of us we go ... when we go home we're exhausted ... totally exhausted and um, I think that goes for a lot of other people including the nurses as well (Sophie).

It is an ongoing issue for the NUCs who work there in rotations, several having expressed concern about making mistakes while processing the orders at reception because there are many distractions and interruptions. NUCs all said that the workloads were heavy and that they need more staff to accommodate the demand. Supervisors call in casual staff when the department is behind or short staffed to help with the workload. However, Kayla (NUC) said that her supervisor was told that she could not keep calling in casuals because the department was over budget. For a while, staff were doing overtime on the weekends, but some fell sick afterwards due to the stress. Kayla (NUC) said that staff have families to take care of, and all of the stresses that life tends to bring. She expresses how she feels about being overworked in the following quote:

It's just ... ehhh ... [sigh, frustrated] ... **work work work head down, work work work, you know like there's no ... and I think the workplace ... yes, you have to work**, of course you have to work, and I think we're all willing to work hard ... but every once in a while you have to also have a bit of **fun** ... or a bit of ... you know... be able to **talk to somebody** ... and say "hey, how's it going for you?" and maybe take five minutes from work, **yes you're chatting**, but hey ... and you think about how much time you spend with these people, you sometimes spend more time with these people than your family at home ... I'm lucky I don't have a long commute so ... I have lots of time with my family at home, but if people commute over an hour each way ... you get home and there's not much time with your family so ... I think it's important that you feel comfortable at work and you're, it's sort of a happy environment, and especially because it's ... the nature ... the people that come to us ... are in a stressful situation ... it's not like it's a happy place **that way**, you know ... where people love to come and they're in a good mood ... **they're stressed, they're sick, they're dying** ... [raised voice] they have to make very important decisions about their treatment and so they deserve understanding, and that we take the time to kind of, you know... accommodate their needs and understand where they're coming from.

Kayla's expression reveals the reality that the work environment is a place that is not always as happy and cheerful as she would like. She talks about her desire to have time to connect with her coworkers and be social in a positive manner, as well as the importance of family. The reality, however, is that in a busy Cancer Centre, there is often little time to socialize while performing work tasks. Both MSs and NUCs said that there was barely time to look up or take a break. All participants said that they considered the work that they do to be high-paced and stressful. They felt that the bulk of their stress was due to not always completing tasks in a timely manner and worrying about making mistakes which they said could affect patient care and safety. High

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workload has consistently been shown to be linked to high levels of stress in oncology staff and nurses in contemporary health care settings commonly report work overload. There has been little research in the area of heavy workloads in the oncology setting, but a low sense of control over the work environment has been associated with increased stress in oncology staff (Cashavelly et al., 2008; Glasberg et al., 2007; Grunfeld et al., 2000; Mack et al., 2003).

Although all of the participants said that their work was busy, high-paced, and stressful with no end in sight, not all felt that stress wore them down or exhausted them. One participant said that she enjoyed working with people, being busy, and that she enjoyed what she referred to as *the challenge of being run off her feet all day*. This highlights what Wainwright & Calnan (2002) point out about how work stress does not reside exclusively in the objective characteristics of work or in the personal attributes of the individual. Rather, it is in the relationship between the two, a relationship that is mediated by subjective interpretations and appraisal.

For those who said that stress affected their health and spilled over into their home lives, some of the physical manifestations affecting their health include musculoskeletal pain, carpal tunnel syndrome, repetitive strain injury, sore backs, headaches, high blood pressure and heart disease, cancer, and insomnia. Mental symptoms include things such as feeling burnt out, exhausted, worried, angry, sad, depressed, and reflecting frequently on their own death or that of their loved ones. These findings correspond with the literature wherein multiple health outcomes have been linked to female clerical workers' work-related stress appraisals and coping strategies, and work environments (Long, 1998; Long et al., 2008; Morris & Long, 2002).

Participants said that their employer has on occasion distributed pamphlets on how to handle work stress and on rare occasions remind them that they can make an appointment with a counsellor at Patient and Family Counselling. This is a service that is provided free to all staff, it is located off-site, and is anonymous and confidential. Some participants spoke about using this service, mainly to talk about their work conditions as well as problems in their private lives. One participant said that assistance should be provided for work related issues on paid time, not after work. Opinions were raised by two women regarding the pamphlets on stress, both who criticized them saying

that they were offended by the images that showed sketches of women stressed on the phone as they were yelled at by patients, holding their heads, with a pounding and racing heart, among other things. The solution in the pamphlet was to take a step back, breathe deeply, and walk away from your workstation for a few minutes. It was felt that they were insulting and ridiculous, that in the heat of the moment when things are difficult on the job, it is almost impossible to follow those recommendations. One of the findings in this study was that staff disparages and resent management and the Health Authority that oversees the Centre. One woman said that they are distant, controlling, manage things poorly, and waste money (the pamphlets were viewed as a waste of money).

Several participants said that they have tried stress management programs or techniques and this did not help them. In fact, HEU points out that employers frequently rely on stress management courses to teach employees how to handle their jobs better. More specifically, management often blames the worker for their job stress arguing that the employee is responsible for their stress. Unfortunately, the employer's attitude of blaming the victim is all too often expressed in society (HEU, 2000). Overall, participants felt that hiring full-time permanent staff would help to alleviate their heavy workloads and high levels of stress. Although many of the women interviewed put the blame on budgetary constraints, management and the union were viewed as unhelpful and not advocating for them. Overall, department supervisors were perceived as powerless with respect to hiring more staff, and most participants stated that their supervisor had little authority or power with respect to decision-making and budgetary issues. Participants were aware of economic constraints within the health care system, but they did not discuss them with respect to the larger factors at play such as the political economy.

4.1.2.   *Heavy Supervision and Monitoring*

Oncology support staff are heavily supervised and monitored not only by their department supervisors and management, but also by the oncology team. Their whereabouts must be known at all times, the all-pervasive gaze watching their every move and action. They are always visible, out in the open, and there is never privacy.

Rachel (MS) told me in our interview how she feels about always having to tell someone where she is going:

> You know how it is ... asking your partner if you can forward your phones to her so that you can go to the loo and take wee ... I mean, it's humiliating to have to do that really ... and ah ... yah [sigh] ... when I think about it it's kinda stifling ... it's like begging in a way isn't it? Or, can I go pee now Mommy? I guess I'm used to it really, but I've never liked it ... there's no freedom to just move around and feel relaxed, you're always worried that you're dumping your work on your partner or that you might miss an important call ... and then when you get back you've got all those messages your partner's emailed to you to take care of anyways ... and let's face it, when you're covering two phones, calls always go to voice mail anyways [laugh] ... so it's kinda ridiculous.

For years, secretaries have had the telephone partner system where they are teamed up with another secretary who is responsible for answering her partner's calls whenever she steps away from the desk. This includes when her partner arrives late to work or leaves early. This adds extra work because as any secretary will tell you, the phones are busy. Management said that employees whereabouts must always be known in case a doctor or resident is looking for them or there if a telephone emergency. In fact, physicians expect that their secretaries will be at their desks throughout the day except for running the odd errand around the clinic. They do not like it when a call falls to voice mail or when a secretary takes too long to pick up the messages from her voice mail.

MSs spoke about how they felt controlled by supervisors and management and that surveillance of them was ongoing. One form of monitoring that takes place is through email usage. Support staff, especially between secretaries and physicians, use email. This is a preferred form of communication, including most patient related correspondence, and everyone is expected to see, read, and respond to email in a timely manner (often within an hour). Jillian (MS) explained:

> Physicians will often request things to be done in an email, and if [you are] busy, on the phone, or juggling a myriad of tasks, it's not always easy to get to email promptly ... everyone is keeping track of everything, and there's always someone there to point out what hasn't been seen or tended to.

Amanda (NUC) said, "we are not understood, respected, or appreciated for all the hard work we do." When I asked Sophie (NUC) if she thought that her work was understood and appreciated she said:

> No, they don't understand ... they actually need to come, sit, and watch us. Actually it's funny my boss came around once one time ... 'round at lunch time, and **you know how**

> *we're really really busy busy mad mad mad* and then it's lunch time [and] everybody's gone for lunch, [well] one of the other girls I work with called [management] to see if we could get extra help because it was really really busy, and [the boss said], "Oh, it didn't seem that busy when I was just walking past" ... it's like, "*Hello, it's lunch time*," so they're really ... they don't really know ... the clinical director should come and sit with us for a week ... better yet, she should answer the phone for a day ... making decisions behind closed doors in management meetings doesn't really help.

There were similar feelings echoed by other participants who felt that management, supervisors, doctors, and nurses should walk a mile in their shoes to gain some understanding of their work. Many participants shared their feelings of anger and resentment, and they spoke about how they have become defiant and harbour feelings of retaliation. Several women articulated how some staff exert their resistance by verbally undermining management, calling in sick regularly, coming in late, leaving early, taking long breaks or taking weeks off at a time. In response to the high rate of employee sickness, participants said that new policies regarding sick leave have been implemented which they view as violating their privacy and monitoring and controlling them excessively. Employees are required to meet with supervisors, management, and the union to discuss their absences that are calculated according to percentages, and if they go over a certain percentage, they are told that disciplinary action will be taken. One participant said that in a meeting with management she was asked if she had specific mental health or physical issues that impede her ability to attend work regularly. She said that she felt that her privacy rights had been violated. There is only so much information that an employee is required to reveal to the employer, and one woman felt that several of her coworkers were not aware of their rights. Kayla (NUC) said that this system is unpopular with the NUCs in general, and that many of them feel that management does not trust whether they are really sick or not. This is what she had to say about feeling gazed upon:

> [It's like] *we're watching you*, don't you dare to be sick more than two days a month or whatever it works out to be, I don't even know what it works out to be, but ... *Who comes up with these ideas?* ... like who, where does this all come from? ... because we don't really know ... it's a bit like *Big Brother is watching* (laughing) sometimes I feel that way because you don't even know *who is out there*. I know my immediate supervisor, I know the next one ..., and then it already becomes a little obscure right? Who is out, who is above that and who actually makes up these ... who comes up with these ideas? (Kayla, NUC).

Other interviewees also discussed the sick leave process, for example, Sarah (MS) reflected, "it is difficult to get time off to go to a medical or dental appointment now,

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and if I'm sick with the flu or something I have to fill out forms and have my doctor sign them." Alisha (MS) said that she felt harassed about her health:

> I've been fighting with management for two years now with my medical condition, they are always calling me in to meetings and cross-examining me ... demanding doctors notes and personal information, which is nerve racking ... and now this new sick leave procedure, it's such a power trip ... I feel exposed.

The message that participants gave with respect to how they perceive management is that they do not have a direct personal relationship with them, they do not fully understand how management operates, and they feel a sense of powerlessness with respect to their everyday lives at work. The relationship that they have is subordinate, it is from a distance – but at the same time, it is intimate. Intimate in that some participants feel that they are always being watched, as though through a looking glass, by those in higher positions who have power to make decisions on their behalf without their consent. A NUC said that management's strategy of creating a reliable and efficient worker has actually backfired in the sense that it has only created a deeper wedge and increased conflict. A MS said that it is difficult to be a clerical worker at the bottom of the organizational hierarchy where there is little control. Most of the women said that it is stressful to be watched all of the time, and that having no freedom and always being scrutinized was the cause for resentment, anger, and anxiety. Many said that feeling powerless makes them feel mentally exhausted and physically sick.

4.1.3.   Lack of Control and Decision Making

Participants articulated that they did not have control over their work or job tasks and said that it was a significant factor for their stress. One way that a lack of control was experienced by MSs was through their involuntary relocation: Having doctor/secretary groups changed without explanation. Rachel (MS) explained:

> I came into work one day and after so many years of dedicated hard work working with my doctor group, I was taken aside by my supervisor and told that I was no longer going to be working with them ... I was just shocked, it was like my heart stopped right then and there ... I didn't even know what to say, my head was spinning. I thought I had a good relationship with my doctors and that they were happy with me, **but I guess I was wrong**. When I asked why I was being switched to another doctor group, all I was told was that I needed a change, that the desk was too busy for me ... I was so disappointed, I went home and cried and cried, and to this day I still have a bad feeling in my stomach about it. I still don't know why that happened.

MSs and NUCs both said that there were many times that they were not informed about decisions that had been made regarding changes that would affect them directly. Chloe (MS) said:

> In our department we don't have secretary meetings, uh ... we haven't for years, none of us get to express what our problems and concerns are, and even if we did, no one would care ... all of the decisions for us are made behind closed doors.

Participants said that they are excluded from meetings and therefore cannot give input, make suggestions, let alone have their suggestions implemented. Megan (MS) said that she has worked at the Centre for years and has a lot of experience and insight that she could share with upper management, or even her supervisor, but she has given up trying to do so because it is never taken seriously. By being excluded from meetings where decisions are made for staff, these participants feel that management is creating conflict and resentment. Support staff know their job extremely well, and they take pride in the knowledge they have, but not being able to convey that knowledge so that it can improve processes in the clinic makes some of them feel deflated and degraded. Amanda (NUC) put it this way:

> I've got my opinions on how these processes can be changed **and they asked me for my opinions** ... we'd like to see what we could do better ... I gave them, over a year and a half, I gave them **tons of things**, they never implemented **one ... nothing** [but when you do give] an idea to a supervisor ... they take credit for it mostly because they have to implement it, you can't implement it you're a ... you're a clerical worker, you can't actually implement a process change in your department so who would do that, the supervisor would do that so then the supervisor gets credit, and they **never say** "Amanda came up with these ideas last year we just didn't know how to change them" or something like that ... like **give me some kind of credit**.

This excerpt illustrates Amanda's disappointment and frustration for not getting the recognition that she feels she should have for her ideas. It shows how important it is for staff to be recognized and appreciated, to feel that their experience on the job is valuable and meaningful. However, unfortunately participants do not feel that way. Alisha (MS) said that it bothers her deeply when physicians have meetings and decisions are made and implemented that affect the MSs work without their prior knowledge. She said that there are occasions when the supervisor will send the MSs a group email informing them of procedural changes that affect their everyday routines. Participants said that they know their jobs extremely well, they know the problems with the system, and they are valuable resources in making suggestions for improvements. Several stated that they could not understand the logic of not being included in the

meetings and asked their opinion on matters directly related to their work. Many of the women spoke about how they personally do not feel that it is safe to question management's decisions or to offer suggestions for fear of being reprimanded. Overall, management was perceived as being authoritarian, as sending orders *down* from *above* without knowledge or regard for the workers. It was felt that decisions were made on their behalf behind closed doors, and that most of the decisions clearly were not made and implemented with a working knowledge of the work that they do. The examples given in this section highlight how participants have a lack of control and decision making power in their work. The lack of control and decision making in support staff parallel the findings from the literature that state that clerical workers have little control over their work (Cohen & White, 1986; HEU, 2000). This has been found to be the most important cause of stress-related health problems (Landsbergis, 1989; Marmot et al., 1999; Wainwright & Calnan, 2002).

4.1.4.   *Physical Health Hazards*

Concerns with physical environment also emerged as a theme. Participants described being situated in uncomfortable, cramped, and noisy workspaces, with poor building ventilation, poor lighting that led to eye strain, and outdated equipment and computer programs. Many said that there was minimal relief from interruptions and few means to avoid the gaze of others or to take a break. Megan (MS) said, "we are like grand central station of the whole place, everyone congregates around us, there are constant interruptions, asking us for things, demanding things, it's really hard to get work done."

Many expressed concerns about inhaling photocopy and fax machine toner, and inhaling fumes from chemicals used for cleaning which caused coughing, nausea, nasal congestion, and dizziness. Several women said that they suffer daily from muscle strain in the neck, shoulder, back, or legs, which they attributed to sitting at their desks for long periods, talking on the phone, and looking into the computer. In fact, several participants said that they have back pain that has resulted in extended leaves of absence. Although both NUCs and MSs spoke about ergonomic problems, the NUCs had more of an issue with how their workspace was set up. Kayla (NUC) said that the recent new clinic that opened was a real disappointment for her:

> I was very disappointed when the clinic opened, those desks they put in for us they are useless, and I couldn't believe it, like this is brand new right? There's no, like you cannot have the chart in front of you and the computer there so you can look straight on, always this ... so you're twisting and turning because there's no space, the desks are so shallow and the computers are supposed to be wall mounted but they didn't end up being wall mounted so they're sitting on the desk and that takes up quite a bit of space. Even though they're flat monitors, but still, and so we have to have the chart on the side and your keyboard is here and there's no room to put the reqs and its like, and this is a new office ... I was so disappointed ... the system is so frustrating, and it's always, or often it's the same issues that come up, it's the same thing ... who comes up with these ideas?

This quote is another example of having no control or ability to make decisions in ones work. It is placed in this section though because it also highlights the difficulties Kayla has with the particular physical set up of her workspace. Nicole (NUC) echoed what Kayla (NUC) said, adding:

> ... the ergonomic assessments I don't think ... they would agree you know ... you're writing sideways ... monitors are just way too close into your face and it's not adjustable, like you know, we have different heights, we do not have desks assigned to us ... I get sore neck and headaches, and my shoulder pains too, it's hard.

Unlike the MS's who have their own desk that they sit at daily, the NUCs rotate in the clinic and sit at different desks depending on what task they are assigned. This means that they have to regularly adjust chairs and get used to the room, the reception desk, or one of the stations every time they move around. A common complaint was a lack of space, Pippa (NUC) said, "it's just so cramped in our work area ... people are talking, coming and going, it's just too noisy." Amanda (NUC) concurred:

> It drives me crazy to have to sit in that teeny little room [with other staff] ... it's hard to hear, they talk loud, the doctors come in talking with their demands ... it's inhumane to pack us in there like that and expect us to do our work.

Noise was a particular problem. Alisha (MS) who also shares a very small room with other staff commented:

> When patients call in and have pain, or are crying, or need a triplicate for morphine, and I need to take down the information accurately, I often have to plug my other ear to try and hear, especially when [others are] on the phone and talking loud.

Participants all had concerns about their physical work environment but they were acutely aware of the fiscal restrictions such as decreasing operating and capital funds that leave little to no money for purchases or renovations that would ameliorate such problems. Researchers have demonstrated conclusively that stress levels vary depending on the organization of work, the physical and social environment in the office and the economic status of the worker (Cohen et al., 1989). Having said that, HEU

(2000) states that "physical hazards are no longer the leading cause of workplace injury and illness - today, healthcare workers are more likely to be hurt by jobs that are designed poorly, have poor management practices, and top-down power structures" (p. 7). These, along with the effect of broader socio-economic shifts such as the political economy, are oppressive and subjugating to female clerical workers. That the women in this study have a powerful union that represents them is a positive factor in their employment. Their wages for their occupation are higher than those in similar non-union jobs; they have benefits, and pay into a pension fund.

4.1.5. Healthcare Restructuring

All of the participants spoke about healthcare restructuring and downsizing across the Health Authorities. Participants said that jobs are being deleted and positions that were once unionized are being privatized. Alisha (MS) said that approximately 70 transcription positions at local hospitals have been deleted in order to save millions of dollars. Apparently, some positions in the Health Records Department at the Centre have also been deleted. Alisha expressed concern that transcription jobs could be outsourced to overseas countries where quality standards in medical transcription services may be lacking, thereby affecting medical records. Concern was expressed regarding how safe, private, and confidential medical records are, and are going to be in the future. Alisha feels that although deep cuts have already been made over the years, she said, "it is the beginning of the storm ... further cutting of jobs and outsourcing will continue." Her concern is backed up by HEU who issued a news release that was circulated to all members stating that "a plan by Lower Mainland Health Authorities to contract out all medical transcription services threatens to put the confidentiality and accuracy of patient records at risk" (HEU, 2012). In March 2012 "Health Authorities issued a request for proposals to contract out the work of more than 130 medical transcriptionists" (HEU, 2012, p. 30) in several areas of BC. HEU says that this proposal is due to a shortage of medical transcriptionists and failure of Health Authorities to fill vacancies with qualified staff. They also say that such a move "transfers control over the accuracy and confidentiality of sensitive patient records to a private contractor" (HEU, 2012, p. 30). The privatization of medical services means lost jobs and protection for workers and medical information.

Participants expressed that women in the Cancer Centre where this study was conducted have lost their jobs when employees with more seniority have replaced them. This occurs because employees either at the Centre or at other hospitals either lost their job due to downsizing, or were displaced themselves. Job security is not guaranteed and many workers are on alert after the HEU strike in 2004. This strike emerged as a theme in the interviews, with all of the participants bringing it up and speaking about it at great length. There were no differences in perception or attitude among participants regarding the outcome of the strike. Participants felt that they are still recovering financially from it and that the low morale that it created among employees is still present. These findings concur with research that found that the strike created low morale among employees, a lack of loyalty and commitment, negative effects on quality of care to patients, low recruitment and retention rates, negative effects on personal finances, and negative effects on the family life of the health care workers (Darcy, 2008; Gillespie, 2007; Lee & Cohen, 2005).

Nicole (NUC) said that she still clearly remembers going on strike and picketing for two weeks:

> I remember as if it were last week picketing and fighting for our rights, that was a really scary time, but it was amazing how strong union solidarity was ... I really thought we were going to have a general strike in the province and I was so excited ... but then after that hideous and disrespectful deal was made behind closed doors I'll never respect the union again ... they should have gone to jail for the cause in my opinion, that would have shown a true fight for rights and equality... that really upset me and I think it deflated and demoralized everyone.

Nicole's reference to the strike demarcates a critical turning point for staff, noted by several participants. Jillian (MS) said, "I remember just after the strike staff in the Centre were in shock, some workers expressed a lot of anger, some cried at work, and a friend of mine booked off on medical leave." Hospital Employee Union members experienced disbelief, feelings of betrayal from the union, employer, and government (Gillespie, 2007). Chloe (MS) spoke about how cutbacks in health care have added stress and low morale among staff:

> I think maybe a big change was when we were on strike and they cut our wages back right, that really caused, because that was a significant amount, a very significant amount, it's not that we could say OK I am just not happy my salary was cut, it was way beyond that ... and I think it put a lot of stress on a lot of people, financial stress, and people, some people I know had to go out and find another job, so they're doing a second job on the weekend ... or working a few hours in the evening ... well how is that gonna help the

system? Right? When somebody brings it up *it still makes me so mad*, and that's how many years now [raised voice]? It definitely has lowered morale among staff, we work so hard and this is how we're treated? We were already worth more, but instead of being rewarded we got humiliated and exploited ... I just ... like it's not like I'm thinking about it every day, or you know, almost every week it comes to my mind, but when somebody brings it up it just, uh, (sigh) ... we're just not valued or appreciated for what we do.

Megan (MS) expressed similar sentiments:

It made me feel like I was worth nothing ... all those years of hard work and dedication to be treated like this? And although I would say that my wage and benefits are good considering my education level and position, it is still low and not enough to get by. I have kids and the cuts really affected me, I mean I have a mortgage, bills to pay, after the dip in wages I've taken up a second job on and off, it's exhausting, but I have to make ends meet.

Participants had common feelings of degradation and some said that either they, or someone they knew had to take on second jobs which further influences work-life balance, stress, and health. When workers are stressed and tired they are more likely to fall ill, call in sick, and thus everyone is ultimately affected.

4.2. Interactions on the Oncology Team

Patient care requires the work of several staff members who play various different roles. A key aspect of the everyday work of support staff is teamwork, which involves a considerable amount of communication. Themes in this domain that emerged with respect to team interactions include: *Roles and division of labour; Interpersonal relationships with coworkers and physicians; and Lack of value and recognition.*

4.2.1. Roles and Division of Labour

The oncology health care team consists of individuals with different levels of training and expertise that perform very different roles. Most MSs and NUCs are women, indicating a gendered division of labour and thus gender inequity. MSs and NUCs are situated at the bottom of the team hierarchy and their role is subservient in the support of professional staff. Generally, physicians, nurses, and social workers are considered the most important members of the team because they are professionally trained to provide direct patient care. However, support staff are also very much part of the oncology team because, without them, professional staff would not be able to carry out their tasks. In fact, many important roles that workers fill are essential in order to

deliver patient care. These include health records clerks, admitting clerks, radiation therapists, and others. NUCs and MSs interact with these members of the team daily. Participants nonetheless reported primarily interacting with MSs, NUCs, physicians, and nurses in the course of their daily work. Most participants described the division of labour wherein the physician makes medical decisions regarding diagnosis and treatment, nurses determine the patients' physical and emotional care, MSs provide direct support and coordination for oncologists and patients, and NUCs book and coordinate chemotherapy, radiation and other necessary treatments or tests. There is, however, an overlap in duties for all members of the team. Staff perform a myriad of tasks that often go well beyond their job descriptions. For example, MSs said that they frequently perform personal tasks for physicians that are not in their job description. The role of secretary, as Wichroski (1994) points out, is as ambiguous and uncategorized as that of a homemaker with much of her role unnamed and unclassified (p. 34). Megan (MS) provides a glimpse of some of her tasks:

My primary responsibility is for the patients. I work directly for my doctors, they are my boss and I do whatever they need done, mostly patient related, but I am also responsible for doing their administrative stuff too, which can be pretty much anything, including taking personal calls like from their broker, spouse, travel agent, interior designer [laughing] ... I also book appointments and tests, when I think about it, my job is complicated and involves a lot, but it is mainly involved in coordinating patient care like helping them find accommodation if they are from out of town, informing them about resources in the Centre and the community, giving them information about their treatments and what to expect, and I spend a lot of time listening to patients problems ... uh ... and acting almost like a counsellor or social worker ... except of course I'm not [smile]. When things get too complicated I refer them to the social workers whose job it is to provide emotional support and help them with social problems ... but there is a lot overlapping that goes on, you know, especially the emotional stuff, so ... I kinda do a bit of everything really... but primarily I would say that I am the link between the patient and the doctor ... but we have to communicate and interact with the nurses, pharmacy, health records, the unit clerks ... we're pretty much who everyone goes to when they need something.

As Pippa (NUC) said:

The main aspect of my job is booking chemotherapy treatments and any test that a patient needs. I also book follow-up appointments and tests at outside facilities. We work close with the doctors and nurses because we are who they come to when they are in the clinics seeing patients. We do pretty much whatever they ask us to do, mostly has to do with patient care, getting reports urgently, calling for the chart, booking appointments, that kind of thing ... the doctors are like the boss of everyone, their job is most important ... they diagnose and treat and do symptom management, the doctor is the one who is responsible for the medical management of the patient, and uh, the nurses they uh, they are mainly responsible for carrying out some of the treatments, like chemo, as well as the physical care, but they do a lot of emotional work too, I've seen them spend a lot of time talking to upset patients, or explaining things to 'em, the nurses take the time with patients ... we of course work around the radiation therapy unit clerks, and often we have to coordinate chemo with radiation so we have to coordinate with them the timing of radiation

and chemo ... we also interact a lot with the secretaries. We have to call them when there's no space in a doctor's clinic and ask where we can book a patient or if we can squeeze them in. We also have to sometimes transfer patients to them when we can't answer a question or if a patient is being too difficult. So we collaborate a lot with everyone really.

The oncology team has a clear division of labour and each member understands what their role is, as well as the delineation of roles of the others on the team. In order to provide excellent patient care, it is important for members of the team to have knowledge about the roles that each team member plays, as well as an awareness of what is going on with the patient. There is considerable interaction that takes place, with physicians sharing information and discussing treatment options, nurses calling secretaries, secretaries relaying important medical information to doctors, nursing unit clerks relaying information to nurses – everyone is relaying information to each other regularly throughout the day.

Participants said that in order to provide the best possible care for patients, it is important to have a team that functions well. Several said that there are glitches, inefficiencies, and mistakes that need to be corrected through improved communication among staff. It was felt that good teamwork requires communication, cooperation, and respect. Although some of the participants said that these elements exist in their interactions with the team, most feel that the professional staff (doctors and nurses) do not value the work that they do making their work invisible, and that there is a lack of respect towards them. When asked if they felt that the team contributed to or buffered stress, there were mixed responses. Some felt that the team buffered their stress, having someone to talk to about situations or to vent to if needed, or when others were polite, friendly, cooperative, and helpful. For those who said that the team contributed to their stress, the main reasons were due to a lack of communication, lack of cooperation, disrespect, gossip, and verbal abuse.

4.2.2. Interpersonal Relationships

This section highlights the interactions and relationships that MSs and NUCs have with their coworkers and professional staff (mainly doctors and nurses). A typical day for a support worker involves regular interaction with several members of the oncology team that span numerous departments within the Centre. There is also interaction that involves a variety of outside calls that come from sources such as

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physicians, hospitals, clerical workers, coroners, funeral agencies, outside insurance companies, lawyers, drug companies, and so forth.

4.2.2.1. Relationships with Coworkers

When I asked participants what their relationships were like with their coworkers there were mixed responses. Most said that their relations were negative and unsupportive; however, there were some who said that they had positive and supportive relationships. Overall, in analyzing the transcripts, what emerged as a pattern was a lack of trust, destructive gossip, bullying, blaming, and isolating that creates a lack of cohesiveness among workers. Despite this, participants articulated the importance of working together as a team in order to get the work done. Therefore, they make an effort to communicate clearly and respectfully. Despite efforts to be cordial, however, some participants said that there is a lot of negative interaction that takes place. Some participants said that what makes the environment toxic is how workers undermine one another through gossip. Several participants said that they feel sad, angry, alone, and alienated. A few said that they had been bullied and ridiculed and they were angry and hurt. One woman said that she had been the recipient of racial slurs and that she has overheard others making fun of certain ethnic groups. Some participants said that they felt discriminated against because of their age, that some of 'the girls' in their departments were young, immature, and didn't know how to handle themselves professionally. These differences were found to create tension and discord, causing rifts between coworkers. Pippa (NUC) spoke at length about issues she had with some of the younger women she worked with:

> Some of the girls treat me differently because I'm older ... there's quite a few younger ones now and we don't see eye to eye ... not in telephone manner with patients, how we dress ... I think it's really inappropriate how some of them come to work ... you know ... in tights or with low tops ... this is a health facility, what will patients think? I don't get invited for coffee or lunch ... and I wouldn't go if I did ... but uh, ... yah ... some of them talk to me like I am a child, even though I've been here longer.

Participants who brought up the issue of racism and ageism said that it is very much in place in the Centre, that it often takes place quietly in the form of gossip behind an individual's back. It also manifests in the form of excluding individuals, ignoring them, not being friendly or helpful, and so forth. The process of discrimination filters its way throughout the organizational hierarchy at all levels and creates a toxic work place that is stressful, and that can be unhealthy to the mental and physical well-being of employees.

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What also became apparent in the analysis of the interviews is that there is a hierarchy among the MSs and NUCs. Neither group of clerical workers seems to fully understand the others role. MSs collectively felt that the NUCs did not think critically or problem-solve and that they were constantly calling them to ask how, when, and where to book appointments. Some of the NUCs trivialize the MSs role and feel that they make more money than they deserve. Tara (NUC) spoke at length about what she perceived to be an attitude of superiority from some of the MSs:

> This is an area that I feel that the medical secretaries, okay, do think they're superior to the clerks and they treat them that way ... I've felt on quite a few occasions that that the secretaries have been short, that, you know, now that I do have a problem with sometimes. Uh, um and you know, I I really think that maybe they're overworked, they've had a bad day or they're too busy, but you know what, we're all busy and that I you know, I really find a difference there. Um, whenever I speak with [certain secretaries in a certain department] they're much better. And [some secretaries] ... they're more patient, they try to help you. [Some] medical secretaries they're like ... it's not my job, it's ... you know what I mean ... like deal with it kind of thing, and I really have a bad feeling about that ... so that's who I actually have a problem with.

There are also perceptions that have to do with the age of workers; for example, some of the MSs referred to certain members of staff as being too young, unprofessional, and not having what it takes to work in a Cancer Centre. These findings point to hierarchies among support staff, similar to Tabak & Koprak's (2007) study that identified interprofessional conflict among healthcare workers with respect to gender, age, ethnocultural differences, and a lack of understanding and sympathy. Some of the stories of the women interviewed for this study painted a picture of a social world of invidious comparison and backbiting. Individuals try to create personal identities by criticizing others, thus indirectly asserting their own individual worth and even superiority. Each individual knows that she herself may become an object of criticism, which creates an apprehensiveness of others judgements. Such a negative social atmosphere results in significant personal antagonisms between employees.

Despite the negative perceptions and conflict in the workplace among workers, there were terms such as cooperative, helpful, reliable, independent, efficient, venting, and supportive when discussing positive relationships. Terms that surfaced in discussions that touched on negative relationships were unhelpful, slacker, gossiper, brown noser, racist, bully, unreliable, uncooperative, and inefficient. When I asked participants if they felt that their co-workers contributed to or buffered stress, they felt

that it depended on the situation, the day, the mood, and so on. In response to this question, Jillian (MS) said:

> I think it helps to buffer stress ... I have found all the people in the network that I move, both in the clinic and outside in outside hospitals or doctor's offices to be very helpful, they all try to uh provide you with what you need and we are responding the same way of course.

Sarah (MS) shared her experience:

> Well, for the most part staff are pretty easy to get along with; most of them want to cooperate and help to get the job done. Most of the staff in the other departments are quite cooperative and helpful, of course … when your coworkers are reliable and efficient it makes your job easier too ... but everyone has their moments, it's not always smooth ... but it's nice have friends at work that you can trust, go for coffee and lunch with and the odd event after work ... I just wish we had more time to actually socialize, I really like my coworkers.

Most participants spoke about how, as a team, they appreciated being able to vent to each other, be it about the supervisor, other staff, patients, or families. The transcripts revealed that there was plenty to vent about, much of it having to do with the subjective feelings regarding the condition of so many of the patients who are extremely ill and suffering immensely. All of the participants spoke about venting, whether they felt supported or not, indicating that although being able to vent can be perceived as supportive, it could also be perceived as simply getting rid of tension and frustration. Participants' descriptions painted a picture of the interpersonal nature of relationships in a healthcare setting and their descriptions of how they gather to vent resembles the communities of coping that healthcare workers formed in Smith & Cowie's (2010) research. These communities were found to allow staff to share negative emotions about difficult interactions with patients, which is what participants in this study described. Several participants said that by venting to each other they were able to release negative emotions with respect to negative or upsetting interactions with patients and their families. Forming informal communities helps them to cope with the daily emotional pressures giving some relief. Venting is a way of being in the work world of women in a Cancer Centre; Kayla (NUC) said that coworkers are always venting, that it is "second nature":

> Sometimes one of the secretaries will come running down the hall after a difficult interaction with a patient, you know ... just run up to my desk ... even stand there and wait 'till I get off the phone, and and uh, just vent ... tell me the whole story unloading what's bothering her ... like after being yelled at by a patient ... could be anything, you know, the patient wants to speak to the doctor like right now ... or they want this that or the other

right now ... [a co-worker] came by one day, she was crying, a patient called her every swear word in the book ... so I tried to help, tried to console her ... and later she felt a lot better.

The participants who said that their experiences were positive spoke at great length about interactions with those in their departments, in the Centre as a whole, and with others outside in the community. They all felt that being polite, helpful, and respectful is crucial in not only getting things done, but in the quality of one's life at work. Unfortunately, most of the participants did not feel that their relationships were positive and supportive. For example, Alisha (MS), felt that interdepartmental negativity was a large factor in what she described as a stressful situation for her:

> To tell you the truth, there's a lot of negativity in this place. In fact, the most difficult part of the job is all of the negativity and crap that goes on in the department among the secretaries. There's uh, just so much gossip ... I find it really destructive ... It's just such a problem that it makes me want to quit my job at times. I can handle the patients and all of the problems on the phone much better than the gossip in the department. It just really stresses me out ... you can't trust anyone around here, I feel sad about it, and uh ... just really negative and angry too ... sometimes I wonder how [coworkers can bad mouth each other] and then go and sit in the mall ... day after day for lunch ... it's so two-faced, I just shake my head.

Megan (MS) spoke about problems she has seen for the occasional newcomer that comes to her department where the team can sabotage them by being unhelpful, rude, ignoring them, not providing adequate training, and so forth:

> We had a lovely woman come into our department and I thought she was great but I felt sorry for her because she was bullied in a way, she didn't get adequate training which I thought sucked ... no one wants to train anyone because it's more work and you can't get your work done ... so this poor woman ended up running up and down the hall ... asking questions and trying to get help. I was disgusted with my coworkers in how they gossiped about her and ignored her, they made fun of her accent and joked about her ethnicity... it was terrible. She ended up leaving and we ended up short.

Rachel (MS) said that she had been bullied, verbally abused, and humiliated by the other secretaries in her department on a daily basis. In expressing her dislike for the environment, she said:

> *I absolutely hate being there*, um, the only thing that keeps me, um, not losing it is my doctors ... and my patients, definitely not the staff, um ... it's really hurt me personally, it's um, *really really hurt me a lot*, it's um, I've left a few days, one day in tears, I was just like ... so angry and upset, um, and then I, you know, I was questioning my capability, you know ... am I overreacting, am I expecting too much, um ... and you know ... I don't think I am ... and I can't, in good conscience, be any other way than what I am, um, but as far as the interaction with staff, *I hate it* ... you don't find ... any support ... nnnooo ... no ... I'm actually shocked, I'm just like whoooaaa.

Throughout the interview, Rachel spoke about how she could not believe the lack of support or respect between coworkers. She also spoke about what she considered a poor attitude of some of her coworkers:

> A lot of times you'll hear the secretaries, you know, arguing with the patient and you know, like "I don't book the CT Scan" um, "I don't have anything to do with the chemo, you need to talk to them" and "I don't know what's going on" and you know, just, **even their tone of voice is ... rude, it's just downright rude**.

When employees are overworked and stressed, they triage phone calls as quickly as possible. In the process, polite and quality communication can be lost. Having too few workers with too high of a workflow often creates conflict on health care teams. Individuals' backgrounds vary, influencing their beliefs, attitudes, and behaviours regarding the complex interactive dynamics that take place in providing health care. It is common that health care workers observe and judge one another, and there is no one, not the doctors, nurses, or management that escape critique.

In summing up this section, some participants said that they had positive relationships with other members of the team and that they felt that they helped to buffer their stress. Several, however, reported interpersonal conflict resulting in a stressful work environment. Support staff have little status in the organizational hierarchy, which can make them vulnerable, and those who are vulnerable typically look for others who are more so, in order to bolster their self-esteem. Several support staff are isolated and pitted against one another, and this can result in workplace bullying. Bullying includes verbal abuse, threats, humiliation, and intimidation. It also manifests as accusations of incompetence, gossiping about coworkers, racist comments, age discrimination, constant feelings of stress and fear of additional bullying events, and screaming or yelling at a fellow worker in front of others to make them look bad. These behaviours, among others, can lead to demoralization, victimization, and stress for the individual being bullied. Furthermore, bullying is also present when an employee approaches supervisors and is told to work out their own differences. Interpersonal conflict among support staff should be addressed by the organization that should provide leadership.

4.2.2.2. Relationships with Physicians

Oncology support staff interact regularly throughout the day with physicians in providing patient care. The differences in the roles of MSs and NUCs create different

working relationships, expectations, and social interactions with physicians. At the same time, participants reported similarities in their relationships with physicians. This section highlights the similarities as well as differences in the following key areas that emerged in the interviews: *Disruptive behaviour; Positive relationships; Performing inappropriate tasks; Poor physician hand writing; and Perceptions of class differences.*

MSs and NUCs both experienced disruptive physician behaviour and one participant relayed an experience of sexual harassment. Participants said that it was common to either be at the receiving end, or to witness disruptive behaviour in the form of doctors swearing, insulting, humiliating, berating, reprimanding, not answering pagers, slamming office doors, and so forth. Tara (MS) said that she regularly experiences angry outbursts from physicians, especially when she pages them. She gave an example of a doctor who yelled at her after she paged him/her during a busy clinic. It had to do with a patient who was flown in from out of town for a medical emergency and there were no available beds. The doctor reprimanded her for interrupting and paging him/her in error (even though she had not), and told her that she was "stupid" and should have checked the on-call list before paging, that h/she was not on call. After uttering other inappropriate words and accusations, Tara said that the doctor slammed down the phone. She said that she was shaking and angry after the incidence and had to take a break outside of the building to debrief. Several participants spoke about being uncomfortable or afraid of paging doctors because they never knew what mood they would be in when they answered. Doctors are required to carry and answer their pagers promptly, and guidelines are in place for staff regarding when a doctor should be paged. Although most doctors answer their pagers in less than five minutes, some are notorious for forgetting them at home, not turning them on, or not answering them. When they forget their pagers, their secretaries have to send out an email to let staff at the Centre know that they do not have a pager and that if someone needs to contact the doctor they should call the secretary. This puts extra work on the secretary who supports several oncologists.

There was the perception among participants that physicians do what they want to simply because they can. Alisha (MS) referred to disruptive physicians as the elephant in the room and said:

> There's a level of forgiveness given because it's such *a stressful job* right ... and your *sooo brilliant* that we will ... overlook your inadequacies with other people and how rude you are because ... you get so much money in foundation money ... and oh, we'll overlook the fact that you swear at the secretaries every single day.

Rachel (MS) said, "can you imagine what would happen to us if we did half the stuff they do? Swearing, slamming down phones, we'd be reprimanded so fast." Alisha (MS) gives an example of a physician swearing on a day that she had to stay half an hour late:

> I heard Dr. H screaming ... a blast down the hallway swearing, using [vulgar language], really loud, talking about his/her secretary, um, telling personal things ... [it's] disgusting ... and it's like ... I didn't need to hear him/her swearing and bad mouthing his/her secretary like that ... *I've had to work with physicians who are extremely difficult and rude and they have god complexes and they just treat me like crap because they think they can* ... I think I can finally say now, in order for us to work together *I need to have dignity, I need to keep my dignity* and if you can't give me that then I think I'm finally at the age and I have the words and the tools to be able to say that now, you know, but I know that my GP cannot believe the environment that I work in and how badly we're treated.

Chloe (MS) also spoke about disruptive physicians, acknowledging that she has seen and heard them behave poorly:

> There's definitely doctors in other departments that I'm afraid of that I wouldn't want to like step on their toes ... some of them can be abrupt, but, that's just part of their personality and they've usually had a bad day, but there are some doctors outside of our department but in the Centre *that are scary and I do my best to stay out of their way! Seriously, seriously*, I mean, this is your job right, I mean we spend five days a week here, if you have somebody yelling at you every day that you come into work I mean, that's just ridiculous, I would have quit a long time ago if that was happening every day to me, it just makes for a terrible work environment ... I've never been yelled at by a doctor that I've worked for, I've been yelled at by *outside doctors* before and it just makes *you feel little* like your worth, *like your value is not there*, like you're not worth anything ... I just can't believe it, it's very upsetting. If we did that we would be put in our place immediately.

Interviewer: Why do you think they feel they can do that?

> Chloe: Probably because they're doctors and they think that they can get away with it, and that they you know, are, *smarter* in their opinion maybe they have more education they just think they're better or they're higher up on the totem pole, they're the doctor so their word *is it* ... and I just think some of them just have an attitude, that they just think that they're superior to, to the uh, support staff I guess is the word for it ... to the *peons*.

The above quotes illustrate perceptions of where support staff perceive themselves in the medical hierarchy, how they disapprove of behaviour that they think is poor, and how they think that they would be corrected immediately if they behaved similarly. Several said that disruptive behaviour causes low morale, affects patient safety, and a NUC said that she has seen a couple of clerks leave their jobs. Participants said that support staff talk about these events, or episodes, on a daily basis

but rarely bring them to the attention of their supervisors. Some participants interpreted these events as challenging, intimidating, and humiliating. Others described them as something that affected them personally, feeling that the behaviour was directed at them as individuals. These experiences are parallel to research that has investigated the "disruptive physician" - one who occasionally or repeatedly shows disrespect for others, especially those with less power (Dimitriadou et al., 2008; Leape & Fromson, 2006; MacDonald et al., 2011; Rosenstein & O'Daniel, 2008; & Shamian & El Jardali, 2007).

Although most participants said that they experienced disruptive behaviour, some MSs said that they had positive relationships with the group of oncologists that they support. When I asked Sarah (MS) how her relationship was with her doctor group, she said:

> The doctors in my department, every one of them is absolutely fantastic ... just, I've been so lucky ... each one of them I just find they're completely compassionate, um, just absolutely stellar human beings, really, I love my job, the work can be crazy but I absolutely love the people I support and it's like, I find them completely inspiring, um, because you know they're doing this, they're putting in late hours, they're calling patients at home at night, um, and still, you know, they're still driving their kids to school in the morning, and they're still having their family life and things too so, I don't know how they do it really ... and they're really aware of what I do, and they're really grateful for it.

Jillian (MS) also said that she has good working relationships with the doctors she supports. Having said that, she said that the doctors often ask her to perform tasks that she feels are inappropriate for her role:

> There have been times in which I have felt that what needs to be said to the patient should come from the doctor, not from me ... I have felt that is it is a load on my shoulder's that I shouldn't be carrying and I don't necessarily feel comfortable with that ... and I think to myself well, this person is not going to be happy, is probably going to scream at me, and this is probably why the doctor is not telling them. So, it's a very difficult because of the wonderful relationship that I've developed with my doctors over the years. I don't think it would be appropriate for me to say, "you know what um, I think you should be telling them that" because I'm not going to tell my doctors how to do their job and they trust me enough to do that, I appreciate it really, deeply I do appreciate it, other than when they know the patient is going to be not very happy with me, and they're trying to really avoid the wrath of the patient and put me on the line of fire I don't feel comfortable with that ... I just suck it up and do it and cross my fingers. One day I even told someone that was there with me, could you please stay here with me and listen to the conversation in case I need a witness? 'cause I knew how difficult this patient was going to be and I had to tell them what the doctor has said. I am sure that if the doctor was the one that was calling they wouldn't be abusive to them although they are abusive to them too, but not as frequently as they are with us.

Interviewee: Do you think that might have something to do with the hierarchical position?

Jillian (MS): Oh yah yes, ***definitely***, yup, the patients know, they know which tree to climb, or which tree not to, and sometimes uh when it's a difficult patient I ask my doctor "so how did the appointment go, was it a good appointment?" ... "Oh no he was a sweetheart" ... this was ***from the doctor, my doctor*** told me that ... so, so yes, they know that uh they cannot be, or they shouldn't be abusive with the doctors, but, if they have any frustration they, they allow themselves to take it out on us because ***we are lower in the hierarchy as you have said***. Yah, that's, that's the truth.

Jillian's example of being treated poorly by patients compared to how doctors are treated was echoed by most of the participants. Her example illustrates her subordinate position in the hierarchy of the team and highlights the status and power that physicians have. Like Jillian, there were several participants, mostly MSs, who said that physicians regularly allocate tasks to them in order to save time, or if they think it is going to be too time consuming or troublesome. For example, physicians often have their secretaries call in prescriptions to pharmacies, sign off on imaging requisitions, call patients with test results (if they are negative), and much more. Secretaries regularly bemoan having to call a patient with a message that they know the patient will be upset or angry about, one of the reasons the doctor passes on the task. To illustrate, Sarah (MS) said that it is common for MSs who work with prostate cancer patients to engage in discussions about personal issues related to bodily functions such as difficulty urinating, erectile function, and problems engaging in sexual intercourse. She said that physicians regularly ask their secretaries to call patients and relay personal and sensitive messages that some MSs feel is the doctor's role. More dramatically yet, Rachel (MS) shared in her interview that she has been asked by a doctor to call a patient and tell him that his/her lung cancer is incurable and that s/he is palliative. Such conversations are both emotionally charged and time consuming and raise some serious ethical issues. MSs do not have training or skills that allow or prepare them to convey medical opinions or to be prepared for these kinds of interactions with patients.

Such issues have been brought to the attention of managers who bring them up in meetings with doctors. This is of little value because physicians rely heavily on their secretaries for support, and they tend to reallocate whatever they can within what they consider reasonable and legal grounds to alleviate their heavy workloads. Alisha (MS) spoke about a physician that she supports describing him/her as "extremely challenging" to work for because they give her more work than many of the other doctors. She felt that this extra and inappropriate work is given to her because that particular doctor does not do his/her job and expects the secretaries to do work that they should not be doing.

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Alisha said that she (and other secretaries), are doing a variety of tasks that would be considered unsafe for patients, like writing doctors orders, and several other tasks. She brought up her concerns about this to her supervisor about physicians who have the propensity to reassign tasks to her inappropriately. When I commented to her that that was actually illegal, she said:

> Alisha: It's totally illegal ... so then when I finally uh, I had had enough of that so I brought it to the attention of my supervisor and my manager and then other doctors that I was working for and they said um, I just finally went to the Head of the Department with it and he said this stops now and he said no more writing doctors orders and that was brought up in the doctors meeting ... the problem is that everybody's **too stressed out and stretched too thin** and everybody can't give what they used to give and so because of that everybody's short and angry and they talk about what they're not getting rather than what they are getting and giving - it never used to be like this [years ago].

MSs spoke about taking on too much responsibility and not feeling comfortable with it. Several said that it takes experience to be able to juggle the demands of their work and to have the knowledge and discrimination regarding where to draw the line.

Some participants, particularly the NUCs, spoke about how they refuse to book any doctor's orders unless they are properly filled out and signed. Poor physician writing is an everyday struggle for NUCs. Kayla (NUC) gives an example that illustrates her frustration and discomfort in approaching physicians to clarify their writing on chemotherapy orders and other tests and treatments:

> The doctors have bad writing, so you can't read their orders, so you have to find them, ask them what it is, and they are really hard to approach or ask something, they get really short with you and you know they're annoyed by the questions, and it's only you know, explain your order or tell me what did you write, and they really do chicken scratch ... you're supposed to have some courses in the mind reading and you know, and to transcribe those orders, and sometimes they don't really make sense, they write something, they forget you know, you kind of (sigh) try to stand up to them but, all the levels, sometimes when you ask questions, and the answer, or the gesture, or the tone of voice, you just get you know, **you don't know that stuff like that?** Like, you can feel, that's the, there's the anger, there's the **undercurrent of judgement** kind of message.

Amanda (NUC) works in a different department than Kayla, and said there are physicians who do not properly complete requisitions:

> There **are** certain individuals who go out of their way to make our jobs difficult, for example ... [some doctors request for] diagnostics and the requisitions [are] not be filled out so we're tryin' to **chase [him/her] down** to get the requisition filled up because we can't book it without it, like for example, a CT a MRI a MUGA or anything like that [and s/he will request] for the tests but not fill out the form so we're having to chase [him/her] down, and then [h/she will] fill out the form but not fill out **what [h/she] wants done** like the site for example [is] not ... filled, so it's just that sort of like playing games ... on an ongoing basis so [staff] are having to run around trying to make sure this is booked and

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I'm trying to chase him/her down to get this booked and it's just a ***lack of respect*** really, I mean if h/she [is] writing down on the treatment order that [they want a test] I don't see why not h/she asks for that form and have it filled out and given to us right away, there's no reason why that shouldn't be done ... and I think it's just [a] way of ***making life difficult,*** unfortunately [such personalities are] sort of like, um, a power trip almost, you know what I mean? I don't think that respect is there for us as unit clerks, we're like really low on the bottom, like on the totem pole and then, you know, ***we're just a clerk, but we're the ones who are doing all of this work*** and arranging for all these things and making stuff happen for the patients ... if it wasn't for us then ... you know?

What these quotes illustrate is that there is a feeling of disrespect, judgement, and discomfort in having to approach a physician for clarification. Improperly filled out forms or forms that have writing that is ineligible creates countless numbers of calls from outside pharmacists, labs, xray facilities, and hospitals. Although the problem has been brought up in meetings, it is difficult to correct. Participants said that the issue creates inefficiencies in the system and wastes valuable time for everyone involved, including the doctors. Not only that, it is concern for patient safety because of possible delays in tests and treatments or incorrect areas being treated or examined. The irony regarding improperly filled out forms is that physicians are known for being intolerant of others perceived inefficiencies. As Sophie (NUC) said, "the doctors are perfectionists, and if you make even a typo they point it out to you ... can you imagine one of us berating them for a mistake, it just wouldn't fly." This statement, as well as comments from participants about how they would be reprimanded if they, for example, were to behave disruptively, reflects their subordinate status. Most of the participants said that it was clear where they stood – at the bottom of the hierarchy.

Some of the women said in the interviews that they thought that they were at the bottom of the hierarchy because they did not have enough education. Conversations about having little education and working among those with a lot of education led to topics that touched on class differences. These differences were felt by many to be the reason why they perceived themselves as not equal to the doctors, why they did not mix socially, and that there was a line in the sand that should not be crossed. Jillian (MS) expressed:

They are way up there in status and prestige ... they are the big kahoonas, they call the shots. The pharmaceutical drug reps just suck up to them right [laugh]? They really butter them up with gifts, fancy lunches and dinners, I'm always booking my doctors in for lunch meetings at nice restaurants ... they get a lot of perks. They go to big fancy conferences around the world, travel first class, stay in five star hotels, all paid for ... they go on sabbaticals ... have big research money, train residents, most are profs ... oh, and they get parking here too, something I could definitely make use of. I can't imagine how

nice it must be to live such a life and uh, be so admired, sought after, and uh, respected.
... I think we should get sabbaticals too. I guess all those years of education pay off.

I asked Tara (MS) if she ever socialized with the doctors or engaged in every day friendly conversation. She said:

> Doctors don't mix with the support staff, mind you, I've seen a few affairs that have resulted in broken marriages ... but usually they'll just say hello, sometimes they'll ask you as they run by how your weekend was, but for the most part they keep a cool distance. Some of us talk about how we're just pieces of furniture, present, but not really. We're there when they want something done. I've worked here for years, and the doctors pretty much only talk to us when it's work related.

Megan (MS) commented on lifestyle differences between herself and the doctors:

> A lot of the doctors are hoity toity ... take Dr. B, I heard her say one day to one of the other doctors she's a gal like me from [an expensive neighbourhood] ... really? Whoopty doo ... A lot of the doctors live in [expensive neighbourhoods] in big houses ... they drive Porsches, Mercedes, ... look at where most of us live, and we drive average cars or take the bus ... most of their kids go to private school ... not like mine ... they have nannies, I wish ... and many take awesome vacations to Europe and they stay in expensive places.

Pippa (NUC), said that she feels like she is invisible physically:

> You know, I've worked here a long time now, and, and most of the doctors **know** who I am, but they are so rude, so strange, you say hello to them when you pass them, and they most often don't say hello back, like they didn't even see you there or hear you greet them ... I wasn't brought up to be like that, and I can't understand it. So many times I've said hello in passing them down the hall, in the elevator, stairwell, outside on the street or in the mall, and most of them barely whisper a hello back ... they just ignore you and keep going. It's like they've never seen you before, don't know you at all ... so I've stopped saying hello to them.

Participants described social interactions with doctors that pointed to class differences and social stratification. One MS expressed that being at the lower rung of the hierarchy was "palpable." Physicians are considered to rarely engage in friendly conversation with support staff. MSs spoke about differences in material rewards and social lifestyles. Some participants said that they have compared themselves to physicians, which produced negative emotions when they thought of their own struggles and difficulties. These accounts resemble findings that have shown that income inequality and low status, among other factors, can create negative emotions, which can cause ill health and premature death (Krieger, 2005; Raphael et al., 2006; Sapolsky, 2005; & Wilkinson, 2000). Several participants said that they were aware of the difference in status and privileged position between themselves and the physicians. The social stratification in a hospital is organized where the work features a high degree of

interdependence between workers who have different ranks within and an extremely different social status outside.

Class divisions in the medical hierarchy have elements of what Acker (2006) refers to as "class controls," a term that she uses to describe how organizations use control. Class controls are directed at maintaining the power of managers, ensuring that employees act to further the organization's goals and accept inequities in the system. On the level of staff interaction, the findings in this study reveal class differences between members of the health care team in terms of status, prestige, money awarded for work done, quality of living, style of communicating, social networks, opportunities, and much more. It seems that the occupational hierarchy is a gap that cannot be bridged, and it appears to promote conflict. Many of the women said that being at the bottom of the hierarchy rendered them invisible, having no voice, status, value, or respect.

4.2.2.3. Lack of Value and Recognition

All of the participants reported that the work that they do is undervalued and not recognized. They referred to it as being invisible, which is known in the literature as *invisible labour* – that is, the work that they perform is not apparent to employers and/or clients (Adams & Welsh, 2009; Armstrong et al., 2008). Participants said that much of the work that they do is not seen and there is a lack of recognition as a result. Akin to the findings of Hall, Stevens, & Meleis (1992), participants in this study perceived themselves to be at the lowest strata of the organizational hierarchy in which they work. They said that they often feel patronized rather than consulted or listened to by the doctors and nurses they work with. They also do not feel appreciated or respected. In parallel with Cashavelly et al., (2008) the support staff interviewed felt there was inadequate recognition of and value attributed to their work. This suggests that support staff are not included or recognized as oncology team members. Tara (MS) expresses how she feels about her work being invisible and unrecognized:

> I didn't know it before, but I know it now ... [our work] is the essence of human beings, it is our essence and nobody sees it, it cannot be quantified in a written ... in our job description, you know, it's not even there right? 'cause if you look at the job, it's all about the clerical, the paperwork, the typing ... like our job descriptions don't state what we do ... none of it says telephone work, or deep conversations, or listening to crying patients ... that's not listed ... it's not valued, it's not seen, in some instances and in my instances it is pushed down, that's what I feel like they are doing to me ... pushing me down, like I'm

getting shorter and shorter ... 'member I said I was starting to not value what I was doing because it didn't matter?

Sophie (NUC) said that her work is invisible until something goes wrong. She said, "the Centre wouldn't run if it weren't for us, yet we aren't recognized for our hard work ... even our bosses, even our immediate supervisors don't know 'cause they never come and sit with us." Nicole (NUC) echoed the same sentiment saying:

> No, they don't understand and value [management] what we actually do ... ***they don't understand how much stress is put on us***, definitely they don't understand that and they don't understand our processes, like how we work as [a clinic], the demands from the patients ... they don't deal with patients on a daily basis the way we do, or the time and effort and energy we put into the complex bookings that we do ... the higher levels ... I don't think so ... from the perspective of being here so many years ... ***I don't think so***.

Kayla (NUC) said that there are many moments throughout the day where she feels degraded due to being interrupted regularly in order to help either a doctor, a nurse, or any other team member. Some of the MSs said that the doctors and other professional staff did not value or understand how hard they worked or the emotional intensity and effort required in speaking with patients and families. Participants indicated a struggle with balancing the functional aspects of their role with the emotional impact of the day-to-day work. Jillian (MS) said that support staff have to be able to think quickly and problem solve. They also require knowledge in order to know when something is urgent, an emergency, and/or if the doctor has to intervene. In many cases, they have to tell the patient to call an ambulance and get to the nearest emergency department. In being the first to receive calls that are emergencies, Sarah (MS) describes a scenario:

> A doctor will call from emergency ... you've gotta get somebody in right away for emergency[treatment] ... and all of a sudden it's like ***full on*** it's like ***boom boom,*** transport, confirmations, give the doctors' a head's up, have him get the order done, have that run [to the unit] ... so this patient can be seen in half an hour ... and that's pretty stressful ... we do a lot of ***emergency work*** where everything else ***just gets dropped***, and this has to be done, and ***it's gotta be done now and it's gotta be done right***, you know, ***you can't miss steps*** you have to contact everyone who needs to get a head's up and all that kind of stuff.

Other participants said that their jobs were demanding and required problem solving and making split-second decisions. Despite this, several staff members said that they thought that their work was viewed as unskilled and unimportant. The work of support staff is highly task-oriented; they may answer hundreds of phone calls a day from patients, along with the clerical work that is required. Many of the women said that the formal training and support that they received was based on completing clerical

tasks rather than on the emotional work that they engage in. Some felt that they do not have the training or tools to fully engage with much of the intensity that they encounter, and they do not feel that they are adequately rewarded socially or financially. Several participants said that there is insufficient acknowledgement of the emotional impact of their work in providing care for and assistance to oncology patients, indicating that the effort and work that they put in is invisible. Several women said that it is important to be recognized and appreciated not only by the doctors, but also by supervisors and upper management. All support staff expressed feelings of being worth more and earning one of the lowest salaries in the Centre. This was associated with low value and feelings of indignity. The issue of being valued was important to participants who said that they value their work and feel that their involvement in cancer care is just as important as it is for the professional staff.

4.3. Relationships with Patients and Families

Interacting with patients and families is central to the work of MSs and NUCs. For many patients, navigating their way through the Cancer Centre can be a daunting experience, and support staff help them through the process by directing them to the appropriate places, giving information about treatments and procedures and about services available at the Centre, other hospitals, and the community at large. In interactions concerning care, patients take part as actors and their communication with support staff indicates their desire for the flow of information. The support staff worker is the communication link between patients and their doctors and the primary channel through which messages can be relayed to doctors. Support staff screen and triage calls and must make important decisions about their urgency.

Oncology support staff recognized and described the importance and value of their relationships with the patients of the Cancer Centre and their families. The MSs and NUCs descriptions of their relationships with patients and their families had similarities and differences. Both said that the purpose of their work is to help patients and their families and that when patients show appreciation for their assistance it makes their work very rewarding. At the same time, both MSs and NUCs spoke in detail about the difficulties and challenges that they face daily in their interactions with patients and

families, saying that it can be stressful and exhausting. Participants gave examples of patients who are verbally abusive, anxious, demanding, and angry. Additionally, participants gave examples of interactions with patients that involve conversations about personal health that are intimate and private. Several also said that family members call frequently on behalf of patients. The NUCs said that they transfer these calls to the MSs who take detailed information and act accordingly.

The differences described by participants in their relationships with patients and their families were in keeping with the role that they play. MSs described interactions that involved in-depth conversations with patients regarding all aspects of patients' medical care, social issues (travel, accommodation, finances, and family affairs), and emotions. They spoke about forming relationships with patients and families, some with whom they have known for many years. The NUCs on the other hand, described interactions that focused more on conversations that related to appointment bookings, changing appointments, and referrals to outside medical appointments. They said that they did not form long-term relationships with patients or families because they rotated through the clinics daily which meant that patients and families calling in regarding appointments reach a different NUC each time they call. The themes that emerged that highlight these experiences include *Intimate and private interactions; Difficult and challenging interactions; and Rewards of patient care*.

4.3.1.   Intimate and Private Interactions

Participants reported that conversations with patients touch on intimate and private areas of their lives, which require communication skills that allow one to respond in an appropriate manner. Many participants, especially the MSs, said that patients call and have a great need to talk. Staff said that they have to find diplomatic ways to cut off conversations due to time constraints and knowing that they are not qualified to discuss certain matters. Sometimes, if a patient is distraught, MSs will ask them to contact the Patient and Family Counselling Department. MSs said that they feel like social workers or counsellors at times, a role that they can unwarily slip into if not alert, and for which they are not trained. Several said that it is easy to be drawn into patients' problems and difficulties because they empathize with their suffering.

It is a common occurrence throughout the day for support staff to receive calls from patients or their families regarding side effects of treatment. For patients on chemotherapy, some of the side effects that they call about have to do with vomiting, severe nausea, diarrhea, dangerously low blood counts, loss of appetite, fatigue, nerve and muscle problems, infection and fever, and so forth. Tara (MS) gives an example of a patient who called in with side effects from chemotherapy:

> A patient called me crying saying that she vomited all night, was too weak to clean it up ... she said that she was alone and didn't have anyone to help her ... that she had been sweating all night and thought she was burning up with a fever. She also told me that she had severe pain in her lower back, that it hurt to breathe and she couldn't stand up. I spoke to her for a while and told her that the doctor would call her back shortly ... I paged the doctor, gave the information, and left it with him.

Patients undergoing radiation therapy often call in regarding side effects such as skin changes in the treatment area, fatigue, changes in appetite, anxiety or depression, changes in sleep patterns, and hair loss in treatment areas. Some are also alarmed when skin turns black at the site of radiation. Chloe (MS) discusses a call she had from a patient who had recently had radiation treatment to her chest wall:

> I had a call from a patient who had recently had radiation, she was, uh, really upset and scared ... she told me that the nipples on her breast had turned black and that her breasts were bright red, itchy, and developing sores ... she wanted to know if that was normal and wanted me to ask the doctor what she could put on it. She was also concerned about her radiation tattoos and wanted to know if they would fade in time ... other things she talked about were her recent partial mastectomy and how she thought that her husband was unattracted to her sexually ... she wanted to know about reconstructive surgery and how long the wait was ... it was awkward, but you do your best to respond politely and give as much information as you can ... sometimes patients just want to talk.

Side effects from treatment are common, and even though patients receive information about them prior to their treatments, many of them are frightened when they start to manifest and they are at home. One of the most common things that patients call about is pain. Support staff are often the first to be aware of patient's pain. Patients in pain are taken very seriously and are considered an urgent matter. Participants perceived their role in addressing pain to include tasks that involved providing emotional support to patients, and alerting doctors, and in many cases nurses, to patients' pain so that immediate intervention can take place. Rachel (MS) said that she receives calls throughout the day from patients or family members regarding pain:

> Sometimes you know right away that a patients in pain because there will be moaning or sighs ... and some are crying, and saying they need a different medication, that the morphine isn't working, or it isn't strong enough ... I can tell really fast if they're palliative

> by looking at their notes in CAIS [patient database]. Quite often adult kids call in saying my mom is in a lot of pain all over the place, she can't sleep, she can't walk ... stuff like that. A lot of patients are bed ridden and are dying. One patient called and told me that she had so much pain throughout the night in her abdomen that she thought that it uh ... was going to split in half ... her voice low and barely able to get her words out.

Participants described several scenarios similar to the above excerpt, and said that it is important to listen to patients carefully and to let them know that you are doing so. They said that when patients call in with pain they are distressed and need to be assured that they are being taken care of. Discussions with patients about their pain are often intimate in that patients talk about their bodies and frequently about their emotions. Cancer patients have unique concerns and challenges as they move through their journey. Participants spoke about conversations that they have with patients that they consider personal such as anxiety, depression, stress, and loneliness. They also said that they talk to patients about socioeconomic issues that have to do with disruptions to work, school, family life, a lack of transportation, insufficient resources, etc. Jillian (MS) spoke about a patient that had radiation to his larynx and could barely speak:

> Some of the Head and Neck patients lose their voice, not necessarily permanently, but for a time after treatment ... and uh, I received a call from a patient who could barely talk ... you know, his voice was low, scratchy, almost impossible to make out ... I had been conversing with him for weeks ... he had a lot of financial difficulties, was on welfare, and I was trying to arrange his medical requirements through his worker ... he told me all about his difficulties, how he was alone ... some patients are really lonely ... the problems he was having with his feeding tube, how he had no money to buy the food he needed for the tube because it was so expensive and welfare wouldn't cover it ... I was really upset about his situation so I called his welfare worker and they wouldn't cover his food ... so I told the doctor and asked him what we could do to help this man ... after I did a lot of calling around and looking into things ... the doctor wrote a letter and social services ended up covering his necessary medical supplies, like the food for the feeding tube.

Patients with low socioeconomic status are forced to manage competing stressors, the stress of financial hardship and the stress of a major health event. Participants showed compassion and empathy for patients having such difficulties, making comments like, "it is difficult to see people struggle," "I can't imagine being a single mother with cancer and three kids," and "it must be hard to have to take a year off work to recover."

Along with interactions that have to do with social aspects of patients' lives, participants reported that patients call for many different reasons. Several MSs spoke about brain cancer patients calling to report seizures and unexplainable neurological manifestations that are frightening; breast cancer patients who discuss fears and worries

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about having full or partial mastectomies; prostate patients that are anxious about their PSA levels; GI patients (gastrointestinal patients) calling with problems and concerns with their colon and rectum; and so on. Participants said that they considered these conversations personal and intimate. Others said that the longer an individual has been a patient, the more likely it is that they will open up to support staff and develop trust. Sarah (MS) describes what an interaction can be like with someone with brain cancer:

> Sometimes a patient calls and has just had a seizure, or a series of seizures and their speech is delayed, it is very slow ... so I have to stop what I am doing, let the calls ring out, and take as much time as is needed to listen to the patient ... some of the brain patients have terrible headaches and severe pain, and their Dilantin levels have to be adjusted ... it can be tricky to get the meds right ... sometimes they are really scared and have ongoing issues and worries about neurological symptoms that the oncologists can't explain, so they worry a lot and sometimes like to talk a lot about their symptoms, like falling over, not being able to lift something or move a leg ... so I try to be as compassionate and help them as much as I can. Sometimes I wonder how brave someone has to be to have brain surgery and or stereotactic radiation to the brain ... it amazes me how strong the spirit can be.

Megan (MS) talks about a patient that she has gotten to know over the years:

> I've been talking to ... a patient who has had breast cancer for over ten years. It's like we're friends, but of course we're not … it's a professional relationship but she is someone who I've formed a kind of a bond with over the years … I intimately know all of her medical issues, her pain, sorrow, fears, joys … it's kind of strange to have such an intimate relationship like that with someone … some of the patients are really guarded and defensive, only wanting to talk to the doctor ... maybe that's a good thing … but [this patient] has always talked openly with me … I've shared many joys with her over the years, like every time a test comes back and it's not mets … and her family, I know all of her kids by now … I know all about them and she knows all about mine.

MSs in particular said that they had gotten to know many patients over the years and in some cases knew about their hopes, dreams, and fears. Participants said that they also interact frequently with family members who call to advocate, represent, or get medical information. MSs said that family members call requesting medical information regarding patients' diagnosis and prognosis. Of course, this cannot be given out, so the message is passed to the oncologist who often has information about family members and knows who can and cannot receive confidential information. Sometimes family members intervene and try to protect their loved ones from information they think might upset them. Kayla (NUC) gives an example:

> I spoke with the patient's son ... he wanted me to tell the doctor not to give his dad the prognosis at the next appointment because he didn't think that he could handle it ... that it would uh, you know, throw him over the deep end ... somehow I also got the daughter calling from [out of town] wanting to know her dad's diagnosis ... so you do get, several family members calling in and you have to be careful what you say.

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Support staff have to be alert regarding their conduct with respect to what they communicate to patients and families. Many participants said that they walk a fine line with respect to what they are expected to do in their role and what they actually find themselves doing in a typical day of work. The interactional dynamics that support staff have with patients and their families is multifaceted and involves communication that touches on personal troubles and public issues. Support staff do not have opportunities to attend workshops, training seminars, or conferences that discuss communicating with patients and many said that it would be helpful for them.

4.3.2. *Difficult and Challenging Interactions*

Participants shared stories that were similar to what Theodosius (2008) describes in her vignettes of nurses and the emotional work that they perform. The women in this study articulated interactions with patients that are difficult, complex, and challenging. Interactions with patients and families swing from one extreme to the other, ranging from trust and reciprocity to verbal abuse. In this section, participants describe patients who engage in aggressive behaviour by swearing, yelling, insulting, and demanding things be done a certain way. Participants said that it is extremely stressful and exhausting to have to deal with this on a daily basis, many saying that it lowers their self-esteem and morale. Several participants stated that receiving a diagnosis of cancer is stressful and often creates high levels of anxiety in patients as well as in their loved ones. Chloe (MS) said that not all patients are anxious, but many are:

> The anxious patients call repeatedly and often and they have the same questions and worries ... in the end everyone realizes that it's cancer that they're dealing with ... I try to take a step back and realize from their point of view how scared they are ... the ones that cry and are very anxious and just worried, I don't consider them hard to deal with, the ones that are aggressive and demanding, uh, those I consider the difficult patients because that just puts my back up and it just takes away my sympathy ... but yah, some of them will just demand to speak to the doctor right away at that precise moment ... and they expect you to just drop everything, and uh, they want to come and see the doctor on a specific date and time and you know, they're just very aggressive and demanding, a lot of them are, and some of them swear and are extremely rude.

It can be a difficult time in an individual's life where emotions, fears, the feeling of losing control, and severe illness are just a part of what is to come. Participants said that along with the emotional turmoil that is common in cancer patients, they are sick and in many cases suffering with pain and side effects from treatments. The possibility of losing body parts to surgery, of losing mobility, the ability to work, are all very real

concerns for patients. The young, the old, and children often arrive in wheel chairs, on stretchers, using crutches, accompanied by friends or family. Some have physical signs of the side effects of treatment and are not well. Additionally, it can be overwhelming to navigate ones way through the maze of bureaucracy, different departments, and to have to interact with several members of the oncology team. Participants said that it is understandable that patients and families are worried, concerned, and want to ensure that their care is delivered in an appropriate and timely manner. Alisha (MS) said that she receives calls throughout the day from patients wanting test results:

> I find that most patients are worried and anxious about their test results ... the breast cancer patients are really anxious about their mammo results, some of them call three, four times a day, every day ... you feel for them, you really do. Many cry, they'll tell me what's on their mind and how scared they are ... how they are sitting at home waiting and waiting ... they are often ***really demanding, and I've been yelled at many times*** and have women telling me to get the doctor to look into what's going on, or to phone them ... that is common for the patients to do that ... or they plead and beg you to hurry the process up ... but sadly there's not a lot I can do to speed things up. It can be really draining and tiring.

There are large numbers of patients being treated and tested daily, and with departments that are understaffed or have staff away, care is not always as prompt and efficient as patients would like it to be. Participants said that they explain daily to patients and families that there are waiting lists for treatments and diagnostic tests, waiting periods to get the results of those tests, and that physicians' clinics are booked full. For someone with cancer, time is everything, and having to wait is understandably unacceptable. Several support staff said that they thought that anxiety was at the root of the aggressive and demanding behaviour of certain patients. Jillian (MS) said that it takes a lot of energy to try to help and accommodate patients that are difficult:

> You really have to make a conscious effort to not let yourself get affected by the swearing or the yelling or the abuse of whoever is calling, sometimes patients, sometimes family members. Um, and still be able to provide information and be able to do your job and do it well – ***that takes a lot of effort, a lot of effort*** ... uh, um ... I've had to ask a patient to call me back when they have calmed down and I have told them that I am going to finish that conversation ... ***it takes a lot out of you***, and uh, when that has happened I hang up, on some occasions I have to leave my desk and go to the bathroom and have a good cry and uh breathe deep and just get myself collected again and go back. Sadly, it's ... ***part of the job, I think it's a job hazard***, just like when you are a construction worker, you have to use uh steel toe boots you know because that's part of the job, you may get injured ... I think we should use some sort of ... shields, emotional shields, or something, because it's part of our job.

Sarah (MS) spoke about intense interactions over the phone with patients, some who have drug addictions, mental health issues, and financial problems. She said that

she has had patients scream and swear at her over the phone, crying and telling her their difficulties, and in one case, accusing staff of not caring if they died. Sarah said that some interactions with patients are difficult and sad, at times traumatizing, and that she sometimes feels helpless with respect to helping patients. Several secretaries gave examples of extremely distraught patients who were sick and terrified of what was going to happen to them. Some new patients are concerned about who the physician is that they are going to see and will often call MSs to request a female (especially breast cancer patients) or a male physician. Some call and request to see a doctor of a particular ethnicity as this quote from Tara (MS) describes:

> A new patient called in and wanted to know what the race was of the doctor he was going to be seeing, was he Chinese, was he Black, was he Brown, was he Indian ... it made me uncomfortable getting into a conversation about race ... but anyways, I uh, I told him [his ethnicity] ... and the patient started yelling, getting all worked up, telling me he didn't want to see that doctor, put him with [a doctor of another ethnicity] and so on ... they just think you can accommodate their demands just like that ... it's so frustrating ... the new patient clinics are so full and booked up ... when I told him that his request would delay his appointment, he got even more angry ... they just don't understand ... anyways, I told him I'd look into rebooking him ... and it's not that easy, he has to be reassigned, I have to get the ok from the doctor he's booked with ... so I went into the doctor's office and told him what happened ... anyways, he uh, he said good, I don't want to see that patient anyways, I know all about him, send an email to Dr. S and ask him/her if [they will] see him.

Staff understand that patients are concerned and want the best possible care given their diagnosis, and many go out of their way to accommodate requests and do whatever they can to help patients. Unfortunately, however, time and the availability of resources limit what can be accomplished. Patients with cancer have a potentially life-threatening illness, and many can become quite upset over their care. The NUCs see and interact with patients and their families directly in the clinics, and all of the participants who are NUCs reported patients that were angry and demanding. Sophie (NUC) describes a scenario:

> We have people that get very angry...you know I had once, one lady once that **totally screamed at me**, but ... you have to think it doesn't have anything to do with me, it's because she's not well and she's just takin' it out on me right? But it's very difficult to deal with because she just stood there and just totally **shouted really loud the whole place could hear her** ... she was actually quite sick and like I think she had a little bit of a problem too ... **but you see that's what happens when you work here** you see that's what you get 'cause they're frustrated and they take it out on **whoever's there** ... but I was thinking, if I'd a been one of the younger people with not as much experience I probably would've burst into tears ... you just have to take a deep breath and realize that they're not taking it out on you ... I think that if people get mad you have to talk quietly so it kind of calms them down and all that kind of stuff ... but it is **always stressful**.

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Several other participants said that they thought that age and experience were factors that helped them handle angry or upset patients. Some participants indicated that although it is difficult and stressful, they can handle the difficulties and they do not take it personally. Others, however, do not feel that way. Nicole (NUC) shares her perspective:

> If they have a problem they scream, they yell, they call you names ... you don't really want to help them ... and you know what's behind it, but it's just, you know, treat someone with respect ... ***it's not my fault that you got sick*** ... but people don't understand ... there's the attitude, the personality, that if they have you on the phone probably they are ***more abusive***, because they know that on the phone you cannot look at them or do anything to them. They are upset over many things ... ***to the patients they are the most important in the world and there's nothing else, period***. It's very stressful ... I feel it in my whole body, I have to go away, get some fresh air, come back, we've been told to call security and I have no problem with that ... and it's not only you know the male patients, the females they are too ... or they come with extra support you know kind of do *a theatre scene* so they have someone you know ***to empower them to yell and raise their voice ... and they bring the whole stress to this place***. It's wrong what they're doing ... it gets to me just 'cause ***I don't deserve it***.

Many participants said that after experiencing interactions that were difficult or challenging, they would try to go outside for a walk to clear their heads and debrief. One woman said that difficult patients were enough of a problem that she sought outside help in the form of professional counselling. Some participants said that they do not take it personally, that patients often have bad days. Many reported that they understood that patients are going through difficult times and that they need as much support and compassion as they can get. Despite frustrations, difficulties, and challenges that MSs and NUCs experience, they also said that their work with patients could be rewarding.

4.3.3.   Rewards of Patient and Family Interactions

Although support staff have difficulties and challenges in their work, several of them enumerated the rewards of working with cancer patients. Some of the rewards are making a difference for someone, helping others, receiving recognition and appreciation from patients and families, having intimate connections with patients, and being inspired by the strength and courage in patients. Many participants said that the purpose of their work was to provide patient care and they expressed its importance by saying things like, "we are here for the patients," or "I will go that extra mile to help patients." Sarah (MS) said, "if you go out of your way to help a patient, it comes back to you ten-fold in the form of incredible appreciation." Tara (MS) expressed:

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You've got to see the patients first hand, and, you know, a lot of patients have sent me thank you cards and letters, and, I remember one patient, she ended up dying, her partner came, like two months later, and brought me this beautiful note saying she always looked forward to coming to the [Agency] because she knew you were there so she could chat ... you know, things like that ... so ... that propels you to keep going with your heart ... and the satisfaction that I got from the cards and letters and good wishes kept me doing what I was doing.

In a discussion with Chloe (MS) about what she feels is rewarding in her relationships with patients and families, she said:

When you see that the patients are going through the treatments and things are going smoothly for them and they're getting to the other side, they're healthy, and they get cured and they only come every one or two or three or five years, and they call you and say oh I got my results and they're all fine and I'm so happy ... you feel happy with them, and, the families are also appreciative, so that's very rewarding, that is rewarding when you see patients going through tough times and coming out of them and looking back and saying *thank you because you were there, and you helped, you made a difference, it was good to have you there, thank you very much*. That's very nice, that's the rewarding part.

Rachel (MS) said that she feels that she makes a difference and that it is noticed:

When you tell people you're working at [a Cancer Centre] they just think your insane, 'cause you know, you're dealing with patients with cancer, so yah, it is stressful, but it's also, it's enjoyable, I mean, I've told everybody this is the best job I've ever had ... at the end of the day you feel like you've accomplished something, that you've helped somebody, and you've done something good ... even though we're not high on the hierarchy, you know, we do put our two cents in and we do make a difference I think, and I think sometimes some patients are very aware of that, they're very thankful to the secretaries for all the help.

Sophie (NUC) articulated that the she feels rewarded by being able to help patients:

I actually had a patient the other day that came in when I was on the phone at reception ... and he was asking a question about something, his appointment or something, and he just said, and he was a new patient too, I don't know how you guys manage to deal with all these patients and all these appointments for all these days and he said I think you do a wonderful job. It's so nice when you actually get that from a patient and so I usually say well, this man said we did a wonderful job (laugh), and I tell everybody 'cause we do. At the end of the day you know you've done a good job and helped people ... and often patients will tell you, you know, you'll phone them about something and they'll say thank you that's a load off my mind ... patients do appreciate us. Even though we rotate around, we do remember patients that come in sometimes, and they often remember us ... we have a patient that comes in all the time, he is so sweet, and every time he comes in he brings this bar of chocolate ... one to us and one to the nurses.

Megan (MS) said that she has developed long-term relationships with patients that have been rewarding for her, that some have developed into quality friendships. Jillian (MS) said that although patients rarely show appreciation, she treats them how she would like to be treated:

There is a very small percentage of patients that are very appreciative who go above and beyond, who write you a nice card, say thank you so much. There is a lot done behind the scenes that they don't realize ... you don't advertise it, this is the first time I've talked about it ... you don't advertise, oh see how good I am, I thought beyond my duties and did more than what is expected from me so that things flow easy, I made calls, got reports on time, spoke to radiologists to ask them to read and dictate your scan so it is ready for your appointment ... this is what I did so that you could have a better day or that um you will save some money in travelling ... nobody sees that. ***You do it for personal reward*** because you know that if you were in their shoes that's what you would have liked.

Not all participants felt that that interacting with patients and families was rewarding. For example, Nicole (NUC) commented:

If I have a chance I would quit, yes, I would ... it doesn't give me personal reward anymore, and it did before ... definitely ... I really do not bend backwards anymore just to accommodate, because they don't appreciate, they don't know how much of my time and work is involved to go and change every appointment and try to accommodate their needs and demands.

Like Nicole, other participants felt that the challenges and difficulties they encounter are regular aspects of the work, leaving them exhausted and burnt out at the end of the day. The relationships that support staff have with patients and families is multifaceted, several stating that it is stressful and exhausting, but also meaningful and rewarding. Working in a health care facility where people are critically ill is socially and psychologically complex, and subjective feelings about an issue or a situation can and do change. In the next section participants share their emotional experiences, bringing to life the emotional nature of oncology work.

4.4. Emotional Work

Oncology support staff are exposed to the physical and emotional aspects of illness on a daily basis. In order to carry out their tasks in a professional and efficient manner and remain composed on the job, they have to manage their feelings. This is important in a health care setting because there is a need to face and deal with taboo areas such as pain, feeling exposed and helpless, weak, and in discussion of death. There is a great deal of emotional work involved in being reassuring and providing empathetic and compassionate care that is often taken for granted. Participants used terms such as empathy, compassion, and sympathy to describe their work and said that these qualities are required for those working with cancer patients. Several of the women used the phrase *I put myself in their shoes*, indicating that they treat patients and

families how they would want to be treated. The themes that emerged in the interviews include *Empathy and compassion; Coping with death and dying; Emotional survival; and Perspectives on life.*

4.4.1. Empathy and Compassion

Empathy is the capacity to recognize, understand, and share feelings that are experienced by another person. It is a deep appreciation for what it is like to be in another's situation from their perspective. Compassion encompasses empathy; it involves understanding and being concerned for the suffering of others. All participants said that it was necessary to have empathy and compassion in order to work in a Cancer Centre. The following excerpt demonstrates how Amanda (NUC) views her role:

> I think it really helps to have an empathetic caring person doing this ... ***I always put myself in their shoes*** and think how would I want someone to treat me and my family ... so I'm always like trying my very best to get things done for them in a very timely fashion, and ***I really do make an effort*** to do the best that I can because I think if I were suffering or my loved one ... So, and that's always been my approach and I think for the most part, I find people at the [Centre] have that same approach, not all mind you, most I would say have that approach and I think it makes a really big difference to the patients 'cause I mean ***they're ill and their hurting***, they're afraid, and it's just that friendly face and someone that you know that you can count on is there to sort of oversee everything and have your best interest at heart, you know? So, I mean, I look at it as ***how would it be if we weren't there?*** At least we're giving them some hope and trying to make a difference, and yes it works, and sometimes it doesn't, but at least we've tried our best.

Sophie (NUC) said that empathy is a part of her mental state on a daily basis:

> Patients come around to the station and we get calls from people about their problems ... and sometimes when I call people to find out why they didn't come to clinic ... I find that they've ***passed away*** ... so then you're dealing with the family and ***you feel bad*** about that ... you feel compassion for them, and you know what they must be going through.

I asked Sophie if she could give me an example of an interaction that she experienced and she said that there are some that are terrible and make her feel sad for patients and families, sometimes to the point that she feels like it is happening to her. In the following quote, she shares how she felt after getting off of the phone with a patient's relative who had passed away suddenly:

> ***I was pretty shocked*** ... ***I was thinking' about that for quite a while afterwards***. I said ***oh I'm so sorry*** right away ... it was like a movie ... there's some movies that you go to and they're ***with you like for a week afterwards*** 'cause there was something about it that really got to you, [this was] the same kind of thing.

Sophie said that she was tearful after this incident and left her work area to get some fresh air and debrief. Several participants spoke about feeling the pain and sorrow of others, and imagining how they would feel. Many stated that it was challenging to be able to find the right words at the right time when speaking with patients and families, especially in interactions that are spontaneous and unexpected. Participants said that these conversations are usually brief and they feel sad afterwards, thinking about those left behind. Although these interactions are often short, several participants spoke about spending long periods on the phone with patients and/or families when someone is worried or distressed. Jillian (MS) said that she has spent up to 45 minutes on the phone providing emotional support:

> When I listen to someone who is in so much distress and you know they will benefit from just getting it out ... *I take the time and I listen to everything they have to say* ... I show them compassion ... that *can be draining sometimes*, but I have to say that in 100% of the occasions that I have to do that, the outcome has always been positive, the person always feels better ... and uh, and many times you can provide information or support, that will improve that patient's situation *at that moment* ... you can say don't worry or have some patience or have some faith or you have a wonderful doctor, you know, things that are very neutral that won't compromise ... won't get you into trouble ... you are giving *just emotional support* ... something that you would tell a friend.

Alisha (MS) spoke along similar lines, saying that patients often want an empathetic listener rather than an answer to a question:

> Patients a lot of times ... want [an] answer but they want empathy with it ... I think I'm more empathetic and I feel more qualified to be that way with patients and family members, um, the older I get and the more experiences I have because ... I've had two bouts of depression since working at the Centre and I received great care that goes along with it ... so I empathize with patients and families 'cause I know what it's like to go through a medical system ... [also], I've learned that people learn differently, communicate differently, and also that they receive information not always in one go, but often over a series of times ... so I listen to them and respect them ... sometimes a patient wants to just be heard.

Sarah (MS) also spoke about empathy and taking on a certain role:

> *I console people and encourage them* to attend their appointments ... I feel like I often take on a maternal role, but it's almost like a pseudo-maternal role ... everybody who calls is sick, or is being impacted by someone who is *significantly ill*, it's not like they have the flu ... and you're dealing with a huge amount of fear and, and a lot of anger ... I understand that and do my best to listen and help. Often I will look at their notes and see what's going on and if they're terminal or if they've just been diagnosed ... if they're really stressed out and really anxious ... I take that on ... and it's like I'm trying to *calm them down* and at the same time I'm trying to take deep breaths for myself ... it does impact me and you know, if people are crying on the phone then *I'll get upset for them because they are upset* ... you know *it's an empathy thing*.

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Participants expressed deep understanding, sincerity, and many spoke of the importance of just listening. Several women said that they do their best to show empathy and compassion given how busy they are. The message that came across from participants was that cancer patients and their families require and deserve the best of care.

4.4.2.   Coping with Death and Dying

The work and the environment of oncology support staff are unique in that they are exposed to death and dying on a daily basis. Many participants shared what it was like for them to speak to patients and families about death and dying, several saying that it is difficult, sad, awkward, and depressing. They expressed difficulty in finding the right words to provide comfort and often wondered if there was something they should be saying. Rachel (MS) acknowledged that speaking to patients about death and dying was sad and depressing for her, and that she felt ill equipped for such conversations:

> [A] woman who has breast cancer with [small children] at home ... called in to talk to the doctor, she started sobbing, said she needed more info about having [months] to live, that she was terrified ... I told her that I was sorry ... that I could understand how hard it was, but inside I felt just awful, like I don't *really* know what she's going through truly. I assured her that I'd have the doctor call her later that day and told her to call any time for anything she needs. I still don't know how to handle calls like this ... I got off the phone ... and sank into myself for a moment thinking how depressing and dismal it all is.

Amanda (NUC) further spoke to the difficulty of losing so many patients to the disease:

> I still have not learned how to answer those phones when the funeral home calls ... I still don't know how I should handle that ... it makes me feel like I want to cry ... I go, 'another one has died.'

Sarah (MS) discusses a conversation with a young man that she said really affected her:

> [A young patient] ... diagnosed with terminal cancer ... he just felt kind of wonky ... you know, kind of fluey, he did not expect that he ... *had cancer* ... he was told by the doctor that he was gonna die ... he had less than a year to live ... and *he broke down* ... *he absolutely had a melt down on the phone* ... [he's] like I don't have kids ... *all the regret* ... he was calling to find out about storing his sperm so he could actually have children in the event that he died, which he did, he died ... but you know, all of a sudden I think, that affected me *hugely* because he was *young* and he actually said to the doctor *I thought I had so much more time* ... you don't think about this happening ... and all of a sudden that's taken away from you ... and I think that's, that's again where there's a lot of, if there's gonna be fear, that's where it's at, *your future's been takin' away or it might be taken away* ... and um, you know, people have plans and that's not what they think

about so, it's ... fear of not being able to get to do what you planned to do, and it makes me think about my own life.

Participants said that interactions with patients about their diagnoses and prognosis are common, many expressing their fear and sadness, plans that they have before they pass on, worries about their children and other family members, and so forth. They also reported repeated experiences wherein there was a lack of communication about a patient's death and they sometimes felt like they were out of the loop in communications between families and professional staff, a finding also reported in a study by Cashavelly, et al., (2008). For example, Alisha (MS) said, "there needs to be more coordination and communication around this … it is just so embarrassing when a loved one calls to cancel an appointment for a deceased patient thinking that the doctor has told you … [and you don't know];" Tara said, "we have no follow-up with families, no contact, and therefore no closure. We are left wondering what ever happened to those families." Patient deaths are everyday realities at the Cancer Centre, a fact that cannot be avoided, but without attention to these matters, such interactions can cause stress and burnout. Participants' testimonies point to directions for improvement in communication and preparation of staff who must communicate with dying patients and their families and later, with the bereaved.

Some of the women who have worked for many years in cancer care related how they had learned through experience and time to manage their emotions in the face of sad and difficult situations. They said that when they were younger it was much harder on them and they spent a lot of time feeling emotionally distraught. Some of the participants who have worked for fewer years at the Centre said that they frequently feel overwhelmed and that there are times when they leave their desks to cry. Overall, participants said that it was stressful to be regularly exposed to sickness, pain, dying, and death on a daily basis.

4.4.3.   Emotional Survival

The tasks that MSs and NUCs engage in involve emotional labour and personality management. Emotional survival involves processing difficult emotions on the job. Participants said that this could be challenging because there is little time to self-reflect on the job and there are no immediate resources available. In caring for

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others, the women in this study talked about how they must control their emotions and portray those expected of them such as being friendly, helpful, tactful, and courteous. Participants spoke about calming down upset or angry patients, soothing them when they are afraid or unhappy, pleasing and satisfying doctors, nurses, and other professional staff. Controlling one's emotions and managing those of others was described as exhausting, and participants relayed situations that upset them, create fear, anger, and sorrow, and that leave them feeling drained and stressed. Such emotional challenges and interactions require self-reflexive dialogue and emotional management, facets of the work for which support staff are not rewarded. These findings are similar to Hochschild's (1983) that detail the ways that jobs associated with women incorporate extensive demands for emotion work. They also resemble Gray's (2010) research that found that emotional labour requires an individualized but trained response that assists in the management of patients' emotions in the everyday working life of health organizations.

An example of this was articulated in an interview with Megan (MS) who discussed a situation that she was involved in with the oncology team that involved news of the sudden and unexpected death of a patient's family member. She said that the impact of this incident was upsetting for many members of the team. Megan spent weeks interacting with the patient's family members integrating communication and coordinating care. She reported that the incident was highly stressful, emotionally upsetting, and exhausting. There were no immediate services available on the work site that she could go to and debrief. Rather, she said that she felt that she was left to cope on her own and help others. Megan said that she managed her emotions in this situation as professionally as she could, telling herself that it is not hers to own. She also sought out a coworker to discuss the matter. She said that although speaking to a coworker was somewhat helpful, it was not entirely satisfactory because there is little time, and she did not feel that it was appropriate to go into detail about her feelings.

This sentiment was echoed by other participants who said that emotional expression at work is rare, except when staff vent to one another to let off steam or when others, particularly doctors, express their anger and frustration. Pippa (NUC) said that doctors, nurses, and all other members of the health care team rarely, if ever, show emotions such as grief or sadness. This lack of emotional expression is particularly true

in the case of physicians. Physicians are socialized to objectify the human body, which results in depersonalization and detachment. The culture of medical school instills in them the values of emotional control, distance, and detachment. Professionals in many fields have been found to force themselves to display the acceptable level of detached neutrality because the display of emotion is often seen as unprofessional and a sign of incompetence (Hoffman, 2007). This workplace culture affects support staff because they are engaged in emotional labour, but there is an unspoken rule that emotional expression is not appropriate. Therefore, it is a strange paradox; emotion is expressed due to the nature of the work, yet it is not deemed appropriate.

Jillian (MS) gave an example of an interaction she had with a parent that had just lost a young child and said that it was difficult for her to remain composed:

> I can remember one case in special, um, the mother of a young child, who has received ... treatment recently and about six or eight months after the last visit, uh, the patient passed away and the mom came to thank my doctor for all she did. She stopped by my desk and she thanked me too ... so I stood up and uh hugged her and she started to cry ... of course I started to cry with her ... and, um, that was very hard, that was *very hard*.

Interviewee: How do you take care of yourself?

> Jillian (MS): I personally ... when that happens, that was ... *very emotionally distressing for me*, I stopped my work, I put my phones to voice mail, and for a couple of minutes I just sat there and uh, and prayed for her ... for God to give her, um, the strength to go through that and the peace that she needed ... and just knowing that she would receive some help from God to go through that moment gave me peace. And I just, you know, I hand it over to God ... so that's how I cope with that.

Participants had various ways of coping and managing their emotions while at work. For Jillian, prayer helps her to cope and assimilate painful moments. Several participants said that self-awareness, self-control, non-attachment, shielding, and keeping things in perspective were some of the ways that they coped. Some women said that they coped by not allowing themselves to think too deeply about painful events, and that they ignore or hide their feelings at work. Many reported that they have to keep going because the work has to be done and others are waiting. Several women said that if they are feeling sad, angry, disappointed, or paranoid they monitor their facial expressions and their speech so that it is not obvious. One woman said that when she is extremely upset after a difficult interaction she would escape into a vacant doctor's office. Others spoke about going into the stairwell or bathroom to cry and debrief.

Support staff are not trained to deal with crises, yet they find themselves in the middle of very difficult and charged situations on the phone daily. According to Smith & Cowie (2010), it is necessary that employees be taught how to manage emotions through induction, training, and supervision. The support staff I spoke to had not received training of this kind. Rather, whatever coping skills they have learned have been on the job or are self-taught. When a situation is ambiguous, the women I interviewed were left to make their own judgements which they based on what they felt was acceptable to them and to the patients. This often contributed to high levels of self-reported work-related stress. This finding is consistent with other studies in oncology that have found high levels of stress and emotional exhaustion as measured by the Maslach burnout inventory (Grunfeld et al., 2000, 2005; Mack et al., 2003).

Support staff struggle to balance the functional aspects of their role with the emotional impact of the day-to-day work. The work that they do is highly task oriented, at the same time it is emotional. Chloe (MS) illustrates:

> It's difficult to pay attention to emotions and stay balanced ... stay focused when, uh, the phone is ringin' off the hook, you have several lines on hold and they're all important ... and they're usually complicated, it's never straight forward ... there's a little bit of everything involved, um, 'cause if the patient calls and their *upset* you have to sort of, try 'n get to the what's, ***why is the patient upset, what's the problem*** ... and there's counselling involved in that you're either a private investigator and at other times tryin' to look for things 'n tryin' to figure out what to say, how to resolve ... where do I get this from, who should I call ... 'n things like that ... so, you wear a bunch of different hats.

Taking on different roles that engage an individual in supporting and helping others is demanding. It also involves being caring and nurturing, roles that have been traditionally identified as women's work. For example, it was reported that taking care of physicians' needs was like taking care of children. Alisha (MS) said, "they are needy, demanding, and thankless ... they need to be doted on constantly." Support staff not only take care of the needs of physicians, but other members of the team, patients and families. Participants reported that regulating and managing emotions was exhausting. Sarah (NUC) explains:

> I just wanna crash when I get home on the couch or something like that and it's kinda like you shouldn't feel like that when you finish your job ... it's ***mentally exhausting*** 'cause ... the intensity and attention to detail and all that kinda stuff and doin' all that ... ***it is, it is exhausting*** and I thought ***oh, maybe it's me 'cause I'm older but I've checked with the young ones and they're exactly the same***.

Alisha (MS) also said that she is exhausted when she gets home:

By the end of the day, I am fried ... my head is spinning with the constant go go go and I usually have a headache and ache all over. Is work supposed to be like this? Is it suppose to be this hard? Thankfully I have my [family] and religion to keep my faith ... it's just exhausting listening to problems and demands all day long.

Tara (MS) who has worked for twenty-five years shared:

I don't take it home with me so much anymore ... I've changed over the years ... in the beginning I was afraid to pick up the phone because it would be the coroner's office, the funeral home, a crying loved one, a patient in pain ... a medical emergency ... things like that. [At first] I used to break down and cry right at my desk … but I'm much better now ... when a patient gets bad news I have empathy, but it's not my stuff ... if I let it get to me I'd break down and wouldn't be able to do the work.

Like Tara, there are participants who said that they didn't take their work home with them, one woman saying that she doesn't get paid to get upset about things, brood, and grieve at home. However, several participants said that they carried the emotional burden of their work home with them, and that they sometimes dream about their job and the patients. Some women said that they drink alcohol or overeat in an attempt to lower their stress and cope. These women acknowledged that their strategies to reduce stress and cope were not ideal, and they mentioned that if they had more time they would engage in more healthy and productive coping mechanisms.

Participants' gave suggestions for creating a supportive environment at work that included activities such as weekly staff meetings with a focus on enhancing collaboration and communication, complementary therapies with a focus on wellness and stress reduction, support groups, educational programs, and appreciation events.

4.4.4.   Perspectives on Life

Several support staff said that working with cancer patients has changed how they view life. Some participants said that it is frightening how a person can get sick so quickly, suffer, and die. Others said that they have deeply realized the transient and impermanent nature of life, which has facilitated a spiritual lifestyle. Some women said that they are grateful for what they have, they try not to take things for granted, and they look at the bigger picture. Jillian (MS) spoke about how fortunate she is:

There's something that I have learned as a person, as a human being working there, is the stoicism of some patients that really stand out for me. I have seen some patients and families that cope with their situation in such a heroic way that has taught me a lot about endurance and strength ... it also makes me count my blessings and see how fortunate I am and how fortunate so many people are for being appreciative of their lives. It gives you

a little more of the big picture because we deal with life and death situations, so, the trivial things in life they just, uh, they fade away really and you go back to what is essential.

Sarah (MS) said that the patients inspire her:

I would say probably 85% to 90% of people I talk to are just **grateful to be alive** ... it's amazing and it has really inspired me. What I've come away with is that a lot of people sort of take life for granted ... and I really appreciate being alive and try to focus on living life to the fullest and being present every moment ... that's what I've taken away. Life is busy and stressful and challenging, at home and at work, it can be totally overwhelming and totally draining and totally exhausting, but at the end of the day you know what? **I'm alive and I'm not sick** and I can actually help people who are sick.

Pippa (NUC) said that her work experiences facilitated a change in how she views the meaning of life:

Life is precious and it is also very short ... when I see patients come in, and fight for their lives, it reminds me of how precious life really is ... and it has made me think about and question things like, uh, like what exactly is the meaning of life? Why do people die? Things like that, you know ... I went through a period of time where I was troubled by these questions, but my faith and my spiritual practice helps me and gives me guidance and hope. I think that it is important to ask the bigger questions in life like why are we here and what is our purpose ... even if we don't get an answer.

Oncology work reminds support staff of what is important in life. Many participants shared that working in a Cancer Centre has inspired them and made them appreciate and value life.

4.4.5.   Summary

These qualitative findings depict a broad picture of the experiences of oncology support staff. The qualitative data highlight that these women work in a demanding and challenging environment that they describe as high-paced, extremely busy, and stressful. They have heavy workloads, are understaffed, and have complex social interactions and relationships. Their experiences demonstrate that the work that they do is gendered, their labour is invisible and undervalued, and they work in a hierarchical environment where they have little power or control. In fact, power, control, gender, emotions, and stress are themes that weave their way through the data. An important finding is that participants feel that their work is invisible, undervalued, and that they do not have a voice. Several participants' stories reveal their experiences of power and how it inhibits their autonomy and ability to make decisions with respect to the overall organization of their work. Participants said that they are heavily monitored and supervised by management and professional staff, which is another facet of power over

them. The work that they do is demanding, yet they have little control over it in terms of quality, quantity, and process. Several spoke about perceived inequities regarding power and control over resources, security and employment, and in how they felt an overall lack of respect from management and professional staff. Many said that they are not adequately rewarded for their contribution to patient care, and that they are worth more. The issue of health care restructuring emerged as a theme, and participants spoke about restructuring and downsizing across the health authorities.

Most of the women said that their jobs are stressful and that the stress manifests itself in various ways. Interestingly stress is perceived and experienced differently, some see it as a challenge and others feel exhausted and sick. It is common for participants to deal with abusive and difficult patients; however, it is also common for them to have positive and fulfilling interactions. Some women felt that the most stressful aspect of their work is heavy workloads, others that it is management or relations with co-workers, as well as abusive physicians and/or patients. Of course, there is a mix and overlap of several of these dimensions. Issues around racism and ageism surfaced, as did problems with being harassed and bullied. These problems make the workplace toxic and contribute to stress and poor health. Many said that stress exhausted them, and their descriptions mirror the descriptions in the literature on burnout, that is, the experience of long-term exhaustion and diminished interest. Several participants spoke about being emotionally exhausted, drained, helpless, and having difficulty coping with their work. The findings reveal that some participants feel that there is a link between the work environment, their stress, and health problems such as headaches, back problems, depression, heart disease, and so forth. It was felt that there are not enough resources to cope with work-related stress and that it spilled over into their home life. Many expressed concern about patient safety and the potential for errors. They perceived that their workload negatively affected patient care including their ability to provide empathetic and compassionate care. In fact, emotional labour is a large component of the work performed, and the skills required to perform this kind of work are invisible.

Although the job has many difficult and stressful facets to it, several participants said that there are personal rewards. They enjoy helping others and making a difference in someone's life and being a part of something that they consider important. The

women are proud of the work that they do, despite the fact that they feel that it is underappreciated and invisible, and they feel that they have expertise to share. Interestingly, the qualitative data highlight the similarities across MS and NUC roles more than the differences despite the distinctions they make. The findings confirm the importance of researching individual experiences as a way of gaining a better understanding of social life. Each of the women has a unique perspective to contribute to the study of work relationships and experiences. Focusing on individual experiences has provided a deep understanding of how oncology support staff perceive their role and their position in the steep hierarchy of the organization. Therefore, an interpretive approach, focusing as it does on "lived experience" has been beneficial in improving understanding how staff experience and are affected by their work.

5. Implications, Recommendations, and Future Research

5.1. Implications and Recommendations

The unique situation of the women in this study reveals a range of experiences that provide a glimpse into their everyday working lives. There is a complex interplay between experiences at work and a worker's attempt to interpret and give meaning to such experiences. Health problems, for example, can be created, aggravated, and made chronic through the meanings associated with certain conditions of work and the social relations in which the worker is located (Wainwright & Calnan, 2002). An individual is an emotionally expressive, embodied subject, who is active in the context of power and social control. Thus, a worker negotiates their relationship to the external world, affected by it at both a conscious and physiological level (Wainwright & Calnan, 2002). If the everyday experiences of women working in healthcare contexts can be understood, then these contexts can be restructured organizationally and politically to maximize the strengths of particular groups of workers. The structural conditions under which support staff work need to be improved and developed in order to create equitable work environments. As has been demonstrated in this thesis, government and institutional prerogatives, budget priorities, and domination by medicine have been imposed on support staff. Managers and leadership need to reorganize these work contexts and renegotiate meanings and roles within them. Women healthcare workers must be able to participate in an equitable workplace, avoid gender inequities, and participate in decisions pertaining to providing healthcare (Hall, Stevens, & Meleis, 1992).

There are important implications for managers, supervisors, those working with support staff, unions, health authorities, and governments. With respect to workplace interventions, organizational conditions that recognize the work these women do would aid in rendering the work less invisible and help them to manage their work more

effectively. If the work is to be valued, management needs to value the actual process of the work as much as they do the outcome of work (Long et al., 2008). This study has highlighted the complexity of the work that oncology support staff do, the stressful and demanding nature of their roles, and the ways that social and structural work contexts affect them. Organizational characteristics of the workplace along with the subordinate role that these workers find themselves in are factors that limit their access to resources and adequate support. These processes contribute to the invisibility and lack of value for these women. If the role of MSs and NUCs is to be recognized, valued, and respected, the ambiguousness of the work performed must be made visible. For example, much of the work that these women perform daily is unnamed and uncategorized, and this is a problem that is exacerbated by, "the difficulty of superimposing an economic model onto work tasks that are not considered labour, domestic labour for example" (Wichroski, 1994, p. 34). Furthermore, according to Armstrong et al., (2008) "the way the work [for health care workers] is defined and organized has an impact far beyond ... harm to workers. It shapes the nature of health care itself" (p. 6). Therefore, the consequences of the invisibility of the work affect society as a whole. A starting point in making the work visible is to reassess and classify the roles appropriately. As has been demonstrated in this study, much of the work that support staff do is invisible, that is, it is *invisible labour*. Also, the emotional work that these women engage in on a regular basis is an example of work performed that is not recognized. Invisible labour also consists of intellectual skills that are not recognized by supervisors, management, or professional staff. According to Wichroski (1994), "some of the ambiguity in clearly defining the roles of these women is due to the fact that gender expectations are interwoven into work [roles]. Much of clerical labour, including the intellectual and emotional aspects of the work, are invisible to organizations, yet they are essential to fulfilling organizational and professional goals" (p. 33).

In fulfilling organizational goals, it is necessary that safe, appropriate, and supportive environments are created for workers who are responsible for providing excellent patient care. Better management is required not only in terms of recognizing skills, but also in teaching them in ways that are more formal. Additionally, managers should receive education about gender and racism in the workplace, as the workforce is profoundly gendered and racialized (Armstrong et al., 2008). According to Armstrong et

al., (2008), "without an understanding of the pervasive impacts of gender and racism, managerial strategies are bound to fail, especially for women and visible minorities and especially in the long term" (p. 177). These authors recommend education for managers in cultural competency, structural conditions, and relations that create inequities and discrimination in the workplace. This would facilitate a shift in how organizations think about workers and their work roles (Long et al., 2008). As highlighted in this study, the work environment is toxic with respect to interpersonal interaction between staff members. Interventions should be put in place that would aid in reducing interpersonal tension, racism, ageism, etc., and contribute to a healthy psychosocial work environment. For example, workshops that address these issues and that provide resources and tools that help to increase cooperation, trust, support and respect among employees. This could enhance support staff's personal growth, commitment to their work, as well as their job satisfaction (Long et al., 2008). If staff are to have job satisfaction, it is important that their voices are heard. One of the best sources of information about the work done is those who do the work. Therefore, listening to workers and acting on their advice can improve both work relations and conditions for care (Long et al., 2008). Additionally, staff should be involved in the decision-making process and their suggestions taken seriously.

Organizations require funding from governments for a variety of needs, and the state is in the position to legislate, monitor, and regulate conditions for work. The state should be responsible and regulate health and safety regulations that recognize the particular nature and conditions of work (Armstrong et al., 2008). However, this is not always the case, and governments increasingly act like private sector employers, making policy making a challenge (Armstrong et al., 2008, p. 173). In fact, an important policy implication concerns the increasingly market-driven atmosphere in health care. As we have seen, support staff are stressed and challenged in meeting the high-patient volume demands of their workplaces in addition to the demands of oncology work itself. As workloads increase, it becomes difficult for staff to achieve a balance. It is likely that when workers cannot achieve balance in their work, they will not be able to sustain their work for very long. Thus, the stressful aspects of the work may become more problematic than they are currently, creating concerns for patient safety. Cancer patients require complex levels of care, and in order for this care to be administered,

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healthcare teams require many different individuals trained to perform different roles. In order to provide excellent patient care, there must be adequate levels of trained personnel. There also needs to be understanding and recognition of the emotional toil of caring for people in sickness and as they die. This aspect of the work is rarely referred to in policy, even though stress is inevitable when working with seriously ill patients and their families. At a wider policy level, therefore, there should be emphasis on interpersonal skills, teamwork, and leadership that promotes a fair and democratic workplace. Armstrong et al., (2008) state that, "workers want more access to public education and on-the-job training that leads to credentials and recognition of skills so that they are in a better position to improve their care and the conditions of their work" (p. 172). Additionally, support staff could benefit from formal orientations to their organizations when they are first hired. A workshop could be put in place that would socialize staff to the environment of a cancer facility, what is expected of them in their role, and so on. Workshops that resemble ones that nurses partake in, such as lectures on different cancer treatments, side effects, the psychosocial aspects of cancer patients and their families, would also greatly benefit oncology support staff.

As health care becomes more complex, coordination of health care services is essential. Patients are increasingly asked to assess their experiences of access to and quality of care. As health professionals need to continue their professional education, so too do the support staff that support them. Programs that build a mutual understanding of the challenges that are faced by all members of the health care team can only help to improve key working relationships, foster mutual respect, and ultimately provide quality patient care (Cashavelly et al., 2008). I also suggest that medical school and nursing curricula continue to evolve to include topics of teamwork and interpersonal relationships. Issues including, but not limited to, gender inequity, racism, ageism, classism, and so forth should be taught to aspiring physicians and nurses. Some medical schools do have some social courses in place, but they can certainly be improved and updated. Such courses should also be included in the institutions that train MSs and NUCs, and ultimately all staff. Organizations usually have policies on harassment, bullying, and verbal abuse, but all too often they sit in a manual and are inaccessible to staff. Organizations should send out reminders to staff, and hold workshops on these social issues.

Stressors such as heavy workloads, understaffing, high levels of staff turnover, decreased job performance, increased absenteeism, decreased work productivity, lack of control and decision making, verbal abuse, and physical health hazards are managerial matters and require solutions at the organizational level, and more specifically, at the level of Health Authorities and government. These issues are costly in terms of administration, training, and workers' health. Support staff in this study reported that work conditions affected their health poorly and that there was low morale and reduced commitment. Considering that the stressors identified in this study are beyond the control of support staff, the health promotion and wellness programs often suggested for stress management interventions might not be sufficient in the case of these women. While, for example, relaxation exercises to relieve stress might have positive effects on some individuals, these effects might disappear rapidly once they return to their work environment. As long as there is no change in the work environment, stressors continue to work on individuals' minds (HEU, 2000). Therefore, in the case of stressors identified in this study, interventions that address organizational factors are particularly necessary.

Additionally, unions and other forms of collective organization should be promoted. According to Armstrong et al., (2008), "research shows that workers fair better with unions, and this is especially the case for women. Unions help to protect employment and conditions, and they also give women the right to say no to unfair demands, giving women a voice" (p. 177). Unions are also aware of discrimination, harassment, violence, gender, and racism in the workplace. They are in the position to protect workers, and can work to make employers recognize the importance of workers' skills (Armstrong et al., 2008). Unions are also in a position to "enhance both workers' and management's understanding of the larger economic context" (Long et al., 2008, p. 1425) and to facilitate the understanding between personal troubles and public issues. Further action can be taken in collaborating with labour and advocacy organizations, for example, advocacy organizations such as 9to5 National Association for Working Women can educate and encourage support workers regarding their work-related issues (Long et al., 2008). Furthermore, when research is undertaken, it is important to disseminate it so that voices can be heard and changes made. This is where knowledge translation comes into play, a process that the Canadian Institute of Health Research defines as a

process that is dynamic and iterative. It includes the synthesis, dissemination, exchange, and ethically sound application of knowledge to improve health and provide effective services and products that contribute to strengthening the health care system (Ueffing et al., 2009). The goal is to translate the findings of research directly into practice. Knowledge transfer requires that an organization be conducive to facilitating change, which requires that they recognize the value of new knowledge, assimilate it, and then implement it as the basis of decision-making. This requires collaboration, teamwork, receptivity to change, and shared goals for improvement (Ueffing et al., 2009).

There are creative avenues that have and continue to be explored that transfer knowledge such as literature and live theatrical performance. For example, a short play could be performed regarding the everyday experiences of work at a Cancer Centre. This could be "followed by an identical presentation wherein the audience members are encouraged to rise and physically replace the main character when they feel inspired to enact an alternative approach that might result in a more favourable outcome" (Ueffing et al., 2009, p. 11). Knowledge translation is useful in raising awareness, and it has the potential to raise awareness of the importance and contribution that support staff make in their role. It can affect change through the reflection of assumptions, staff behaviour, and organizational policy (Ueffing et al., 2009, p. 8). Improvisational theatre has been found to aid in extending research findings and make them more accessible and relevant in health care settings. This type of performance is used by researchers to recognize and transform the conditions of oppression. Its goal is to engage those who are disempowered and create ways to implement better conditions (Ueffing et al., 2009).

The purpose of this research project was to understand the experiences of oncology support staff. In obtaining a rich and detailed picture of participants' experiences, and in hearing their voices, it is important that the findings of this research be disseminated so that strategies can be developed that recognize the critical contribution they make to health care. Although this project did not engage in an analysis of the political economy of health and health care, it is strongly linked to both. From a sociological perspective, the micro and macro elements in society operate hand in hand. Thus, the experience of workers is affected and tied to the political economy. Perhaps if policy makers had more exposure to research that clearly demonstrates that

workers, for example, have heavy workloads and are understaffed, thereby causing stress and ill health, they would be forced to develop policies that would be in the interest of not only support workers, but also society as a whole (Armstrong et al., 2008; Long et al., 2008). In order to transfer the knowledge from the findings of this research, a policy paper will be given to the Cancer Centre where the research was done (and possibly other centres), the Hospital Employee's Union, the Health Authority, and the Minister of Health. Although change is difficult, and governments are cutting back in their budgets and spending less on health care, it is nonetheless important to advocate for change. It is important to develop strategies to recognize the contribution of oncology support staff to health care and to improve working conditions in ways that make it possible for them to work in an equitable environment and provide quality work for appropriate rewards. Now, more than ever, workers need to unite, unions need to be promoted, and governments and organizations need to listen.

5.2. Strengths, Limitations, and Future Research

The strength of this study is its qualitative design where in-depth interviews were conducted yielding incredibly rich data that provided a deep understanding of participants' lived experiences in a Cancer Centre. Qualitative research methods are unparalleled in their capacity to capture women's voices. Further research on support staff working in Cancer Centre's should be conducted so that existing gaps in this population can be filled. Specifically, in-depth interviews should be done because they are very good at capturing details of social interactions and subjective experiences. Such interviewing techniques have the potential to create a positive rapport between the interviewer and interviewee, which is crucial when trying to find out about personal and sensitive issues. Additionally, they allow for topics to be discussed in detail and depth, the interviewer can probe areas suggested by the respondent's answers, it is easy to record the interview, and the nature of an interview allows for deep and rich data (Bryman & Teevan, 2005). Additionally, given appropriate time and resources, it would be beneficial to conduct an institutional ethnography. As part of the ethnography, participant observation and focus groups could be conducted which would be helpful in further understanding work-place dynamics. Documentary analysis could be included as a research method which would allow for the examination of union, institutional, and

government documents. This would facilitate an in-depth analysis of organizational structure and neoliberal ideologies. I also recommend participatory action research, for example, Storch et al., (2009) found that the ethical distress in healthcare settings can be understood and improved through the use of participatory action research. These authors developed strategies for taking action to improve the quality of the work environment and they state that their strategies can be used as templates or designs for use in a variety of settings. The benefit of this kind of research is its direct involvement with the community, which gives voice to participants, and helps to understand and identify issues that are important and relevant.

Of course, qualitative research is time consuming and labour and resource intensive. With respect to my thesis research, it was therefore necessarily limited to one health care organization. Due to the small size of the sample, the findings cannot be compared to all support staff in oncology settings. The women who participated in this study may share similarities with others who occupy similar positions in our society's stratification system, but this does not necessarily represent the multiplicity of backgrounds in society. This indicates a need to expand research on oncology support staff to include women from more diverse social backgrounds in order to determine if their experiences differ. In order to understand gender inequities, groups of oncology support staff in different social locations should be compared emphasizing women's subjective experiences. In order to understand the experiences of a wider range of support staff, a mixed-method research design using a survey to measure stress and burnout levels, and in-depth interviews to further understand experiences could be beneficial.

To build a framework that creates an understanding of inequities for support staff, I suggest that concepts from the political economy of health be incorporated into future research. Feminists who adopt the political economy of health approach emphasize the importance of social contexts and their impact on women's health. For example, support staff who work in healthcare organizations are subjected to medical dominance, a social force that is unequal and oppressive (Gu, 2006). By incorporating a political economy approach into research, it is possible to analyze how larger structural factors (political, social, economic, historical, and cultural) affect women and their health (Gu, 2006). In addition, it would be beneficial to examine stratification hierarchies, social relations,

power relations, and power structures that subordinate and oppress women. And because gender is experienced socially according to one's ethnicity and social class, the intersection of gender, class, ethnocultural background, age, sex, and geography should be further examined (Armstrong et al., 2008; Gu, 2006). From the perspective of the political economy of health, the macroeconomic structure, class, ethnicity, paid and unpaid work are important contextual dimensions that affect women's health and their lives. The benefit of a political economy approach to research is that it brings attention to structural factors that shape inequities. Given the dearth of studies that have been done specifically on clerical workers in cancer care, there are many possibilities and opportunities for future research on oncology support staff.

5.3. Conclusion

In this thesis, I argued that health care work is women's work, that power relations contribute to gender inequities among oncology support staff, that the work that they do is significant and crucial to care, and that if a comprehensive understanding is to be attained, structural forces must be taken into account. Using a critical-interpretive feminist lens to guide this study helped me to unpack issues related to women's work experiences. It helped me to identify aspects of women's experiences that reflect power differentials associated with gender, ethnocultural background, class, age, sex, (dis) ability, and geography. Critical theory offers a research perspective that is helpful in uncovering the nature of enabling and/or restrictive practices, and thus creates a space for potential change. The critical analysis in this research is not meant as a critique of individuals or of the research site in this study, but of patterns of inequality that develop, even when people have the best intentions. The stories of the women in this study reveal the power and control that subjugate and oppress them. At the same time, however, their stories reveal remarkable resistance, knowledge, insight, and passion for better working conditions. The attempt to make sense of the experiences of oncology support staff from a social and institutional perspective within a critical framework is an emancipatory or liberating methodological approach. The purpose of which is to bring about equality for all individuals.

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Appendices

Appendix A.

Interview Guide

How do Oncology Support Staff Experience their Work Environment?

Work Organization

- Please describe to me your role at your workplace

- Please explain your experience of a typical work day

- How do you experience your workload?

- What do you consider to be some of the challenges of this work? What situations are most difficult? How do you cope with these stressors or challenges?

- What is your relationship like with your supervisor?

- What would improve your day to day work experience?

Team Relationships

- Please tell me about your experience of working with other members of the oncology team
  What are interactions like?
  How do you perceive team collaboration?

- Would you say that the team generally buffers or contributes to your stress?

- Please explain how you think interactions on the team could be improved, if at all

Patient & Family Relationships

- Please explain your experience of working with patients
  What are interactions like?
  What is your relationship like with patients?

- How about family members?
  What are interactions like?
  Describe your relationship with family members

- In your typical day, what kinds of things happen with patients and their families?
  What are some challenging situations? How do you handle them?

- Explain what you would perceive to be a stressful interaction with a patient

- How do you feel/cope when a patient is dying or dies?

- What would be helpful for you in working with patients?

Emotional Impact

- What is it like to work in a cancer centre with patients who have a potentially life threatening illness?
  How does this affect you? In what way?

- Would you say that providing emotional support to patients is part of your role?

- Have you ever experienced feelings of worry about patients?
  Have you experienced thoughts of patients and your work when you leave the workplace?

- How do you deal with stressors experienced after a work day?
  During a work day?

- What do you consider to be the rewards of this work?

- Please explain your outlook on life
  Would you say this work has influenced your outlook? If so, how?