

# Double-Duty Caregiving: Women in the Health Professions\*

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## RÉSUMÉ

Le but de cette analyse narrative féministe était d'étudier les expériences de femmes qui oeuvrent dans quatre professions médicales différentes (soins infirmiers, médecine, physiothérapie et travail social) et qui fournissent des soins à certains de leurs proches du troisième âge. Bien que la prestation de soins soit un élément central et commun des vies personnelles et professionnelles de nombreuses femmes (Baines, Evans et Neysmith, 1991; Baines, 2004), la séparation entre les soins professionnels rémunérés et les soins familiaux non rémunérés, chez les fournisseurs de soins de santé, est problématique. Les conclusions de l'étude semblent indiquer que les professionnelles de la santé qui assument des responsabilités familiales négocient constamment les limites entre les soins qu'ils fournissent à titre professionnel et à titre personnel. Malgré l'utilisation de diverses stratégies visant à gérer leur double fonction en matière de prestation de soins, de nombreuses femmes ont ressenti un effacement ou une érosion de ces limites, ce qui a donné lieu à des sentiments d'isolement, de tension et de fatigue physique et mentale extrême. Ces résultats révèlent que les femmes qui fournissent des soins dans ces deux contextes, surtout celles qui disposent de peu de temps, d'argent et d'autres soutiens concrets, peuvent avoir des problèmes de santé, ce qui justifierait des études plus poussées.

## ABSTRACT

The purpose of this feminist narrative study was to examine the experiences of women in four different health professions (nursing, medicine, physiotherapy, and social work) who provided care to elderly relatives. Although caring is a central and common feature of the personal and professional lives of many women (Baines, Evans, & Neysmith, 1991; Baines, 2004), the separation of professional, paid caregiving from family, unpaid caregiving among health care providers is problematic. Study findings suggest that female health professionals who assume familial responsibilities continually negotiate the boundaries between their professional and personal caring work. Despite the use of a variety of strategies for managing their double-duty caregiving demands, many women experienced a dramatic blurring or erosion of these boundaries, resulting in feelings of isolation, tension, and extreme physical and mental exhaustion. These findings suggest that women who are double-duty caregivers, especially those with limited time, finances, or other tangible supports, may experience poor health, which warrants further study.

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\* This study was funded by the Social Sciences and Humanities Research Council of Canada (Internal Fund of the University of Western Ontario). A previous version of this article was presented at the scientific meeting of the Canadian Association on Gerontology and at the North American Primary Care Research Group Meeting. The authors wish to acknowledge the technical assistance of Abram Oudshoorn with the preparation of Figures 1 and 2.

Manuscript received: / manuscrit reçu : 06/07/04

Manuscript accepted: / manuscrit accepté : 29/03/05

**Mots clés :** vieillissement; prestation de soins dans la famille; soins aux aînés; professionnels de la santé; sexe; santé; travail

**Keywords:** aging; family caregiving; eldercare; health care professionals; gender; health; work

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## Introduction

Recently, the Romanow Royal Commission on the Future of Health Care (2002) stressed in its final report that Canadians needed and wanted a comprehensive health care system. What it did not emphasize, however, is that care work is primarily women's work and women's responsibility (Grant et al., 2004). In particular, it failed to address the unique needs of women, who provide the majority of paid health care and the majority of unpaid family caregiving (National Coordinating Group on Health Care Reform and Women, 2003). With the exception of medicine and dentistry, the health professions tend to be dominated by women. In 1998, more Canadian women (9,144) than men (3,516) received university degrees in the health professions and occupations (Statistics Canada, 1999). Women also continue to assume the bulk of responsibility for domestic labour, including personal caregiving responsibilities for older family members (Northouse, Modd, Templin, Mellon, & George, 2000; Ward-Griffin, 2002, 2004). This persistent differential representation of women in both paid and unpaid caregiving means that shifts in the delivery of health care from institution to the household tend to affect women to a greater degree than men (Armstrong & Armstrong, 2001; Gregor, 1997; McKeever, 1994).

In times of economic constraint, when public expenditures on formal services for the elderly are either reduced or frozen, women are usually the ones who shoulder the physical, social, emotional, and financial costs of family caregiving (Armstrong & Armstrong, 1994, 2001; Aronson, 1992; Hooyman, 1990; McKeever, 1992, 1994; Neysmith, 1991; Pearlin, Mullen, Semple, & Skaff, 1990; Walker, 1991; Ward-Griffin, 2002, 2004). During the 1990s, the proportion of provincial funds devoted to home care remained relatively constant, while privatization was used as a primary cost-cutting strategy in health care reform in Canada. Additionally, health care reforms such as shorter hospital stays were based on the assumption that families would look after their relatives at home. A decline in home care and acute hospital care resources in Canada is compelling women to take on more family caregiving responsibility than in the past (Wuest, 1998; Armstrong & Kitts, 2004). Furthermore, this invisible conscription into care work has only increased, as more people are being sent home "quicker and sicker" (National Coordinating

Group on Health Care Reform and Women, 2003). In addition, those providing paid health care are facing increasing workloads and increasing stress (Armstrong & Armstrong, 2001). Thus, women have been burdened disproportionately with the impact of recent health care restructuring, both in the workplace as health care providers and in the home as family caregivers. In short, health care reform in Canada, as it is being implemented, is a problem, not a solution for women (National Coordinating Group on Health Care Reform and Women, 2000).

In order to address the challenges specific to the health needs of women, especially those who provide care at home and at work, the primary purpose of this qualitative study was to examine the personal experiences of women employed in four different health professions (medicine, nursing, physiotherapy, and social work) who provided care to elderly relatives.

## Literature Review

Much of the theoretical literature addressing the interface between employment and family life conceptualizes these two spheres as distinct and disconnected from one another. Conventional models, such as segmentation, compensation, and spillover, tend to assume that what one does at work is dissimilar to what one does in the family. In particular, the spillover model has been used to guide research into health professionals' work and family roles (Barnett & Marshall, 1992; Gottlieb, Kelloway, & Martin Matthews, 1996; MacDonald, 1998). While the spillover model acknowledges that the activities and events in one's work and family influence one another, it is based on the notion that work and family are separate domains. Since the work and family domains in the everyday lives of women (and men) overlap with one another, separating them "obscures the meaning of phenomena in both" (Driscoll & McFarland, 1988). If we continue to think in terms of separate locations when considering women's caring work, we fail to understand the continuities in its purposes and outcomes, as well as the total effects on the determinants of women's health.

Another major limitation of conventional models is that they tend to ignore the gendered underpinnings of family caregiving. While some researchers discuss the effects of gender on what one does in one sphere or the other, most do not ask how gender relations

influence the adoption and development of the caregiving role or the consequences of combining employment and caregiving. To date, there is considerable evidence indicating that the experience of caregiving is different for women and men. Compared to male caregivers, female caregivers report more stress and burden (Blood, Simpson, Dineen, Kauffman, & Raimnon, 1994), more demands associated with illness (Armstrong & Armstrong, 2002), more unmet needs for help with household tasks (Allen, 1994), and a lower level of support (Northouse et al., 2000). These findings suggest that employed women may need additional support and assistance in managing stress as they carry out their family caregiving roles.

Although there has been increasing empirical investigation of employed caregivers, particularly those who care for children, research studies of women who engage in dual caregiving efforts in both the public and private spheres is almost non-existent (Denton, Zeytinoglu, Webb, & Lian, 1999; Guberman & Maheu, 1999; Phillips, Bernard, & Chittenden, 2002; Ross, Rideout, & Carson, 1996; Ward-Griffin, 2004). Most of these studies have focused on nurses' work and family lives. Ross et al. (1996) found that most hospital and community nurses experienced high levels of stress in both their professional and personal lives as nurses caring for relatives of all ages. In a survey of 892 office and visiting employees of three home care agencies, Denton et al. (1999) found that work-related stress is most acutely felt by those in managerial positions, nurses, and therapists. Walters and various colleagues (Walters, Beardwood, Eyles, & French, 1995; Walters, Eyles, French, Lenton, & Mayr 1995; Walters et al., 1996) found that caring for an elderly relative was positively associated with health problems for female nurses only.

Since it is women who are most likely to care for an elderly relative, these findings may point to the negative effects of *double-duty* caregiving for women. In a qualitative study of five women who were both paid health care workers (home-support workers, long-term care managers, and nurses) and unpaid family caregivers of elderly relatives, Rutman (1996) reported a sense of powerlessness and distress that cut across the paid/unpaid caregiver distinction. Similarly, Baines (2004) found that Canadian social service workers described many of the same skills, tasks, and mindsets within seven kinds of caring work, thus blurring the lines between professional and non-professional identities.

In response to increasing and ongoing caregiving demands, Guberman and Maheu (1999) found that 25 employed women, 8 of whom were professionals (i.e., nurse, lawyer, researcher), made continual

adjustments and accommodations in order to achieve "equilibrium in their lives". Phillips et al.'s (2002) study of the experiences of employed caregivers of older adults, some of whom were health professionals, found that work-related knowledge, information, and coping techniques at times acted as a buffer rather than an additional strain. Similarly, Ward-Griffin (2004) reported that female community nurses who were also providing care to elderly family members engaged in a variety of strategies. However, attempts at limit setting and delegation often proved unsuccessful in dealing with the demands and tensions of family caregiving. They voiced a greater sense of obligation to care due to their nursing status. While previous research has revealed that professional caregivers may share similar experiences in managing work and family responsibilities, this study suggests that women who are nurses and family caregivers may suffer an additional caregiver burden. Moreover, it is important to look beyond the personal coping strategies of caregiving to include strategies aimed at changing the structural social conditions of care work for women.

Although the aforementioned studies contribute to our understanding of combining employment and elder caregiving, less clear and less documented still is the meaning of women's caregiving activities in both their professional and personal lives. Moreover, the blurring of boundaries between paid and unpaid caregiving among health care providers is even less understood. Clearly, future research into double-duty caregiving across a variety of health disciplines is warranted. Only when the results of such research are known can we fully understand and address the health effects of simultaneous participation in the private and public domains of caregiving (Ward-Griffin, 2004), as well as identify the socially constructed structural conditions requiring change.

## Methodology

### *Theoretical Framework*

The current study was informed by a socialist-feminist perspective, most notably the writings of Ungerson (1990) and Hooyman and Gonyea (1995). The application of a socialist-feminist perspective helps to address some of the limitations in the conventional theoretical frameworks mentioned above. Since socialist-feminist thought is based on the premise that the public and private spheres are interwoven and interdependent through the idea of reproduction and production (Pascall, 1986), research grounded in this type of inquiry provides a set of sensitive and complex analytical tools for understanding the structure, process, and outcomes

of double-duty caregiving. The construct of reproduction–production, with its emphasis on unpaid and paid work, highlights the artificial boundaries between the market, the family, and the state. That is, the capitalist state has a direct interest and role in reinforcing the public and private spheres and supporting gendered patterns of caring (Clarke, Cochrane, & Smart, 1987; Hooyman & Gonyea, 1995; Walby, 1994; Walker, 1991). A feminist inquiry acknowledges that caring work cuts across the personal and political boundaries of family/employment and family/public policy (Hooyman & Gonyea, 1995). Thus, a socialist–feminist approach to caregiving explores the connections of women’s domestic labour with other forms of work (Ward-Griffin & Marshall, 2003), acknowledges the ways in which economic and political forces shape the personal experiences of caregiving (Armstrong & Armstrong, 2004), reveals hegemonic social arrangements and their ideological frames (Fine, 1994), and supports the development of progressive social policies that promote the health of the women and men who provide care in both their professional and personal lives.

#### *Purpose and Design*

The purpose of this feminist narrative study was to examine critically the ways in which women, as health professionals (nurses, physicians, physiotherapists, or social workers), experienced providing care to older relatives. These specific disciplines were chosen for a number of reasons. First, in comparison to other health care occupations in Canada, nursing (4,302), social work (2,991), medicine (1,663), and physiotherapy (633) graduated the greatest number of university students during 1997–1998 (Statistics Canada, 1999). Second, with the exception of medicine, these disciplines are female-dominated. Moreover, the number of women graduates within medicine has dramatically increased over the past few years (Statistics Canada, 1999). Finally, these four health professions represent a diverse group of women, who provide health care across a variety of settings, including home care, acute care, long-term care, and outpatient clinics.

An exploratory qualitative approach was chosen because so little is known about the experiences of health professionals as family caregivers. This is an appropriate method given the objective of trying to understand the dimensions, strategies associated with, and consequences of a particular phenomenon (Lofland & Lofland, 1995; Morse, 1994). Guided by a feminist narrative inquiry, the following research questions were addressed: (a) How do female health professionals caring for elderly relatives describe

familial caring work? (b) What contextual factors influence the provision of familial care to elderly relatives? (c) What strategies are used to negotiate the boundaries between paid and unpaid caring work? (d) What are the consequences for health professionals who provide familial care to older relatives? This type of inquiry was useful as a framework for conceptualizing the interview and exploring questions of human agency. Overall, it served to explore new understandings of the intersection of women’s paid and unpaid caring work and to identify possibilities for positive social change.

#### *Sample*

Participants were recruited over an 18-month period (fall 1999–summer 2001) from southwestern Ontario. Multiple recruitment strategies were necessary in order to reach as many potential participants in each of the four health disciplines as possible. Nurses employed at two community health care agencies received a letter of information in their company mailboxes inviting them to participate in the study ( $n=72$ ). One of the co-investigators (McNair) contacted local family physicians by telephone and by personalized letter ( $n=237$ ) requesting their involvement in the study. The London and District Division of the Ontario Physiotherapy Association (LDDOPA) was contacted by mail to obtain a list of practitioners in the area. Advertisements were also placed in the LDDOPA newsletter. An e-mail containing information about the study was circulated to practitioners at two major health institutions in the city as well as at the university. Similarly, social workers working in the area of health care in the region received telephone calls and letters explaining the study. The practice leaders in seven health care settings were also sent an e-mail, inviting them to share this information with their social work colleagues. In addition, an invitation to participate in the study was issued at the in-service meeting for social workers at one of the major health care institutions in the city. Finally, known nurses, physicians, physiotherapists, and social workers were contacted directly to determine if they fit the eligibility criteria or if they knew of any of their colleagues who might qualify. To be eligible, participants had to speak and understand English, provide at least 1 hour of care on a weekly basis to an older relative or friend; and work part-time or full-time in a health care facility. Ultimately 37 women representing four different health professions (15 nurses, 6 physicians, 7 physiotherapists, and 9 social workers) enrolled in the study (see Table 1).

Study participants ranged in age from 23 to 69 years, with a mean of 47 years. The mean age for nurses was 44 years, for physicians 54 years, for physiotherapists

**Table 1: Recruitment methods**

Disciplines	Recruitment Strategies	Total Enrolled
Nurses	Letter of information via office mail (n = 72)	15
Physicians	Personal letters via regular mail; telephone calls (n = 237)	6
Physiotherapists	Letter of information via e-mail; advertisements in professional newsletter (n = 55)	7
Social Workers	Letter of information via regular mail; telephone calls; e-mail to practice leaders in seven health care / hospital settings; invitation to participate at an in-service meeting (n = 261)	9

48 years, and for social workers 43 years. The majority of the participants were married, worked full-time, and held a baccalaureate degree with post-graduate training. Most provided care to their parents or parents-in-law. Other elder care recipients included grandparents, siblings, friends, aunts, and spouses. Approximately one third of the participants provided care to two or more elderly relatives.

#### Data Collection and Analysis

The major sources of data for the study were 37 in-depth audiotaped interviews and their corresponding field notes. Demographic data were collected from the participants at the end of each interview and were analysed using descriptive statistics. Interviews were scheduled at a mutually convenient time and place and interviewers used an in-depth, focused interviewing approach (Merton, Fiske, & Kendall, 1990). Almost all the interviews were conducted in the participants' homes or offices.

In keeping with a feminist narrative inquiry, participants were asked non-directive questions, designed to trigger dialogue about their caregiving, as health professionals and as family members. This approach encouraged each participant to discuss what she thought was most important. It also provided an opportunity for each participant to *story* her experience (Riessman, 1993). In response to open-ended questions (e.g., What is it like to provide care to an elderly relative? What are the advantages/disadvantages of engaging in both personal and professional caregiving?), most participants discussed their double-duty caregiving experiences freely. However, only with prompting would participants expand on the similarities and contradictions of providing professional care in the private sphere. As well, probes and clarifying questions were used at times to understand each participant's story and to ensure accurate understanding and interpretation. Time spent in individual interviews ranged from 60 to 120 minutes, with an average of 90 minutes. Participants were also given the opportunity to attend a follow-up focus group in order to respond to emerging interpretations of their experiences as well

as clarify or elaborate their ideas. Twenty-one of the original study participants attended one of the three focus groups, thus serving as a means of member checking of the key findings from the individual interviews.

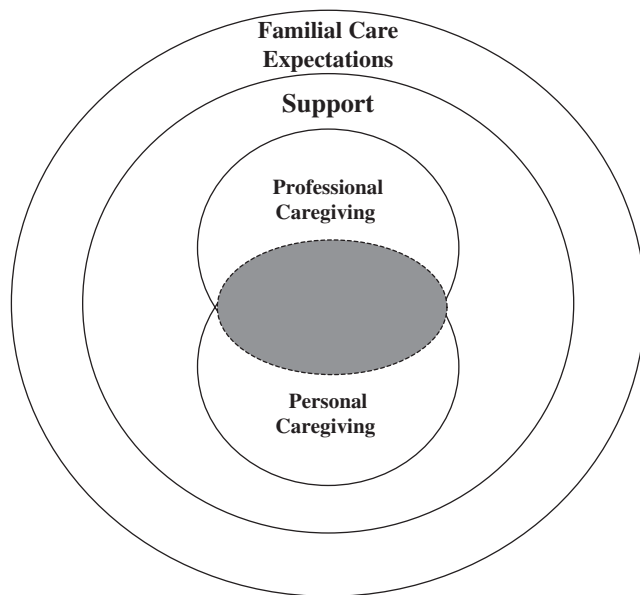
As soon as possible after each interview, data were transcribed and analysed. Following the guidelines of Lofland and Lofland (1995), early analysis focused on key phrases and themes that emerged from the data. As common themes emerged (e.g., expectations, support), an initial coding system was created. Numerous and varying codes were thus inserted into the text by hand and then entered onto NUD\*IST, a software program used to facilitate qualitative analysis (Richards & Richards, 1994). During the final stage of analysis, a conceptual model was developed (see Figure 1).

#### Findings

The goal of this study was to understand better the interface between personal and professional caregiving among health professionals representing four different disciplines: medicine, nursing, physiotherapy, and social work. Findings revealed that health professionals who assume elder family caregiving responsibilities are located at the juncture of the public and private domains of caregiving, where they constantly negotiate the boundaries between professional and personal caring work.

#### The Experience of Double-Duty Caregiving

Figure 1 depicts a conceptual model of the experience of double-duty caregiving. This study illuminated three inextricably linked components of double-duty caregiving: (1) familial care expectations, (2) level of support, and (3) negotiating strategies. As a result of their health professional background, the participants were expected to assume a variety of responsibilities, such as advocating on behalf of their older relatives and supervising their care. As internal and external expectations of familial care increased over time, and for some, during episodes of the acute illness of their relative, participants experienced a dramatic blurring



**Figure 1: Double-duty elder caregiving**

of the boundaries between their public and private spheres of caregiving. In short, health professionals were expected to provide unpaid, professional care in their personal lives. In order to manage these additional caregiving demands, family, colleagues, and professional resources were identified as the primary sources of support, providing emotional, informational, and instrumental assistance. As well, a number of interrelated negotiating strategies were reported by the women as being somewhat useful to contain the expectations of others and/or expand their supports. Thus, the extent of blurred boundaries between professional and personal caregiving depended on the internal and external expectations of providing familial care and the level of support available. The following section will more fully describe each component of double-duty caregiving, accompanied by illustrative quotations.

#### *Familial Care Expectations*

All the participants reported that they were expected to care for their aging relatives and that these expectations were particularly strong. Some talked about the gendered expectations of women and family care, while others described feeling obliged to provide care because of their professional background. Most talked about these dual expectations simultaneously, as illustrated in the following quotation from Crystal, a nurse who had been caring for her mother with Alzheimer's disease for four years: "I was expected to care [for my mother with Alzheimer's disease] because, one, I am a nurse; two, because I am a daughter; and probably three, I am a mother.

Also you are supposed to know these things (as a nurse), so I did have an expectation of myself."

Expectations of self and others had a profound influence on the types of caregiving responsibilities assumed by the women. High expectations of self were attributed to having the necessary professional knowledge and skills. Most felt that they had no choice but to provide care, since they usually had up-to-date knowledge about their relative's condition and/or treatment options. If they did not have the most current knowledge, they knew how to acquire it. Moreover, the women usually provided professional care to their relative because often there were no other options and/or they believed that potential harm might come to their relative if they withheld care. Carol, a physician, had been responsible for monitoring the care of her aging parents, both of whom had chronic health conditions: "I can help assure that they are getting the best care available. I think that they [parents] would both be dead now if I wasn't a health professional, a doctor."

Years of professional training and experience usually placed the participants in the inevitable position of the "health professional" in the family. In a few situations, some of the women shared the responsibilities of care with siblings who were also health professionals. However, where participants were the only health professionals in the family, their family members relied heavily on them, expecting them to explain technical terms and treatments. Since they were familiar with the ins and outs of the health care system, they were expected to navigate the family's caregiving efforts, to be the "family spokesperson." In the words of Barbara, a physician who shared the care of her mother with her siblings:

My two other sisters went to the initial assessment because I wasn't able to go. I was away. And they were really disappointed with the interaction that happened there and they felt that it was not very helpful and the doctor didn't answer a lot of their questions. And so they said, "We won't go without you again", because they felt that I could interpret things a lot for them and help them through that process.

Family expectations were particularly influential, sometimes pressuring the women to take on more caregiving responsibilities than they wanted. Monique, who worked in palliative care, recalled how her mother chastised her for not providing more care to her bedridden grandmother:

It's exhausting. I find that because I work in palliative care and I work as a nurse...going to sit with grandma is probably the last thing I want to do on my day off. But yet, I hear my mom say,

"You do it all the time. You care for other people. You could at least go and visit your grandmother." I know I want to go and give that care to her, but it's so exhausting.

Similarly, two participants explained how being the only health professional in the family was particularly demanding: "I find it more stressful being the only one in the family who has the health care knowledge. I find that part of it stressful because the whole family turns to me to have the answers and to make the decisions and some of them being very difficult" (Paula, social worker). "My brothers and sister were relying on me to be their leader. So, they would say, 'You're the caregiver' and 'Oh, gee you're the health care professional in the family; you know how to handle all of this.' But it is hard at times" (Cindy, physiotherapist).

Expectations of the health profession also had an impact on their caregiving experiences. Restructuring and the resulting cutbacks in hospital, long-term care, and home care settings appeared to precipitate additional expectations of family members who were also health professionals. Donna, a physiotherapist, described how long-term care staff relied on her to provide care to her father, even though she was requesting assistance: "As soon as some people know that you have any kind of medical background they sort of leave you and it's like 'Oh, you'll know what to do here', and it's like 'No, I don't, I am asking for help'".

Similarly Annie, a nurse, commented how hospital staff, once they learned that she was a nurse, expected her to provide unlimited care to her father, who was suffering from kidney disease: "[T]he nurses actually expected a lot of me. I don't mind giving mouth care and I would help them lift him up in bed... I'll help with back rubs, and positioning, but it was almost as if I did become unpaid help."

In another situation, Hazel, who was a social worker, recalled how the discharge nurse in the emergency department assumed that, because she was a health professional, she could therefore provide follow-up care for her mother without any formal instructions:

I went into Emerg[ency] and said, "I'm her daughter. May I speak to someone who saw her?" And the response was, "Well, she has a head injury. You're a nurse so just follow head-injury protocol." And I said to her, "I'm not a nurse. I am a social worker." She said, "Well, you know head-injury protocol." And I wasn't a social worker in a head-injury program. So that nurse sort of left and I am left standing there... It was the desk clerk who went and rounded up one

sheet of paper on what to do for a person in the first 48 hours after a head injury.

Expectations about familial caregiving greatly influenced the types of caring work assumed by the participants. In addition to the usual family caregiving activities (e.g., personal care, providing meals, driving to appointments), participants assumed additional responsibilities, due to their professional backgrounds. Many of the participants provided or coordinated the care of their elderly family member on an ongoing basis. Although providing professional care was a common theme among all of the participants, it was most common among physicians and nurses. While nurses monitored their relatives' physical condition (e.g., blood pressure, response to medications), physicians tended to prescribe medications to family members even though they preferred not to assume this responsibility. Carol explained,

I don't want to be her doctor. I want to be her daughter. But I do things out of necessity. For instance, if the homemakers phone and say that she's out of medication, then I phone the pharmacist. I've done that three or four times now because of this switch over to the family doctor and because they were late getting the records and we didn't get in as early as we needed to. And so I have been renewing her medications myself.

In addition to direct patient care, many women coordinated their elderly family member's care. They realized that delegating care to non-medical family members usually led to making sure that these same individuals carried out these responsibilities accordingly. In the words of one nurse (Natalie), "I just know that I can't be doing everything. Other people have to pitch in. But then I have to coordinate and make sure everybody is pitching in at times, and if not, to find the care that is needed."

Assuming the responsibility of coordinating caregiving efforts usually included the need to teach others and then supervise the care provided by family members who did not have a health professional background. Coordinating the care of a relative did not relieve the participants of any appreciable amount of care; if anything, it increased their sense of responsibility. As one physiotherapist (Jane) explained,

My brother and sister are not comfortable within the medical arena. So I have to teach them to ask, to learn how to do other things... it doesn't help. It doesn't take me off the hook... it doesn't save time. I am still the coordinator. I am still the doer because you still have to do this team teaching, almost kind of thing, all the time.

As health professionals, many participants were asked to provide information about medical conditions and procedures, and sometimes, they were asked to give advice beyond their scope of practice. For instance, the elders or other family members would ask questions prior to or after visiting the doctor to verify their concerns, seek out information about community resources available, or ask their opinions about medications or other treatments. Beth, a social worker, described what it was like to care for her mother-in-law:

My family tends to call me to help them start to problem-solve, like, "What we should do next?" Or things like "She's on this type of drug; should she be taking something like that?" I mean, I even get questions like that and I have to remind them, that's not my skill. I can give them the resources or the information where they can go to get that information. I say things like, "Well the next time she goes to the doctor's appointment, go with her and take these questions with you." And together, we write down the questions.

Sometimes providing information or making suggestions in relation to their relatives' care was not sufficient. The women felt they needed to advocate on behalf of their relatives, especially if they were not in the position to speak for themselves. Due to their relatives' lack of knowledge about the health care system, medical condition, and/or treatment options, the participants advocated on behalf of their family members, especially if the care recipient's physical or mental condition prevented them from making decisions. Participants were adamant that tests, procedures, and treatments be explained and understood fully so their elderly relative could make informed decisions. However, many suggested that their relatives were either reluctant or unable to ask questions about their condition or treatment regimen. One nurse (Annie) explained,

I just felt that being the nurse and being more knowledgeable and given the types of questions he had and how the doctor made him feel, I wanted to check it out, so I went to the most important doctor's visits at first. But during the radiation regime I have become more involved. My dad had a hard time articulating his needs at the best of times, so being in kidney failure, he wasn't that able to articulate anything and so I basically was his advocate. I advocated for my father because he couldn't advocate for himself.

Taking on the responsibility of advocate also occurred if the participant believed that the suggested medical course of action was inappropriate, jeopardized her relative's, health or hindered chances of recovery. As one physician (Brenda) aptly stated, "I'm willing to push the envelope always a little bit further. I know

where the deficits are in the health care system and I don't necessarily have to tolerate them."

In sum, all study participants reported that they experienced greater expectations to provide more complex care to their older relatives compared to others in their family who did not have a health professional background. Although many participants provided familial caring work that closely resembled their day-to-day professional caregiving, few acknowledged this contradiction. Rather, participants reported the expansion of unpaid family caregiving in terms of the need for more supports as their caregiving demands increased.

#### *Level of Support*

The participants received varying degrees of emotional, informational, and instrumental support from family, colleagues, and community resources. For those who were married, spouses were often described as "supportive" and "wonderful", who often "put things into perspective", or helped them stay "grounded". For others, supports from siblings and/or adult children, especially daughters and sisters, were critical to help them manage the care of elderly parents. Carol, a physician, explained, "My daughter is much better with dealing with her [mother/grandmother]... I've got a great resource in my daughter who really, I think, has taken on a lot of my role." Although sharing direct caregiving responsibilities often helped "lighten the load", this type of support helped them to cope in other ways. In the words of Nancy, a physiotherapist caring for her mother with dementia, "I have a brother and he's been pretty fabulous... he admits that he can't provide the physical care but he sees me going through it so he's a huge mental support. He provides companionship. On the days he comes around, it's like a huge relief."

The sense of total responsibility was particularly noticeable for one physician (Brenda), who did not have the sibling support mentioned above: "It's an absolute fact that I have nobody else to rely on. I have my husband and my friends, but as far as counting on other family members, I don't have any."

In addition to or in lieu of family support, a few relied on colleagues to provide necessary support. Allison described how her colleagues in social work met regularly for lunch, which helped her and others provide support to one another:

There's a group of us, probably 10 of us, that meet for lunch almost daily and there are at least three social workers who have elderly parents, and they are the principal caregiver in addition to their own families. So there is a lot of camaraderie there; you know, we understand



[each other's experiences]. One just recently had to place her mother-in-law, that kind of thing. Even at lunch time, you have a place to kind of vent and feel very supported actually. It's a good group.

A few participants claimed that their co-workers would also "cover" for them during short-term absences or alter their schedules to help them out in accommodating their double-duty caregiving demands. For others, colleagues, however, were not considered a support mechanism for a variety of reasons. Some of the health professionals worked fairly independently, which did not allow for much collegial interaction. This was the case for community health nurses and, to a lesser degree, physicians. A few participants said that they did not discuss their elder caregiving situation with their peers or supervisors because these types of discussions were not encouraged in the workplace nor did they feel comfortable about discussing their private affairs with co-workers. Betsy, a physician, finally told her co-workers about her situation of providing daily personal care for her mother because of the pressure to work more hours: "The people that I work with wanted me to take on more clinic hours. So I finally had to let them know what was going on. Once I did that they were fine with it."

In addition, health care restructuring over the past few years has contributed to the creation of stressful, competitive work environments. This type of work environment does not usually provide the collegial and administrative support required by double-duty caregivers, as Cindy, a physiotherapist, explained,

My doctor said, "Well if you're so stressed, just take a leave of absence." I just sort of laughed and said, "Do you want to know how well that would go over in my workaholic's environment where you are expected to do enough work for two people?" It just won't go over well. I mean nobody is going to respect the person who is having the mental health struggle and nobody is going to cover you and if they do they are going to resent you when you come back...I've seen it happen. That's the payback because everybody is already being two people in the workplace.

Another participant, Elizabeth, claimed that a supportive nursing environment is exactly what is required to help manage work and family responsibilities, but sadly, it is hard to find in the current context of health care cuts:

A work place that's caring is the best thing that they can provide but doing that is not easy in this environment. I mean it hasn't been [supportive]

for the past 10 years...I feel that nurses have picked up so much slack and taken so much of a hit with this health care system that they don't feel cared for, so it's really hard to keep the energy up.

Participants who had workplace supports, such as an understanding manager, flex time, and unpaid leave of absences, considered themselves "fortunate". From their perspective, these supports allowed them to combine personal and professional caregiving without too many negative repercussions, either for themselves or for the people they cared for. In most cases, the current shortage of health professionals, however, prevented them from taking advantage of many of these work place supports, especially time off work. Although all the participants acknowledged the need for more community supports, such as home care and long-term care, they were very much aware of the decreasing supports available and of what they had to do to ensure that their family members did not suffer any negative consequences. As one nurse, Kim, aptly stated,

In reality it is very hard to get home care, especially in this day and age, where there is so much restructuring of health care and shortage of resources. I know as a nurse that professional nurses and physicians – they are under a great deal of stress. Unfortunately, I believe that they don't meet all of our [family] concerns. That is why I am the gatekeeper. If you don't advocate for yourself and your family, nobody else will.

In the above situation, it is apparent that the lack of formal supports contributed to the blurring of boundaries between private and public, professional and personal, paid and unpaid caring work. Indeed, the presence or absence of suitable supports had a significant impact on the women's appraisals of their caregiving situations. Thus, the support network, as well as the internal and external expectations, influenced the type of negotiating strategies used by double-duty caregivers, to which we now turn.

#### *Negotiating Strategies*

Narrative inquiry offered insight into the human agency of the study participants and into the connections between the public and private domain of caregiving. A number of interrelated *negotiating strategies*, such as setting limits, using connections, and delegating care, were used by the women either to limit the caregiving demands on them or to expand supports in order to manage increasing demands. For the most part, *setting limits* was consciously used by all the women to help contain the expectations of family and professionals. The decision of whether to limit care depended on severity of need, the degree of obligation felt by the woman, and the availability

of quality care from others. Brenda, a physician, explained,

If my mother's breathing sounds wheezy on the phone, I will sometimes not mention it and after the call, my husband will say, "Gee, your mother's voice didn't sound good." And I say, "Yeah, well I know, but they know what to do with that, they have the drugs there." I am not going to go give them to her. I just can't take anything else on right now, so I just ignore it. Now . . . if she was so short of breath that she couldn't talk, that would be different.

Using connections was another common strategy the women employed to ensure that their family member received quality care. In some situations, they used their knowledge of the system and their professional status to acquire certain types of support, such as home care service or consultations with specialists who were not readily available. Using connections is a good example of how the participants' associations with the paid, professional world of caregiving assisted them with their unpaid familial caring work. In the words of Allison, who worked as a community social worker,

When Grandma was home with her open wound, I got a case manager that I had worked with for six years on the phone. I knew a wonderful nurse who I had worked with on a number of cases when I worked in the community and I said [to the case manager], "I'd like it to be X to go out and see Grandma." So of course, X went and was wonderful.

Another woman, Hazel, described how her nursing connections were helpful in attaining expedient service for her mother: "It [professional position] certainly helped me to direct the doctors . . . to get the care, to get the testing that I felt my mother needed. Like to get her past the family doctor onto the neurologist and onto internal medicine and that kind of stuff to make sure we're on the right track."

There were other times when inadequate care or unsafe conditions put their relatives at risk. They used their connections to obtain professional services that they knew were available but that were often being withheld or denied. This often led to a confrontation between the double-duty caregivers and the paid staff. Cindy (physiotherapist) explained,

I had to kick up a fuss and get a bit "pushy" and say [to the staff], "Do you not think that with 10 days of swollen toes, 2 of them hanging by a small bit of tissue, that they are getting worse? I mean there is something happening here. Can we not assist this by getting some antibiotics on board?" "Oh well, it's Saturday. We can't get the drugs." It would not have happened if I hadn't

pushed for them to call. In that way, I think that being a physio, I was able to get things rolling faster and point out this was going to get worse.

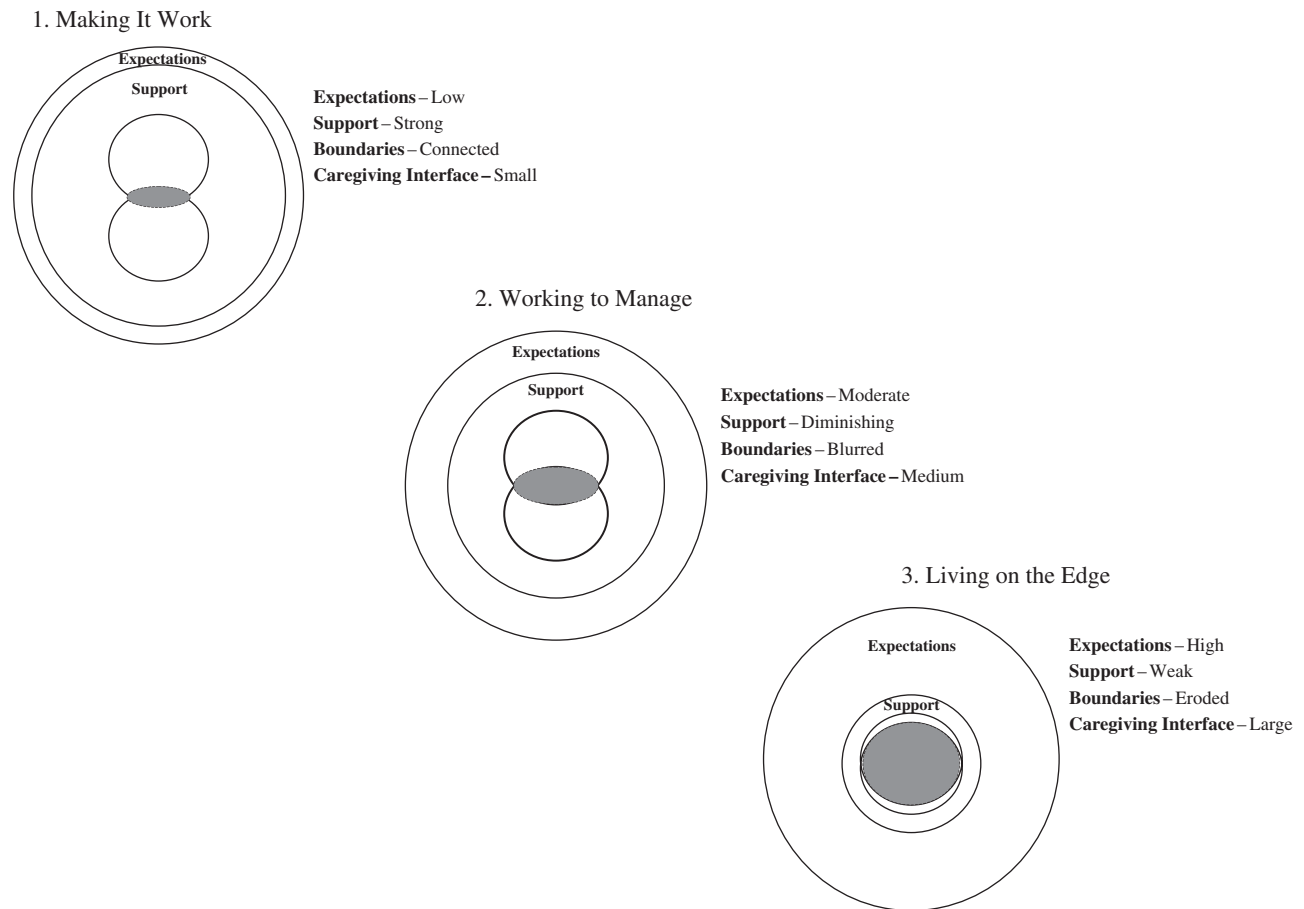
A few women, however, mentioned that they were reluctant to use their connections because they did not want to "step on any toes" or be perceived as "pushing their weight around". In these situations, the participants decided to provide the care themselves rather than bring in other paid professionals. According to one physician (Brenda), it was not worth the effort: "I just thought, I might as well do it myself. I'm over here [mother's house] anyway."

A third strategy, *delegating care* to paid professionals and/or family members, was used with varying degrees of effectiveness. Recognizing that they could not provide all the care all the time, they asked others to take on some of the caregiving responsibilities. Delegating care was primarily used by women when the care demands exceeded their level of supports. Over time, they realized they should not be the sole caregiver and that others needed to provide hands-on care. Often the participants delegated care to other family members, usually their siblings. However, being the only health professional in the family usually meant that they had to maintain involvement in the care of their elderly relative (e.g. supervise and coordinate the care provided by non-health care professional family members). As Jane, a physiotherapist, explained, "I've called my brother and sister to say, 'Get out here. I can't do this all the time.' So I am using them more and more to try to offset some of what I need to do. So I think that it will eventually pay off, but boy, there is just such a big learning curve on their part because they are not at all medically [orientated]."

Thus, delegating care to relatives without a health care background had little effect on the blurring of boundaries between professional and personal caregiving. For that reason, one social worker (Alison) explained how paid help assisted her in managing the expectations of double-duty caregiving:

I now buy some of those services for her [grandmother]. But I think that sometimes people do get caught up into thinking, "I have to do everything really well for my mom because I am the professional and I should be doing this." But I think that I have gotten past that . . . I arranged for frozen meals. So I made sure that she had meals in the fridge and not me running to her every night with the leftovers. That sort of thing. It doesn't have to be me.

The above quotation, as well as the next one, illustrates how setting limits and delegating care are simultaneously used by double-duty caregivers.



**Figure 2: Types of double-duty elder caregiving**

Although these strategies were somewhat effective in limiting demands while increasing supports, especially in the form of instrumental help, it is apparent that the source of these demands, the types of caring work involved and the resulting boundaries of care, involved multiple players, both paid and unpaid, as illustrated in the following quotation: “So I thought. I am not doing this anymore. So I said, ‘I’ll leave you to finish up with my dad and redress him with an appropriate diaper.’ And I walked out and I shut the door. So I virtually shut her in the room with my dad and told her what I needed to have done essentially” (Paula).

*The Blurring of Boundaries between Professional and Familial Caregiving*

Although the previous section outlined how the participants shared a common view of their double-duty caregiving experiences, it is important to note that there was great diversity in the nature of those experiences. Clearly, the nature of professional caregiving (nursing, medicine, social work, and physiotherapy) and personal caregiving in this study varied enormously. The majority of caregivers were

providing care for fewer than 10 hours a week, while others were engaged in more extensive and demanding care for more than one older relative. However, all the women acknowledged that there was a connection between their professional lives and personal lives of caregiving. This interface varied for each participant, depending on the degree of internal and external expectations of familial care and on the level of support available to manage multiple caregiving demands. Although preliminary in nature, study findings suggest that there are three distinct, yet interconnected, types of double-duty caregiving experiences: (1) *making it work*, (2) *working to manage*, and (3) *living on the edge*. Findings suggest that most of the women at the time of study reflected the working-to-manage caregiving experience. However, double-duty caregiving is a dynamic process, one that is not linear but is in constant flux. Consequently, double-duty caregivers tend to oscillate between the three different types of experiences, depending on familial care expectations, level of support, and negotiating strategies, as is briefly illustrated in the next section of this article (see Figure 2).

*Making It Work:* The internal and external expectations tended to be low in this type of caregiving experience, partly because the care needs of the elderly relatives were not excessive. Requests for assistance were usually periodic, fell within their domain of professional practice, and required a small amount of time. In addition, there was a tendency for participants to have strong and intact support systems in both their professional and personal lives. Moreover, using multiple negotiating strategies, such as setting limits and using connections, was usually very effective, especially for physicians and physiotherapists. For example, if the elderly relatives' care needs fell outside their professional expertise, some participants would refuse to provide care. Alternatively, participants with more financial and instrumental support would either refer or delegate the care of their older relative to a medical or nursing colleague. Women who were experiencing "making it work" were able to contain growing expectations, as well as solicit any needed assistance, which resulted in a minimal blurring of boundaries. Consequently, these individuals described how their caregiving efforts were recognized and rewarded by the care recipient and other family members. One physiotherapist (Beth) commented,

My mother-in-law's sister is the one who looks after her finances and the day-to-day care. She comes to me and says, "[Mother] needs a walker." I said, "Here's a couple of companies you can go to. If you need some direction or whatever, I'll be happy to do that." Kind of using your professional abilities and skills and knowledge to help them make decisions in specific areas... I am glad that I can be of some help.

*Working to Manage:* The internal and external expectations in working to manage were moderately demanding, and for some, had gradually increased over time. For instance, as the needs of the care recipient increased, many of the women felt obliged to offer more care than they had previously, as well as the need to acquire more health information outside their area of expertise. In addition, families and health care providers of the elderly relative expected them to assume more and more care and strategies for limiting care were not as effective. These women had little choice but to demonstrate ongoing competence in providing care because not demonstrating competence would carry consequences, not only within the family but also in interaction with other health professionals. At the same time, many of the participants' former supports within their home and workplace were not as available as they had been in the past. However, the supports in this type of caregiving experience tended to offset the

increasing familial care expectations. Nonetheless, in comparison to the first type of double-duty caregiving experience, the blurring of boundaries between their professional and personal domains of care had increased substantially, which frequently led to feelings of physical and mental fatigue, as one physician (Carol) described,

If I wasn't a physician I wouldn't be trying to think two steps ahead to try to prevent or ward off complications that might arise with the various medical problems. So my role as daughter and doctor overlap. It makes being a caregiver more mentally taxing and more physically strenuous because you're just trying to always do that extra bit to make sure that everybody is getting the best possible care available.

*Living on the Edge:* In the last type of double-duty caregiving, living on the edge, the level of familial expectations to provide complex, daily care was exceedingly high. If family and workplace supports had been present previously, they had weakened considerably. Participants said that they were the ones who were primarily responsible for the care of their elderly relative. Many indicated that, in addition to caring for their relative, they had to provide emotional and instrumental support to other family members who lacked health professional skills and knowledge. Consequently, delegating care was no longer a realistic strategy in sharing the care with other family members. Additionally, setting limits did little to maintain the boundaries between professional and personal caregiving. As their family member's care increased over time, the women experienced extreme exhaustion and loss of self. As a result, the boundaries between personal and professional caregiving were almost or completely eroded. Some participants, mostly nurses, took time off from paid professional caregiving work to provide unpaid daily family care. Others provided unpaid, professional care on their "days off", which frequently led to their providing more and more professional care in their personal lives. In the words of one nurse (Annie),

[His] nephrostomy would be leaking from his site. He needed a bed change. Well, they [nursing staff] were so busy, run off their feet. I would say, "That is something I can help with." ... Sometimes, we're not even conscious of when we're being the nurse and when we are the daughter, or the daughter-in-law in my case... I don't think it is separate.

## Discussion

Prior to discussing the implications of this study for social policy and research, some limitations need to

be addressed. Study findings serve as a beginning effort to understand the labour involved in the familial caring work of health professionals. Using a cross-sectional design, this study is limited to the perspectives of paid professionals in four disciplines providing familial care. No doubt the perspectives of other groups of health care providers, particularly those underpaid caregivers in our health care system (e.g., nurses' aides, home care workers, personal support workers, etc.) might be somewhat different. These workers may face more boundary issues, since they have fewer financial supports than the current study participants. Moreover, it is critical that future research focus on the intersections between the paid, underpaid, and unpaid caregivers, especially in the long-term care sector. Only then will we be able to address the resulting social inequities between and among elder care providers. Finally, these individual and focus-group interviews with health professionals have provided only a "snap shot" of the current double-duty caregiving experience. Although the participants recollected their previous familial caregiving experiences, multiple interviews with a variety of health care providers would result in a fuller understanding of how public and private caregiving boundaries blur over time and of how contextual factors shape those experiences. It would also be interesting to know whether the three different types of double-duty caregiving – making it work, working to manage, and living on the edge – are more or less prevalent in a variety of health care providers. This is a question deserving further study in a larger, systematic study.

Despite these limitations, the findings of this research afford several insights that are applicable to unpaid and paid work and to women's health. First, study findings lend support to the growing research efforts that explore work–life balance (Duxbury & Higgins, 2001; Guberman & Maheu, 1999); specifically, the strategies women use to manage caregiving demands (Ward-Griffin, 2001, 2002, 2004; Wuest, 1998) and the caregiving experiences of health professionals (Phillips et al., 2002; Ross et al., 1996; Ward-Griffin, 2004). According to Duxbury and Higgins (2001), work–life conflict has increased markedly over the past decade, suggesting that more employees are experiencing greater challenges in balancing multiple demands and responsibilities. In the current study, it was apparent that health professionals used a variety of strategies and resources in their individual attempts to address the blurring boundaries between their personal and professional caregiving demands. Although there is evidence in this study and others (Phillips et al., 2002; Wuest, 1998) that attempts at setting limits or boundaries help to contain the

familial caregiving demands of health professionals, at times, the women felt that they had no choice but to provide care, at least until other solutions or supports were found. In these situations, they reported feeling isolated in their attempts to provide familial care as health professionals. Clearly, study findings suggest the need to go beyond short-term recommendations designed to help women cope with their caregiving demands (Ward-Griffin, 2004). Rather, it is apparent that double-duty caregiving is not merely a problem for the individual to solve but is a creation of gendered social relations that require change.

Second, the socialist–feminist perspective used in this study offers a different approach from the ways in which the experiences of work–family balance have generally been examined. What makes this research distinctive is the focus on gender and other structured social relations that shape the boundaries and connections between personal and professional caregiving. This type of inquiry sheds light on the traditional dichotomy between paid, professional health care and unpaid, family care. Although many study participants reported using a variety of strategies and resources to address professional and personal caregiving demands, the more time, finances, and other tangible resources a woman had, she was better able to maintain the boundaries between unpaid private caregiving and paid, public caregiving. Moreover, recent health care restructuring has brought about further blurring of these boundaries (Armstrong & Armstrong, 2004). For instance, the cutbacks to health care services, as noted by many study participants, meant either that more care needed to be purchased in the market or that more of it must be assumed by unpaid caregivers. It is also noteworthy to mention that very few participants openly discussed the social inequity of providing unpaid professional care in their personal lives. This is a good example of how caregiving that crosses the public–private divide remains hidden from view, even from those who provide it. Thus, a feminist lens helped to understand that many participants reluctantly provided professional care to their elderly relatives without pay, within the context of a highly ideological and socio-political health care environment.

Third, not all double-duty caregivers experienced the same degree of boundary blurring. Study findings revealed three different types of caregiving experiences: making it work, working to manage, and living on the edge. In the latter two types of caregiving, as expectations increased and supports decreased, there was blurring and eventual erosion of the boundaries between personal and professional

caregiving. Women who found themselves living on the edge described feeling highly stressed and isolated in their caregiving efforts. Not only does the conceptual model contribute to a fuller understanding of the interplay between the expectations and supports experienced by double-duty caregivers, it also has the potential to guide the practice of health professionals. This model highlights the need for practising health professionals to recognize the additional expectations and resulting consequences of double-duty caregiving, especially those associated with living on the edge. Indeed, health professionals need to reflect on their interactions with all family caregivers, ensuring that they support, not hinder the efforts of families in caring for elderly relatives (Ward-Griffin, 2001). This awareness may help health professionals avoid placing additional expectations on family members who are health professionals, as well as assist in the identification and development of needed supports for caregivers, especially with respect to workplace and governmental policies.

Finally, our research confirmed previous observations (Phillips et al., 2002; Ross et al., 1996) that health care professionals experience high levels of stress in both their professional and personal lives. Furthermore, women in professional positions tend to experience higher levels of work overload and work-to-family conflict and report higher levels of stress than male professionals (Duxbury & Higgins, 2001). Since the state plays a central role in what is done in the private and public sectors and in determining the boundaries between them, long-term policy changes that challenge the gendered nature of caregiving are clearly needed (Morris, 2001). Recognizing the impact of double-duty caregiving on women's health can serve to identify the policies needed to address gender inequities. Findings of this study suggest the need for programs and policies that reduce expectations and/or build supports for double-duty caregivers, such as creating more supportive work environments and developing and implementing a national elder care program. However, as shown in this study, not all double-duty caregivers are the same, nor do they all have the same needs. Indeed, more research in this area is needed.

Clearly, we need to understand better the extent and types of double-duty caregiving that exist, and once that is determined, a variety of relevant practices, programs, and policies need to be developed and implemented. Given the structural basis of gender inequities and the magnitude of change required, key decision makers in policy, public, professional, and academic circles need to collaborate in the development and evaluation of these caregiving policies. This will serve to create social change that

hopefully will support all caregivers and those who receive care.

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