# A Study of the Staff of a Convalescent Hospital

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As Americans reach old-age, they are replaced in the dominant positions in our society by a younger generation. Typically, older people no longer hold jobs, their social ties break and many of their valued pastimes become inaccessible to them because of poor health or diminished income. The historical reasons for this are many: increased longetivity, the breakup of the extended family, increased mobility, automation, mechanized agriculture and attitudes toward youth.

This displacement of the elderly, in our culture, has created a need for a unique institution — the home for the elderly. The nursing home is a place where people who cannot take care of themselves live.

Nearly all of the people residing in convalescent hospitals need personal attention for their physical and social needs. Nevertheless, the care old people receive in nursing homes is not similar to the care for old people given by family, kin and neighborhood groups (Townsend 1970). The typical nursing home is a factory for caring for many elderly — not a home for a few. Even the phrase "nursing home" is being replaced by the more common job-oriented "convalescent hospital." The phrase "convalescent hospital" denotes a sense of becoming healthier, an impermanence of the resident's length of stay. Yet, for the majority of residents who pass their final days in the institution, the hospital is "home."

As more and more aged are sent to convalescent hospitals and stay longer periods, contact between the elderly and people outside the hospital occurs less and less. The only contact many of the patients have on a day-to-day basis with the "outside world" is through the hospital staff. The staff assumes the responsibility of feeding, clothing and acting as an intermediary with the "outside world."

The patients may maintain their own social worlds, yet they depend entirely on the staff for their physical needs. The attitude of the staff towards its work determines whether the elderly live in a "work" or "home" situation. The question of how a convalescent hospital staff perceives its jobs deserves close attention before one can judge the adequacy and moral implications of the institution of the convalescent hospital.

This paper is the result of a study which I undertook to discover the views of the small hospital staff of its work. Instead of focusing on the patient community, it deals solely with those who care for the patient community. Only those people whose work is entirely performed at the hospital are included. Such professions as administrators, dieticians, bookkeepers and owners are not an integral part of the 'cultural scene' (Spradley and McCurdy 1972) of the convalescent hospital and thus were not included in the study.

## Fieldwork Strategies and Problems

I selected a convalescent hospital at which I already knew a nurses' aide. She gave me the name of the hospital administrator and told me the hours I could contact the busy administrator. Ethics required obtaining permission of the administrator before I could begin my study.

After setting up an appointment with the administrator, I arrived at the hospital and explained the purpose of my presence to the nurse near the front entrance. The nurse took me to the administrator's office, who was surprised that the hospital could be the subject of a college paper. The administrator said I could pursue this study if I honored the following conditions:

1) The name of the hospital and the names of the staff and patients would remain anonymous.
2) I took no photographs.
3) I "volunteered" three hours a week to talk with some of the patients.

I assured her I would meet these conditions during the six weeks I would be working on my project. She told me not to interfere with the staff's duties and said she would be glad to see me come regularly to the hospital.

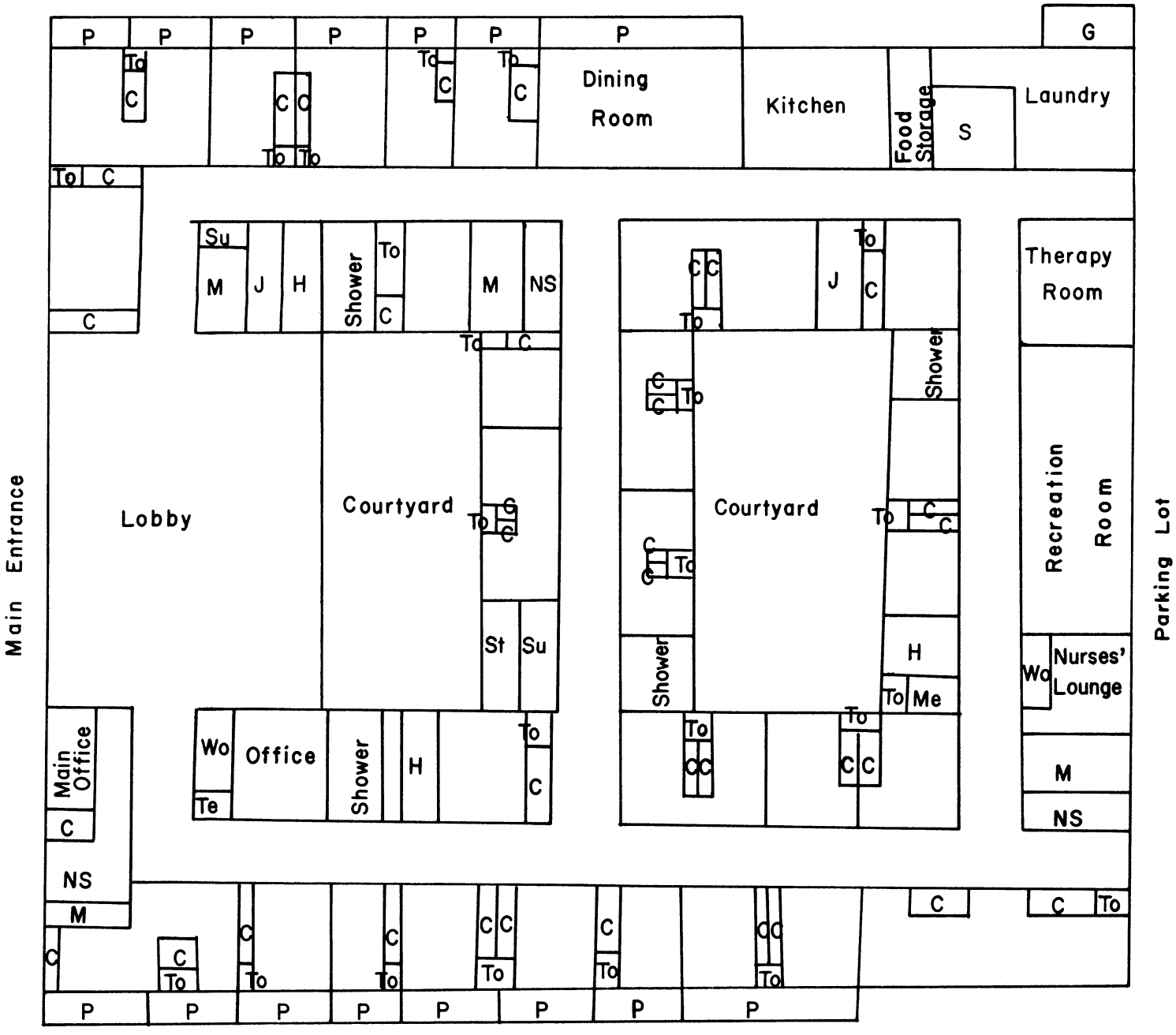
The first few times I visited the hospital I sat in the nurses' lounge for an hour waiting until my friend got off work. Since it was not unusual for friends of the staff to wait in the lounge, I was very inconspicuous. It was an excellent opportunity for me to take notes on activities going on around me.

Later, I introduced myself to people in the lounge and explained to them what I was doing. Some people introduced themselves to me. There was a very informal atmosphere in the lounge which was immensely beneficial to me in soliciting information. I scribbled notes in a notebook during informal interviews and immediately copied them after each interview.

My first attempts at formal interviewing proved disastrous and I soon abandoned formal interviews. The nurses' lounge, the only location in which I could work without disturbing the staff at their jobs, was not conducive to formal interviewing. Since each worker had a different lunch and break time than the other work-

Map Number 1

# Map of Hospital




| | | | |
|---|---|---|---|
| T | Telephones | NS | Nurses' Station |
| P | Patio | M | Medication Room |
| Me | Men's Bathroom | G | Garbage |
| Wo | Women's Bathroom | Su | Supply Room |
| H | Hopper | St | Storage Room |
| To | Toilet | J | Janitor Room |
| C | Closet | S | Soiled Laundry Room |

ers, there was always a continuous flow of people moving in and out of the lounge. Moreover, the staff generally showed a distinct dislike for academia and especially formal questions. Here are some typical answers to two straightforward questions I asked, "Are there any opportunities to talk to other aides while you are working?" and "Has there ever been a serious accident to a member of the staff while he or she was working?":

"Don't they teach you anything at Berkeley?"

"Ask Tom."

"I have to get back to the floor."

"Check at the desk."

Bothering my informants with formal interviews was only one snag that hindered my project. With few exceptions, the nurses (registered and licensed practicing nurses) avoided me entirely. Whatever concepts the nurses had of their jobs, they did not want to discuss them with me.

Accordingly, my main informants were not nurses. My nurses' aide friend proved, after initially showing me the grounds, to be a poor informant. Because we knew each other well, invariably she would change the topic of conversation to topics not remotely concerned with my project or told me the questions I asked were meaningless.

## Principal Informants

My main informants were Linda, Don and Lupe. I asked them detailed questions about how they did their jobs and in the process discovered what things they valued in their jobs. In this paper, I have stressed only those topics the staff themselves consider important.

Linda, age 19 and a student at Diablo Valley College, has been working part-time as a nurses' aide since her junior year of high school. Currently living with her parents, she hopes to become a laboratory technician in the next year and get her own apartment. I met Linda when she introduced herself to me in the lounge. She is very moody. Some days she was very excitable and other days she was depressed about her schoolwork. She was very talkative and asked me just as many questions about my project as I asked her. Linda knows the personal history of everyone who works at the hospital. Like all the women employees, she wears white pantsuit uniforms.

Don also introduced himself to me. He is thirty-two, married the nurses' aide shop steward six months ago and works as assistant cook. His first job at the hospital was as a dishwasher. Prior to that, he lived in Carson City, Nevada, and worked at a gas station. With some of his income coming from welfare, he lives with his wife and four children in a nearby two-bedroom apartment. Don spends his breaks with his wife in the nurses' lounge. He seems to know every monetary and political facet of the hospital. He was the only person I talked to who knew anything about the hospital owner or the legal aspects of the Union to which the entire staff belongs. Though he told me he didn't think much of my project, he always answered my questions in great detail.

Lupe is 23, married and has two children. She lives 10 miles away in a newly-built house with her family. Her husband, a garbage collector, works for the county. Lupe worked as a housekeeper before her marriage and then quit when she got married. She returned to work one month after her husband bought their house to supplement her husband's income. Lupe's mother watches her children while she is at work. Her husband drives her to the hospital in the morning in time for her to eat breakfast in the nurses' lounge before the day shift starts. Lupe was born in Mexico. She speaks English with a heavy accent. I introduced myself to Lupe. Though she is very shy she answered all my questions completely.

## Physical Setting

The hospital (see map number 1) lies in a Bay Area suburb with a population of 60,000. It is surrounded on three sides with low-cost single-family homes. Currently, a supermarket is being built on the remaining side. The hospital houses 163 patients, most of whom pay their room and board with state funds. Twelve nursing aides, 5 nurses, 2 cooks, 2 assistant cooks, 6 dishwashers, 1 maintenance man, 4 laundry workers, 6 janitors and 1 recreation worker are employed either fulltime, part-time or "on-call" (available as substitute workers.) These staff members are Black, Chicano and White, male and female. They range from age 17 to about age 60. There is a high turnover rate; only rarely will a person work at this particular hospital for more than two years. There is also a large amount of absenteeism among workers. The pay scale is extremely low and the chart on the following page (chart number 1), which I copied from the nurses' lounge bulletin board, was the topic of much conversation among the workers. The workers discussed at length which jobs gave the best pay with the least required work and whether or not the pay was sufficient for each job.

The "nurses' lounge" (see map number 2) is the focal point of the social setting. Every member of the staff, with the exception of the nurses themselves, comes into the lounge before and after work, during breaks and during lunch. The room is small; formerly it was a patient's bedroom. It has a private bathroom, a sink, refrigerator, wooden lockers without doors, an open wooden closet, a torn plastic couch, small kitchen table and six stackable plastic chairs that are moved at will and stored in the closet. Reading material is conspiculously absent. A lone, six-month-old, yellowed Jehovah's Witness magazine lies on the floor of the closet. A bulletin board hangs over the kitchen table. On a typical day, the bulletin board held a thank-you note from a nurse for a marriage gift from the staff, a schedule of rock concerts and the pay chart.

## Chart Number 1: Pay Chart

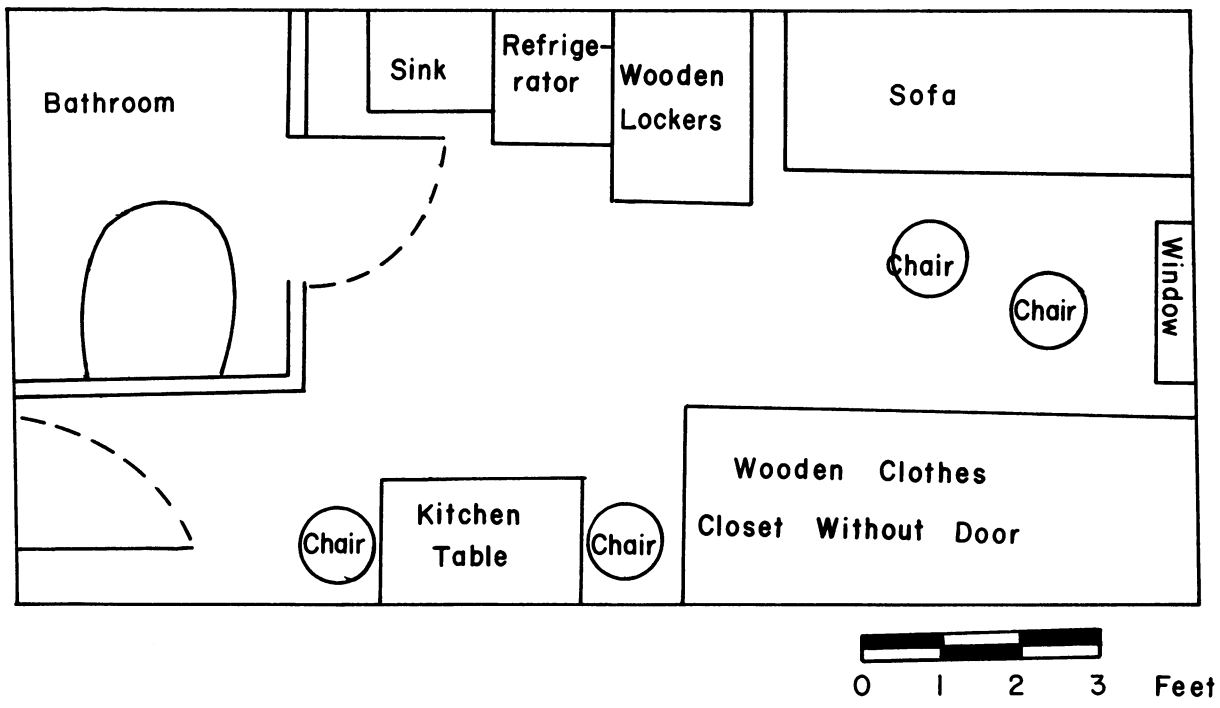
May 1976

| | start: | 6 Mos: | 1 Yr: | 2 Yrs: | 3 Yrs: | 5 Yrs: |
|---|---|---|---|---|---|---|
| Nurses Attendent | $2.25 | $2.35 | $2.60 | $2.75 | $2.85 | $2.90 |
| Licensed Vocational Nurse (LVN) | 3.35 | 3.40 | 3.50 | 3.65 | 3.75 | 3.80 |
| Housekeeper | 2.25 | 2.35 | 2.60 | 2.75 | 2.85 | 2.90 |
| Maintenance | 2.25 | 2.35 | 2.60 | 2.75 | 2.85 | 2.90 |
| Laundry Attendant | 2.25 | 2.35 | 2.60 | 2.75 | 2.85 | 2.90 |
| Kitchen Helper | 2.25 | 2.35 | 2.60 | 2.75 | 2.85 | 2.90 |
| Certified Cook | 2.60 | 2.90 | 3.30 | 3.45 | 3.55 | 3.60 |
| Cook | 2.35 | 2.90 | 3.05 | 3.20 | 3.30 | 3.35 |
| Relief Cook | 2.30 | 2.50 | 2.60 | 2.90 | 3.00 | 3.05 |
| Ward Clerk | 2.30 | 2.55 | 2.70 | 2.85 | 2.95 | 3.00 |
| Psych Attendant | 2.30 | 2.45 | 2.70 | 2.85 | 2.95 | 3.00 |
| Recreation Attendant | 2.30 | 2.45 | 2.70 | 2.85 | 2.95 | 3.00 |

note: Registered Nurses (RN) wages are not included.

## Map Number 2

# Nurses' Lounge



To relax, the nurses go to the nurses' station and the medication room near the main office (see map number 1). Only nurses are allowed in these rooms. The nurses spend their longer breaks outside the hospital at nearby fast-food restaurants. The nurses drive to the restaurants in their own cars. Rarely do other staff members spend their breaks at these restaurants.

### Workers and Their Roles

Employees work in one of 3 shifts — the day shift from 7:30 a.m. to 3:30 p.m.; the p.m. shift from 3:30 p.m. to 11:30 p.m.; and the night shift from 11:30 p.m. to 7:30 a.m. Part-time employees have individual schedules. I observed people on the night shift as well as the day and p.m. shifts. Most of the night staff actually liked their odd hours. They didn't have to feed any patients and there was usually less work on this shift than any other shift.

Because the number of employees (39) is small, each staff member knows the others personally. Each informant I talked to classified workers primarily by authority and profession (see charts number 2 and 3 below) and only secondarily by appearance or personality.

Chart 2: Taxonomy of Staff

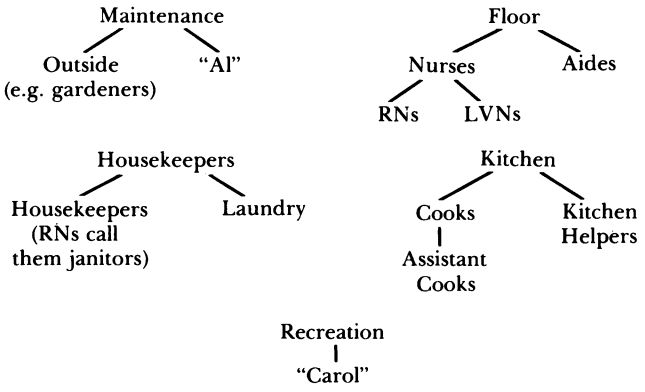
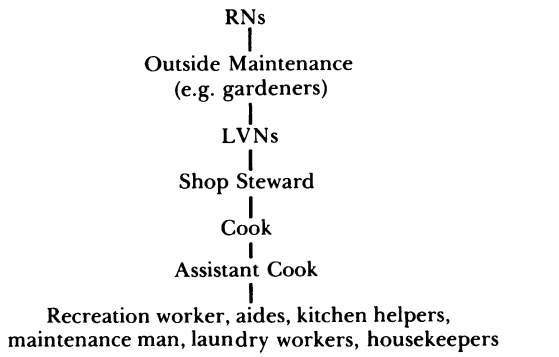



Chart 3: Job Order of Dominance




The following domains — the preparation and serving of meals, the seating arrangement in the nurses' lounge and the process of bringing a glass of juice to the patient — were reported to me by the staff members as illustrating the sharp distinctions the staff members make between each worker's job.

Following the dietician's daily menu guide posted in the morning, the cook, assistant cooks, and the kitchen helper (dishwasher) spend all day preparing separate foods in accord with the many diets of the patients — soft, bland, diabetic, dietetic, (rapid) reduction, or regular. In addition, they must mash and grind these dishes for patients who cannot feed themselves or who have no teeth (called "babies" and "feeders" by the staff) and prepare intravenous "food."

About an hour before 6:00 p.m., when dinner promptly begins, the kitchen helper begins loading trays on a cart. Each of the nine carts holds eight trays. By 6:00 p.m., the kitchen helper must put napkins, hot coffee, sugar, cream, milk, tea, juice, fruit, knives, forks, spoons, sugar substitute, cups, saucers, bread, butter, bread plates and glasses on each tray together with a card stating the name, room number and type of diet of the intended patients. S/he must also put these 163 trays in order according to the room in which the patient eats (the dining room or a bedroom). At six, the food is put onto the trays within six minutes by the cooks according to the type of diet noted on the card on the tray.

By 6:00 p.m., most patients have been seated in the adjoining dining room. (Patients arrive on foot or are wheeled into the dining room at 5:00 p.m. and patiently wait for an hour for their food. They come an hour early for their meal because they have little else to do and because patients eagerly anticipate each meal.

When each cart is completely set up, it is wheeled into the dining room. A nurses' aide or LVN takes the trays off the cart and distributes them to the patients or wheels a cart into the halls were the nurses' aides are ready to serve the "feeders." As simple as this system seems, the serving of dinner is always hectic. The two cooks and the kitchen helper are under enormous pressure to set up dinner for 163 people with special diets in only one hour. Extreme caution must be exercised. If a diabetic patient had sugar on his tray and ate it, the patient might go into a coma. There are never enough nurses to feed all the "feeders" and "babies" at once. There must be two nurses' aides in the dining room during the meal. Usually, this leaves only four nurses on duty to care for the patients in the bedrooms who cannot get up to eat.

Under this system, tempers flare easily. The kitchen crew and the aides are continually in conflict. The nurses want the food to be ready at exactly the right time so they can feed the "feeders and the babies" within two hours. The kitchen staff cannot always set up 163 trays with the designated diets within one hour. Dinner, to the staff, is a battle for time.

The seating arrangement in the nurses' lounge is determined by occupation. The housekeepers and kitchen crew sit at the small kitchen table. The nurses' aides sit on the couch. The RNs and LVNs shun the

lounge entirely. Everyone else sits on one of the chairs scattered in the room.

The positions are rigidly exclusive in the minds of the workers. The place where one eats lunch is determined by one's job — not by whom one wants to be with or where one feels most comfortable. I asked Lupe if she noticed the segregated seating arrangement. She said, "Of course." A worker only sits with one's peers, even if one sees a person of another job category more frequently during the day.

The hierarchy of jobs becomes overt when a patient requests a glass of juice. The patient makes his or her request known to a housekeeper (housekeepers clean the patients' rooms and talk to the patients as they work). The housekeeper will tell a nurse that the patient wants some juice. The nurse will send an aide to get the juice. The nurses' aide will tell the dishwasher in the kitchen. The dishwasher will deliver the juice to the patient. There is no written or spoken rule which prevents a housekeeper from getting the juice. Yet, none of the staff expects the housekeeper to do so even when s/he cannot continue cleaning the room until the patient is satisfactorily quieted with some juice. Staff members determine their actions by their relative positions within the hospital staff structure.

To clarify this, I have compiled a list of duties for each job by asking a member of each occupation to state what s/he does. It should be noted that the job duties indicated on the list (see chart number 4) are perceived by the job-holders themselves and not by the whole staff.

The unspoken expected occupational roles determine the behavior of the staff and provide a barrier for workers in different jobs to achieve common goals. The cooks, aides, LVNs, housekeeper, etc., each have unique goals.

At first glance, the hospital might appear to be a paragon of efficiency. This is not the case. When a problem occurs (such as a breakdown of the hospital's only washing machine), no one steps out of his or her expected role to solve it. No worker offers assistance to a member of another job category even if fulfilling his job depends on this cooperation (such as a nurses' aide waiting for a laundry worker to fold sheets before he or she can make beds).

Chart Number 4: Job Duties

Nurse (RN)
- keep charge of hospital
- tell nurses' aides what to do
- take temperatures
- help patients practice physical therapy exercises
- keep charts on patients

LVN
- give medication
- feed patients
- clean wounds

Housekeeper
- clean all rooms in hospital
- disinfect furniture when patient dies
- clean up "puddles" patients leave on the floor

Maintenance Man
- sweep driveway
- take out garbage
- fix broken furniture
- change light bulbs
- clean ceiling

Cook and Assistant Cook
- make sure food is delivered
- cook three meals

Kitchen Helper
- wash dishes, pots, and pans
- clean dining room
- hand out snacks for patients

Nurses' Aide
- give patients baths and showers
- keep daily charts on patients
- dress patients
- brush patient's hair and teeth (dentures)
- shave male patients
- push chair-ridden patients to dining room and lobby
- collect linens

Recreation Worker
- keep charts
- talk with patient's relatives and visitors
- lead weekly bingo games for patients in dining room (distribute bingo cards, call numbers, award candy or other awards to winners)
- show free or low cost movies (usually advertising and nature films; schedule movies; run projector for patients in dining room)
- contact and arrange dates for state-supported Adult School teachers to come to demonstrate crafts (e.g. making paper flowers and stringing noodles) once a week in the dining room)

### Attitudes Towards Patients

Besides job classification, the workers have also developed their own terminology for the residents of the hospital. When speaking of more than one resident, the staff uses the words "patients," "feeders," and "babies," "diabetics" or "sleepers." The physical needs of patients are stressed in these terms. The social needs of patients, however, are not referred to. The word "patients" reflects the physical care that all the residents at the institution require. The words "feeders," "babies," and "diabetics" refer to patient diet groupings. These words are used in many contexts — not just in reference to food. The term "sleeper" is similar to its dictionary meaning. "Sleepers" are patients who do not lift themselves out of bed in the morning.

More often then not, the staff classifies patients in groups. Even though workers see patients everyday, they seldom refer to the patients on a first-name basis. The staff thus deemphasizes the individuality of each patient.

The staff usually addresses each patient by the patient's full name, e.g., Maude Hendstein or Mara Williams. Patients, however, are sometimes referred to by first name only, especially when the staff member who is speaking is complaining or making fun of the patient:

> Maude kept asking me for a cigarette. I'm tired of her banging on the door. She knows I don't smoke.
> I opened Charlie's closet and he had eight smelly old coffee cups inside. I think he's starting a collection.

## Job Perception and Implications

Collectively, how the staff perceives its job determines whether or not it acts in a responsible manner. Responsibility directly reflects the workers' conceptions of their own jobs. The convalescent hospital workers have a sense of responsibility to their jobs but primarily to the duties seen as *required*. The workers do not have high regard for their positions and do not perceive their jobs as intrinsically stimulating or as an honor to perform. They view their work as necessary care for the patients or as a means of earning money.

The workers, as a whole, try to get as much work done as possible in their respective shifts. At the end of each shift, with the exception of two supervising nurses, all workers are replaced. This procedure might seem an ideal situation for a worker to leave much of his work for the one who is replacing him. The dishwasher might leave dirty pots and pans. The aide could leave a patient in bed, knowing the next aide would have to awaken the patient. Yet, very little job shirking exists. In fact, the workers try to accomplish as much work as they can in each shift. A nurses' aide told me:

> The men only get a shave once a week. But when I work I make time. When I get my charts done fast enough, I have time for one or two shaves. The patients like to be clean — I guess it was the thing to shave when they were younger, no beards.

The assistant cook also had long hours:

> The patients need little surprises — something a little extra. Once in a while — I do it often — I'll make coffee cake or muffins for breakfast. They're not on the menu. They're just a little something extra.

No one complained about workers on another shift not doing their work. I did, however, hear many complaints about persons sharing the same shift as the complainer. Notes like this one I found in the laundry were common:

> TO WHOEVER IS WORKING NEXT SHIFT ... I spilled some bleach on the floor and mopped it up near the window don't mop it again it's clean just has to dry.

Even so, the workers undeniably do not enjoy their labor. The high turnover rate and degree of absenteeism serve as evidence. If a person does not go to work for a day, s/he feels no qualms. S/he knows someone will be available for substitution. In fact, substitute employees work just as many weekly hours as fulltime employees:

> I'm an 'on call' aide which means I have the best nurses' aide job. Every morning I get a call from the hospital and tell the nurse whether I want to work that day or not. I don't have to work. My work isn't obligatory. When I don't feel like working, I don't work. I don't have to call in sick. So many people stay home. I get just as much work as any nurses' aide. Everybody wants my job.

A housekeeper told me when he was absent from work the previous day:

> I don't get paid worth nothing and they were having a special basketball game at my brother's high school.

In addition to high absenteeism, there is a lack of a common goal among the workers other than "keeping the hospital running." The staff sees itself stratified according to individual jobs. Aside from writing notes to the next shift on such things as changes in a patient's feeding habits, the staff does not discuss ways it can improve working conditions or patient care. The workers do not reward or praise one another for work they have done well.

The staff works very hard. There is little time for a staff member to think consciously of the implications of his or her work. The workers see no future in their jobs. The fact that the workers are paid minimally with almost no chance of advancement influences the way workers respond to their jobs. In such circumstances, a high turnover rate is not surprising. The workers do not place much value on their jobs. The workers do not have a common goal because they will not stay at the hospital long enough to see such a group goal accomplished. They only expect their jobs to bring monetary rewards.

The workers believe in the benefits of gaining money through work, even when the work is displeasing:

> After I make it to July, I'll have enough money to buy my M.G. (car), then I'll be able to travel to a better job.

The staff believes in the larger American ideal that hard workers will climb the monetary income ladder to success. They live for their future jobs and do not think of upgrading their present working conditions.

The workers see themselves as products and extensions of their jobs, with little personal variance. They believe they will better themselves by obtaining prestigeous jobs. If a worker does not feel satisfied with his present life, he blames his feelings on his job:

> I'm gonna finish DVC (Diablo Valley College) next year and then I won't have to suffer being a stinking janitor anymore.

The staff shares the overall American attitude that a person's worth depends on his or her job. This attitude represents the view that successful, "good" people have prestigeous jobs and that these people have obtained their jobs through individual merit.

The lack of importance the workers attach to their jobs has a direct effect on the way the staff considers its obligations to the patients. The workers do not consider the actions involving taking care of the elderly a privilege, honor or duty. The maintenance man summed up the general attitude of the staff when he said, "I can't wait for another job."

## Conclusion

The staff's attitude towards its jobs and towards the hospital affects the patient in at least five ways. The staff, a potential link between patients and outsiders, view patients as part of a work situation. There is a tendency for the staff member to treat patients in an impersonal, impermanent manner. The patient is left with almost no chance (except in visitor meetings) of forming new personal social ties with people living outside the hospital.

The patients need the security of lasting contacts — people whom they can see consistently week after week. Because of the staff's high turnover rate, the patient constantly sees new faces tending his or her basic needs. The patient may come to believe people are not concerned or are abandoning him or her.

The patient may eventually question his or her own capacity to physically and socially function if he overhears someone calling him or her a "feeder" or if s/he is treated only as a "baby."

In addition, the patient, continually exposed to the staff's strict job delineations, may come to act as if individuals can only function in accordance with prescribed roles. For patients who are confined to the hospital for long periods, this formality destroys any sense of personal concern or "homelife" the patient may need to feel.

Finally, a patient eats every day with staff members present but no staff member ever eats in the presence of a patient. The very fact that the staff members flock to the nurses' lounge or restaurants during breaks may make the patient feel further isolated from the "outside world."

Clearly, the staff's current attitude towards its jobs and the hospital affects patients adversely. There are many things that can be undertaken to change this attitude. If the staff were better paid, it might value its jobs to a greater extent. The administration could stress the interconnectedness and often the interchangeability of duties. Patients and staff might share meals and other activities. Some capable patients could assist staff members in their work breaking down barriers between staff and patient groups.

Further research could complement this study of how the convalescent hospital staff views its jobs. An investigation of how the workers' social lives function outside the hospital and how the staff interacts with people of different occupational backgrounds might also shed light on this question. The staff's interaction with patients and the patients' attitudes towards the staff also should be studied. Further research might compare the cultural conditions of a staff that has set common goals (possibly in a school, prison or orphanage) to the cultural conditions of the convalescent hospital staff. Of course, a most enlightening manner of research would be for an ethnographer to work as a staff member in the hospital.

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