Lessons From my Life's Work

James Bradley

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ARTICLE

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Almost thirty years ago, I entered the caring profession as an Auxiliary Nurse, on a temporary basis, as a prelude to taking formal training as a Registered Nurse. Since then I have had many titles, held many positions

and roles and worked in many different care settings. I never did take that RN training but that temporary job became my life's work!

I am a carer. A hands-on, at-the-bedside, hand-holding, bed-bathing, carer. Not only that, I am a male carer. I am not a failed doctor, I am not "hired muscle," nor am I gay and I certainly didn't enter the profession to be amongst so many women, as the stereotypes would suggest.

Put simply, I care for people and do for them what they would do for themselves under normal circumstances, were they able to do so. I can cook, clean, sew, iron, and make beds, bathe, toilet and many other things besides. Not only that, I can do more than one simultaneously. Yes, I am a straight, male carer who can multitask, which is perhaps why so many people have difficulty in understanding people like me!?

Every day, come rain, hail or shine; morning, noon and night, I care for others, often with as much compassion and love as if they were my own family. Once you have built up a relationship with a client or patient and his or her relatives, they can seem as close as family. The anomaly in nursing these days though, is that most RNs don't get the time to "be" a carer to the same extent that I do. That is the main reason why I made the decision to not pursue RN training, as per my original plan.

Internal and external politics, in addition to the "culture of litigation," has created a growing chasm between what nurses should be, what they want to be and what they actually are in fact. Many RNs joined the profession to be what I am now, only to find themselves bogged down in paperwork, mandatory annual education and undertaking tasks which once were the domain of junior medical staff. This is not a criticism of those RNs, but an observation on the nature of care, from the grassroots level. As those RNs are pulled away from providing basic care, who is left to fill the void created? That is where my peers and I come in!

There are literally thousands of people like me across the country doing the exact same thing I do every day. Yet, as stated, I am in a minority, for I am a male carer in a female-dominated environment. That

brings a whole set of differences in itself, some of which should never exist in a modern care environment and wouldn't, were they pertinent to females rather than males.

For example, imagine a male doctor telling an RN to "make the coffee" simply because she is female and used to being in the kitchen. Just consider how much upset that would create, with claims of sex discrimination and lack of professionalism. Quite rightly so, too. Then consider why it seems **[End Page 135]** acceptable for females to expect certain responsibilities be undertaken by males simply because "men are stronger than women" (not true either, based on some of the people I have worked with over the years!). These double standards rise up infrequently, thankfully, but the fact that they exist at all says much about the nature of formal RN training.

I was surprised at the job, initially, at how managers, education departments, etc. failed to recognize males in the profession—Florence Nightingale and her crew have a lot to answer for! It's even worse to see that discrimination against males still exists in some places, and by some people (who would claim to be "professionals") even today. There is no place in the Care Industry for those with such biased perceptions because, if they can hold such views about their colleagues, one wonders how they feel about their patients. Especially patients who may be challenging.

Sometimes patients' families can be...

Introduction
Learning From Those Working Most Intimately with the Residents in Long-term Care

Amy Haddad[1]*, Symposium Editor

1) Creighton University
*Correspondence concerning this article should be addressed to Amy Haddad at the Center for Health Policy and Ethics, Creighton University, 2500 California Plaza, Omaha, NE 68178.
Email: AmyHaddad@creighton.edu

Certified Nursing Assistants (CNAs) are responsible for nearly all of the direct patient care in nursing homes or long-term care facilities in the United States and account for nearly two-thirds of the total staff.

Most nursing homes are for-profit enterprises with an average of 107 beds (Centers for Disease Control and Prevention, 2000). The typical resident is female, widowed, and white with the majority over 85 years of age. CNAs are overwhelmingly female and black or Hispanic, or members of immigrant populations that reflect the ethnic composition of a community. To put it bluntly, the least educated, worst paid members of the long-term health care team provide the majority of care to the most complex patients a health professional could encounter. The work is literally back-breaking as most of the residents in a nursing home need help with the basic physical activities of daily living such as walking, transferring, eating, dressing, and toileting. Many residents also suffer from at least one type of mental disorder such as depression or dementia.

Thus, interacting with this frail dependent population places heavy emotional demands on CNAs. The potential for exasperation and abuse is high under such circumstances and CNAs can react with harsh words or neglect. However, abuse isn't one-sided. Residents can become frustrated and angry when care isn't delivered in the time frame or manner they want which can lead to verbal or even physical abuse directed at CNAs. CNAs comprise a vulnerable group of employees in health care with the highest rate of absenteeism and turnover among all health professionals (Fitzpatrick, 2002; Parsons, et al., 2003). The oversight of CNAs is minimal in most facilities. Their orientation to the facility and the residents is often scant. Their work occurs in relative isolation, generally hidden from public scrutiny. Few researchers have studied the experiences and perceptions of CNAs and attempted to understand their attitudes toward their work and interactions with residents, families, and supervisors. The little research that is available, often the result of observational studies, portrays CNAs' behavior as one of extremes—compassionate care givers or abusers (Foner, 1994). Clearly, there are examples of great kindness demonstrated by CNAs who sometimes serve as surrogate family for residents who are literally alone in the world. As with many roles that cross age, race, and socioeconomic lines, the intimate relationship between CNAs and nursing home residents is far more nuanced than these polar opposite types indicate.

In an attempt to tease out some the subtleties in this relationship, the call for stories for this narrative symposium included this request and these questions:

> We would like stories written by nursing assistants that describe their work—what is most

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2715 North Charles Street

Baltimore, Maryland, USA 21218

+1 (410) 516-6989

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