Gender Regimes in Ontario Nursing Homes: Organization, Daily Work, and Bodies*

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RÉSUMÉ

Aujourd'hui, des hommes, ainsi que des personnes immigrantes, travaillent dans le secteur des soins de longue durée. Cette nouvelle donne modifie profondément le stéréotype du travailleur de ce secteur, soit une femme d'un certain âge née au Canada. Bien que toujours minoritaires, on en sait peu sur les expériences de travail des hommes qui prodiguent des soins de longue durée, ainsi que sur les dilemmes et les opportunités auxquels ils font face en raison de leur genre. Cet article examine comment le personnel de deux centres d'hébergement et de soins de longue durée ontariens perçoit les travailleurs masculins de ce secteur. S'appuyant sur une méthode ethnographique rapide, qui comprend à la fois des entrevues et des observations, nous avons constaté que le style de gestion de ces établissements entraîne des répercussions significatives sur l'intégration et l'acceptation des travailleurs masculins. Dans un centre d'hébergement doté d'une organisation du travail rigide et laissant peu de place au pouvoir décisionnel des travailleurs, les travailleurs masculins sont perçus négativement. Au contraire, dans des centres d'hébergement dotés d'une organisation du travail plus flexible qui met l'emphase sur une approche relationnelle du care, les travailleurs masculins sont perçus plus positivement. Finalement, des processus de racialisation influencent également les relations de genre dans les centres d'hébergement et de soins de longue durée.

ABSTRACT

Today more men work in the long-term care sector, but men are still in the minority. Little is known about men's experiences in care work, and the dilemmas and opportunities they face because of their gender. This article focuses on men care workers' integration into the organization and flow of nursing home work as perceived by these workers and staff members. Using a rapid ethnography method in two Ontario nursing homes, we found work organization affected interpretations of gender and race, and that workers' scope for discretion affected the integration and acceptance of men as care workers. In a nursing home with a rigid work organization and little worker discretion, women workers perceived men workers as a problem, whereas at a nursing home with a more flexible work organization that stressed relational care, both women and men workers perceived men workers as a resource in the organization.

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* The research presented in this article was supported by funding from the Social Sciences and Humanities Research Council (SSHRC) for the project Re-imagine Long-term Care: An International Study of Promising Practices and by the Canadian Institutes for Health Research for the project Healthy Ageing in Residential Places (HARP); PI was Pat Armstrong for both projects. The first author has been supported by the Department of Social Work, Stockholm University, and by funds from Swedish Research Council for Health, Life and Welfare (Forte).

Manuscript received: / manuscrit reçu : 03/11/15

Manuscript accepted: / manuscrit accepté : 26/08/16

Mots clés : vieillissement, maison de repos, Canada, organisation du travail, la race

Keywords: aging, nursing home, Canada, work organization, masculinity, race

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Gender Regimes

Does gender matter when nursing home care workers are men and, if so, how? This question has guided the analysis of research data from two Ontario nursing homes, suggesting that organizational conditions shape how masculine gender positions are produced, understood, and accepted or rejected by other workers in these contexts. The importance of care workers' autonomy and discretion has long been a focus in care research, which stresses that organizational conditions and routines are central to both workers' and residents' experience of quality of care (Daly & Szebehely, 2012; Stone, 2000; Wærness, 1984). However, there has been little analysis of how organizational conditions affect gender relations, particularly men care workers' position, in the daily life of nursing homes.

In social science research on care work, broad social inequalities of race, gender, and class have been proven central to who provides care (Braedley, 2006). These inequalities are evident in the disproportionately small number of men who work in nursing home care, about 10 per cent of all nursing home care workers in Canada (Armstrong, Armstrong, & Scott-Dixon, 2008). Perhaps as a result of their small numbers, research on gender and care has seldom included men workers' perspectives in the analysis of the everyday life of care (see Anttonen & Zechner, 2012; Braedley, 2006; Braedley, 2010; Storm, 2013).

According to Wiersma and Dupuis (2010), earlier studies by Goffman (1961), Gubrium (1975), and Diamond (1992) inspired much of the research on the everyday/every-night life of nursing homes. These studies describe the residents' and staff's adjustment to everyday routines within the organization and emphasize how institutionalization affects both the residents' and the staff's discretion and autonomy in daily life. Gubrium (1975), for instance, used the concept of "bed and body work" to recognize that nursing home care is primarily task oriented. Diamond (1992) similarly stressed that daily routines in nursing homes often are recognized and valued as task-oriented duties, whereas the social and emotional aspects of care are made invisible. These studies show that both workers and residents can be trapped within a task-oriented and de-personalized system, and that the quality of care depends on the conditions of work. Specifically, quality depends on working conditions that allow enough time and discretion to create and maintain relationships between care workers and residents (see Turpin, McWilliam, & Ward-Griffin, 2012; Whitaker, 2007; Wiersma, 2010).

Studies of nursing home work put limited emphasis on gender, and analyses that take men and masculinities into account are scarce. Yet, due to demand shaped by aging populations and shortages in the supply of care workers, men in general, and immigrant and racialized men in particular, are increasingly involved in care work (Glenn, 2010). In Canada, as in many other countries, an increasingly racialized work force has been drawn into care work (Armstrong et al., 2008). However, there is a lack of knowledge about the role that race and masculinities play in residential care work (Bourgeault, Atanackovic, Rashid, & Parpi, 2010; Novek, 2013). With its focus on racialized men, the study we discuss in this article begins to develop an understanding of how and whether these workers are integrated into nursing home work, how they are accepted or perceived by their fellow workers, and whether their gender and race matter in care provision. Although resident perspectives are also important, in this article we focus on what workers and managers say about men as care workers and how gender and racialization matter – or not – in their experiences at work.

Analysing Gender in Nursing Homes

Our gender analysis drew on research by Connell (2002; 2005) to consider the significance of both the body and social structures in how gender is understood, expressed, and constructed in nursing home settings. Care work in nursing homes is "body work" and a bodily experience (see Diamond, 1992; Gubrium, 1975; Twigg, 2004). Thus, it is important to use a theory that can include and explain the conditions and experiences of gendered and racialized bodies in the everyday life of care.

Connell (2002, 2005) theorized gender at three levels: *gender order*, *gender regimes*, and *gender relations*. These levels operate in relation to and are marked by power. The *gender regime* concept refers to the institutional and organizational levels. In care research, Braedley (2010), among others, stressed that these power relations shape long-term care, constructing care work as "women's work", with the effect that care work is less recognized and valued than many occupations with a masculine coding. Instead of considering care work as requiring knowledge and experience, care is perceived not as skill but as an integral part of embodied femininity (England, 2005). Owing to both the large proportion of women performing care work and the assumptions upon which nursing home care is designed, nursing homes' "gender regime" is feminine (Braedley, 2013; Braedley & Martel, 2015).

Gender regimes do not emerge by themselves; rather, Connell (2002) suggested that they reflect an overarching structural order, framed as the *gender order*. This structural order cuts through all spheres of society. The structures Connell (2002, p. 55) considered most central are power relations, divisions of labour, affective relations, and symbolic relations. Connell's structures

https://doi.org/10.1017/S0714980817000071 Published online by Cambridge University Press

are all marked by asymmetry of power. This, in turn, contributes to different gender positions including those of variously situated women and men's positions and power in these spheres. However, Connell (2002) pointed out that this order does not determine us. Indeed, people live outside and even against the norms instituted by this order, thereby revealing the fragility of these social structures. However, to act outside norms, as in the case of a man acting "too close" to femininity, is to invite and experience sanctions (Connell, 2005). By this logic, if care work is coded as feminine, a man doing care work risks having his masculinity questioned.

The final level of analysis, and which is our article's focus, is the micro level of everyday social relations, framed as *gender relations* (Connell, 2002). In daily life we often confront, relate, and embody normative expectations about how women and men are supposed to be and act. From that perspective, femininity and masculinity can be seen as gendered "projects": projects based on historical and social norms but always undergoing change. Connell (2005) conceptualized gender as one of many strategies to structure social practices. Further, Connell (2005) and Han (2006) insisted that the relation between gender and race matters in everyday life. For example, Black men are often coded as threatening in the context of White dominance whereas Asian men often are coded as feminine in Western discourses. This coding articulates the importance of considering how gender intersects with race.

Men in Feminized Occupations

Small numbers of men have entered a wide range of feminized occupations, including nursing home work. The first studies to explore this subject demonstrated that men in feminized occupations seldom faced the same kinds of gender discrimination as women experienced in occupations dominated by men, such as Kanter's (1977) classic study in which she argued that the size of a minority group at work determined its status and discretion in the organization. This finding was contradicted by more recent work that dealt specifically with men in feminized occupations. Williams (1992; 2015) elaborated on this work, suggesting that men in feminized occupations often experience a "glass escalator", advancing more easily than women within these organizational structures.

The men who ride the glass escalator are mainly White men, however. A study of Black nurses in the United States (Wingfield, 2009) found that both patients and co-workers considered Black men to be less acceptable nurses than White men, because of the operation of gendered and racialized norms. Price-Glynn and Rakovski (2012) noted that Black men are likely to experience stigma when doing "women's work". Their studies focused on more professional occupations, and it is unclear whether and how these findings may be replicated in personal care work, which is considered less skilled.

Few studies have examined the articulation of gender in the everyday life of nursing home care. However, some Scandinavian studies (e.g., Andersson, 2012; Storm, 2013; Sörensdotter, 2008) have found that care workers – both women and men – believe that men are needed in elder care because of the bodily strength required when assisting nursing home residents'. This belief draws on a normative view of masculinized bodies as "naturally" stronger than feminized ones, rather than the actual behaviour or division of labour between women and men, which, in turn, contributes to legitimizing men's position in care work. This way of categorizing men and women neglects the differences that exist within each category, such as Black, White, and gay masculinities (Connell, 2005).

On the other hand, the aforementioned Scandinavian studies on elder care from a care worker perspective have found that men are sometimes considered to be troublesome in the everyday life of care. A recurrent theme in these studies is that residents, both women and men, often reject help from men (Andersson, 2012; Storm, 2013), creating a significant barrier for men's employment in the sector. Andersson (2012) has asked whether increasing the number of men in elder care might actually increase the subordination of women. She found that women care workers not only had to help the residents assigned to them; they also had to help those residents who refused men.

Issues of race also inflect the everyday organization of nursing home care, as well as the articulation of gender. Although "whiteness" often is considered as an unproblematic category, there are many racist assumptions about the South American, Asian, and African immigrant women and men who work in the Scandinavian care work context. Whereas immigrant women often are considered better care givers because of what are perceived as cultural values of respect for old age, immigrant men are seen as a problematic category (Braedley, 2013). This may be because non-Western masculinities seldom are expected to be involved in care (Storm, 2013; Jönson & Giertz, 2013). Some of the same prejudices inflect Canadian care settings, complicated by the fact that only some of the racialized workers are immigrants whereas others are Canadian born.

Method

We collected the data for this analysis within two larger international research projects (Re-imagine Long-term Care: An International Study of Promising Practices;

https://doi.org/10.1017/S0714980817000071 Published online by Cambridge University Press

Healthy Ageing in Residential Places [HARP]) that aimed to identify promising practices in nursing home care. In the project, promising practices were defined as those that treat both workers and residents with dignity and respect. The project involved an interdisciplinary team of researchers and graduate students from six countries: Canada, England, Germany, Norway, Sweden, and the United States. As one component of this project, research teams conducted short field studies (*rapid ethnographies*) in a number of nursing homes. We based our analysis on rapid ethnography in two of these nursing home settings.

Baines and Cunningham (2013) have described rapid ethnography as a multi-method ethnography involving extensive data collection in teams during a short period of time. Further, the planning, analysis, and writing phases are collaborative.

Each field study was organized to include pre-field study interviews and collection of background materials that were made available to researchers before the fieldwork. During the field period, researchers from different countries and various disciplinary backgrounds at diverse career stages observed nursing home care for one calendar week in six-hour shifts from 7 a.m. to midnight. Due to ethics considerations, this did not include observations of bodily care.

The researchers, working in pairs, also conducted semi-structured interviews with residents, workers, managers, family members, and volunteers. The interviews followed a guideline covering themes such as work organization, approaches to care, and (of particular importance for this article) the significance of gender and race in residential care. The interviews were professionally transcribed, with the interview transcriptions, recordings, and field notes made available for the researchers through a password-protected database.

An innovative feature of the study design was the combining of local and international researchers on site visits to bring fresh eyes to the research. International researchers could observe issues and raise questions that national researchers might take for granted, whereas the local national researchers' knowledge about social policy and local conditions was crucial for a deeper understanding. One advantage of the strategy employed was that a diversity of perspectives was brought into dialogue during both data collection and the process of analysis (Gerstl-Pepin & Gunzenhauser, 2002).

Site Visits in Ontario: Observations and Interviews

This article is based on field studies at two urban nursing homes in Ontario. The two homes were selected through interviews with senior advocacy groups, ministry officials, worker unions, and employee organizations to identify homes potentially offering promising practices. Both homes were private not-for-profit, a form of ownership generally associated with higher staffing levels and better quality of care (McGregor et al., 2006). The field studies were each one week long and conducted during the 2012–2013 time frame. In total, 17 researchers from all countries involved in the research team (except for Germany) participated and with overlaps between sites; 12 participated in each field study. The researchers had different academic backgrounds such as economics, history, gender studies, film and media, medicine, nursing, public health, social work, and sociology. The first author (PS) participated in both site visits; the two co-authors (SB and SC) participated in one visit each.

In this article, we have drawn on observations from the two nursing homes and on interviews with direct care workers and managers. This direct care is the most feminized work in nursing homes, and the organization of daily care is shared among differently qualified workers who must work in a coordinated manner. The workers responsible for bodily care work – such as bathing, toileting, and feeding, as well as providing emotional care – are sometimes called health care assistant (HCA), personal care aide (PCA), or, more typically, personal support worker (PSW), which is the regional term used at the studied nursing homes. Registered practical nurses (RPNs) also provide care but focus on more medically oriented care, such as administering drugs, monitoring health status, and maintaining clinical records. These RPNs work directly under a registered nurse (RN). At Nursing Home 1, we interviewed 17 PSWs (12 women, 5 men) and three RPNs (2 women, 1 man). At Nursing Home 2, we interviewed 11 PSWs (7 women, 4 men) and four RPNs (3 women, 1 man) for a total of 24 women and 11 men. Finally, we included the interviews in our study with the managers, both women, at these homes.

For each interview quotation featured in this article, we mention the occupational position, gender, and race; the latter according to the individual's self-defined position. Although our research participants reported a diversity of racialized subject positions, we have used three broad race categories – Asian, Black, and White. Although this was necessary in order to anonymize the data, we are aware that this is a simplification.

Analysis

The material for this analysis consists of 500 pages of field notes and 300 pages of transcribed interview text. The first author had the main responsibility for the analysis, although all authors collaborated. We read,

https://doi.org/10.1017/S0714980817000071 Published online by Cambridge University Press

and re-read, all field notes and interviews several times in the *template analysis style* inspired by Malterud (2009). Template analysis consists of four distinct phases. The first phase, *thematization*, involves reading the material while putting preconceptions aside. At this stage, we had decided to analyse gender but not from which perspective. We read the material and noted our preliminary impressions covering other topics besides gender, such as relations among different categories of workers, daily routines, and connotations of race.

During thematization, we read the materials from the two nursing homes sequentially. A first brief comparison of the homes raised questions concerning the impact of organizational conditions on expression of gender and race. This, in turn, led us to a deeper analytic focus in order to compare the two homes from an everyday organizational perspective.

In Malterud's second template analysis phase, *from themes to codes*, we used our initial impressions as guidelines and connected them to sentences in the text. This phase resulted in our identifying all relevant sentences in the interviews and field notes that we then marked by a specific code. This coding gave us an overview of the strength of different codes. Overall, this technique helped de-contextualize the material by gathering relevant observation notes and interview quotes.

In the third template analysis stage, *condensation*, we sorted the codes into groups and compared the code contents from the two nursing homes. In the fourth phase, *develop concepts and descriptions*, we re-contextualized the themes in order to create a holistic description that would reflect the research questions (see also Silverman, 2001).

Findings

Our findings showed significant differences in how men care workers were perceived at the two nursing homes and how racialization was implicated in the daily routines of nursing home life. At Nursing Home 1, women care workers described the men who worked on their teams as problematic. These women argued that most residents tried to avoid interactions with men care workers and, therefore, that women care workers perceived that they bore an inequitable extra share of the work, as a result of trying to meet resident preferences for women's care. This situation affected the men workers, who expressed that they had to work hard, both through their talk and actions, to legitimize their presence in the workplace.

In contrast, at Nursing Home 2, men were perceived much more positively by their women colleagues but were also subject to a gendered division of labour. Both men and women care workers described the men as a resource in daily care work. This characterization produced a set of expectations that shaped men's experience of care work in that setting.

Our comparisons of these homes suggest that the organization of care work is a critical factor in how or whether men care workers can integrate into the feminized realm of nursing home care. Consequently, we have organized the following discussion according to four main themes: (1) setting, (2) organizational approaches, (3) men as care workers, and (4) approaches to gendered dilemmas. We present the findings for each home, then link our findings to Connell's (2002) theoretical gender framework and to previous research.

Nursing Home 1: A Rigid Organizational Care Model

Setting

Nursing Home 1 was incorporated in a hospital building in a medium-sized city, within walking distance of shops and restaurants. It consisted of two units, one for residents with primarily physical health conditions and one for residents with dementia. The interior showed significant wear and tear, with worn linoleum, old-fashioned wall coverings, and well-worn mismatched furniture in shared spaces. Staff met and worked at computers in a closed office. The discrete lounge and dining rooms were seldom used for chats or informal activities, by either residents or staff. The units had no direct access to the outdoors, and although many windows offered pleasant city views, the arrangements of furniture and equipment discouraged this simple pleasure.

Thirty-six residents lived on each of two units, most of them in semi-private rooms. Most residents were White women over age 65. The field notes from this home were marked by observations and impressions of a routinized everyday life embedded in an inflexible organization. Daily care work was tightly organized. On day shifts, the residents on each unit were cared for by four to five PSWs, two RPNs, and one RN. The PSWs were responsible for bodily care and the RPNs for administering medicine and other nursing-related duties. The RPNs seldom participated in the daily care work, leaving each PSW on a morning shift responsible for seven to nine residents. Every sixth week, the workers rotated to another section of the unit. This rotation aimed to distribute the work of caring for more challenging with less challenging residents and to give workers a change. But ultimately the rotation decreased opportunities for workers to develop closer care relationships with the residents, whereby workers learn residents' peculiarities, health, and preferences while establishing relationships of trust and warmth. It also required workers to become easily

https://doi.org/10.1017/S0714980817000071 Published online by Cambridge University Press

interchangeable, while limiting their intimacy with residents. On evening shifts, three PSWs, one RPN, and one RN covered each unit, and the night team consisted normally of two PSWs, one RPN, plus one RN covering both units. The staff group was marked by a high degree of racialized diversity. Most of the women were Black or of Asian origin; only a few were White. Almost all of the men PSWs we met during our study were Black.

The rigidity of this nursing home was palpable. Until 7:30 a.m., the lights in the corridors were off, and the only disruption to the quietness was the beeping from the residents' alarms. At 8 a.m. the situation changed abruptly. Bright lights were turned on; the workers left the report rooms and started the morning work. The workers transitioned quickly and smoothly between the residents' rooms. The bodily care and most of the baths were supposed to be finished before breakfast at 9 a.m. Breakfast arrived at the units in big carts with each resident's meal on a separate tray.

Workers complained about the rigid organization of the day, arguing that it caused a de-personalized setting for both residents and workers.

> You wash one after the other and it's like a chain. There's no quality, you know, with patients and talking with them, you know. It's just: "no you have to go, you have to go" you know. (Black woman, PSW)

> I feel in the morning, every time we organize, we plan our day, and non-stop, every, every day. It's physical. And, you know, patients are human beings. I would not appreciate to be pushed like we push the clients. (White woman, PSW)

After the meals, the residents returned to their rooms or were left in the end of the corridor or in the day lounge to watch television while the workers continued with task-oriented duties and documentation. They had little time to spend with the residents after completing their other required and prioritized tasks.

Organizational Approaches: Ideas of Teamwork and Demands for Interchangeability

At Nursing Home 1, notions of teamwork and the requirement that all care workers should do the exact same work in the same way in the same time frame were embedded in a rigid organization of care work. On dayshifts, care workers were divided into three teams, each responsible for one section of the unit. Our analysis showed that the degree of cooperation varied among teams, but most of the workers told us that teamwork, with each worker performing an assigned role, was the best way to handle the daily workload.

> We really work in pairs. Let's say my assignment is on this side; we took a priority. So while I'm starting to wash a patient, Michelle [pseudonym] picks up the clothes. Then she got to make the bed while I'm starting the patient, shaving if it's a man and all that. When she is done she picks up after me, like towels, and we change room[s]. Sometimes we don't count the residents – "it's mine" – we're so used to do[ing] it that we don't count, you know. (White woman, PSW)

This teamwork was designed to meet benchmarks established by management. The morning care work had to be finished before 9 a.m., which meant that all 36 residents had to be washed, dressed, and ready for breakfast within an hour. Because the teams rotated every six weeks, all care workers faced pressure to work in a similar way. This interchangeability required that all workers be able to help all residents, and all residents should accept help from all workers. Those who were perceived as too slow or out of step with the usual ways of caring ran the risk of criticism.

> It's not about the person anymore. Everything is rushed. Care is not about tick. Do you know what? I got in trouble for washing too much of a person in bed". She [the PSW] looked at the person in the eyes and said, "Which part would you like me to wash?" (From the field notes)

We heard about and observed these care workers' continual criticism of each other. Common criticisms were about neglecting duties, arriving late, or distancing themselves from the rest of the staff group. The problem did not seem to be the teamwork itself but rather the expectations for performance within a rigid organizational structure that limited opportunities for care workers to vary the order, the method, or the speed with which they performed their work. This work organization shaped poor working relationships among the care workers as well as causing more distant relationships with residents.

These difficulties were compounded by the demarcated hierarchy of occupational categories incorporated into the organizational structure, with PSWs at the bottom of the hierarchy. Over and over, women PSWs complained to us that changes to the organization of care meant that the RPNs had no time for resident care, spending their time instead on documentation.

> Because before the RPNs were to take … it used to be three patients. Then it went down to two. They had to take two residents, you know, divide it up between whatever groups. Then when this RAI-MDS [Resident Assessment Instrument-Minimum Data Set] stuff came out – which I realize it's important because it's for funding, whatever, – so now the RPNs do not take anybody. They don't even take one patient. (Black woman, PSW)

https://doi.org/10.1017/S0714980817000071 Published online by Cambridge University Press

Provincial requirements for documentation have increased significantly with the integration of a standardized data system (RAI- MDS), leading all nursing homes including the two in our study, to struggle to ensure that this work is done. This factor contributed to less teamwork and cooperation between the PSWs and the RPNs because, according to our notes, RPNs spent more time on documentation than on direct care work.

Men as Care Workers: An Unwanted Category

The rigid organizational context not only demarcated different occupational groups, but it also shaped a clear boundary line when it came to relationships between women and men workers.

Most of the workers we met during day shifts were women, and in our interviews, they mostly talked about men care workers as a problem. The manager of the nursing home was aware of the dilemma but argued, "I have to politely explain to them [the family] that you can't discriminate when you hire based on gender, sex, religion, whatever. We can't do that, you know." According to the manager, the care workers had to "switch and swap", meaning that if a resident refused care from a man care worker, the manager would assign a woman care worker to that resident, switching her resident responsibilities with the man for that particular task. The manager was aware that the women PSWs did not like this top-down switch-and-swap solution. PSWs told us that this work organization meant that they had no discretion to choose how to re-organize who cared for which resident, based on what the women workers saw as the residents' preferences.

> The trouble here on this floor is that we have a lot of women [residents]. They're up in their ages and they do not want a man at all. We have probably a few single women and if a man walks in, they hit the roof. So we try not to have men [workers]. There's one man on evening and they love him. Patients that don't like a man will take him. I don't know why. But boy, put a man down here, it's useless. Even the men don't want a man. (White woman, RPN)

The women most skeptical towards men were those employed on the unit for residents without dementia. According to the women workers, these residents were able to voice their objections and preferences, accepting or rejecting help from a certain worker based on gender. In contrast, fewer problems appeared with men care workers on the unit for residents with dementia, related to the fact that many of these residents were unable to voice their preferences or resist if their wishes were ignored. Indeed, some men care workers had been transferred to the unit for residents with dementia, but the organizational conditions there were almost the same as in the somatic unit, and women at the dementia unit were also skeptical of men workers.

Approaches to Gendered Dilemmas: Women on Day Shifts, Men on Nights

The women care workers' concerns about "the problematic man care worker" appeared to reflect the numerical division between women and men on day shifts. Therefore, it surprised us when we realized that a larger proportion of men care workers worked evening shifts, and that virtually all care workers on night shifts were men. If men were a problem on day shifts, why did residents accept them on other shifts? This was particularly surprising as night shift work requires extensive bodily care, such as toileting or changing incontinence pads, tasks for which residents supposedly rejected men care workers on day shifts. However, the men care workers' description of the work conditions at nights differed from the women's descriptions of day shifts.

> It's a bit different from working during the day […] In general, when we arrive, we do the rounds, to make sure everyone is breathing. There are some residents we need to change, or reposition. And then we go prepare the cart for the big changes in the morning, because in the morning everyone is changed. Then we answer the bells if there are residents who want to eat something or who need medication. And then everyone gets a one-hour break. (Black man, PSW)

At night, the absence of the manager, ward clerk, and reduced staff numbers led to different conditions, and more discretion to plan and perform tasks. In describing their routines, the men care workers used metaphors with a decidedly masculinized character to describe their orientation to the work.

> This is a soldier, okay? When you are here, like you can see, you have to set up your mind when you start, you have things to do. You're a soldier, I'm telling you; there's no question. (Black man, PSW)

> I'm like a military man. I do what I have to do. Here we can't choose what we like and what we don't like. If you start to choose, you're not in the right place. (Black man, PSW)

These metaphors provided a distinctly masculine vocabulary through which to express the work intensity and rigidity they experienced on the job. The men's talk about their work differed from the women's way of talking. Whereas some of the women complained about working conditions, women colleagues working too slowly, and men workers in general, the men talked about the work and work relations in more positive terms. This language reinterpreted their work

https://doi.org/10.1017/S0714980817000071 Published online by Cambridge University Press

as masculine in reaction to the complaints of the women, or perhaps as a way to assert their gender position to an inquiring researcher. However, the language can also be interpreted to mean that the rigid care model created mistrust among the workers, but the men's weak position at the workplace limited their scope to raise complaints and criticism because they represented an unwanted category of workers in the organization.

At the same time, these men also expressed a caring attitude that might be considered surprising, given their description of military-like fortitude. These men care workers stressed that they needed to be very good at caring in order to overcome residents' doubts or misgivings about being attended to by a man. The higher level of discretion at night gave these workers more opportunity than workers on day shifts to establish and build caring relationships with the residents. These men repeatedly related anecdotes that indicated they had managed to help a resident who had previously rejected them.

> I mean, let me give you an example. I said that there is a woman [resident] back there [on the unit], she was Muslim. She doesn't want men. I took my time to "win" her, and after that [it was], "Paul, Paul, Paul [pseudonym]". Very simple, you make people happy. (Black man, PSW)

> There is one lady here. Some people I work with; they are very good, they are not bad people. It's not easy. You see this man, that little man that was here [a colleague], he's White, I'm Black. It's not about colour of your skin, you know, it's not where you are from; you know, it's about your knowledge. (Black man, PSW)

Dave [pseudonym] told us about the need to be strict, but also expressed a gentle side, as our field notes reveal:

> As we're talking, Dave tells us that he's got to finish up the report so that he can "start singing" – he has residents, specific ones, who he sings to as he does his first round of the night; not all the residents, just certain ones he sings to, certain ones that like him to do this. […] We can hear Dave moving around inside the room, talking quietly to the resident inside. There's a pause, then Dave starts to sing – dah dahhhh dah dah dahhh, a song with no words. (Black Man, PSW; excerpt from the field notes)

Although singing was not the only strategy used to develop relationships of trust with residents, these men care workers told us that once they had proved that they could provide good care, it would overcome gendered and racialized rejection from residents. Women care workers' negative evaluations of men as care workers were based on daytime work, when the workers had less discretion to take this more relation-oriented approach. During night shifts, with more scope to build trust, the men workers found ways to be accepted by residents.

Nursing Home 2: A Relational Care Model

Setting

Nursing Home 2 was a three-story building located in a bustling suburb of a large city surrounded by green areas and a short distance from markets, shops, and restaurants. The nursing home consisted of several units. The physical setting featured carpets, up-to-date, well-maintained furniture, and large windows that made it possible for the residents to look out on the green areas around the home. Compared to Nursing Home 1, this home had a more welcoming atmosphere. An open-concept nursing station was located in the middle of each unit of this home. The residents' lounge and dining areas were also organized in an open floor plan, unlike Nursing Home 1, allowing and encouraging both staff and residents to spend time there, listening to music or talking.

We conducted research in two 32-bed units: one for residents with dementia, and one for residents with primarily physical health conditions or need for rehabilitation. Most residents lived, as in Nursing Home 1, in semi-private rooms. The majority of the residents were women, but unlike Nursing Home 1, there were a few residents from racialized groups.

As we had found in Nursing Home 1, daily care work was tightly organized. On day shifts the residents were cared for by four PSWs and one RPN. On evening shifts, three PSWs and one RPN worked, and at night one PSW worked mostly alone, with temporary relief and backup from a "floating" employee covering the whole unit. This staffing ratio was slightly lower than what we had observed at Nursing Home 1. Once again, the PSWs were responsible for bodily care, and RPNs were responsible for more medical nursing duties. This meant that the day PSWs were responsible for eight residents each. However, unlike Nursing Home 1, the RPNs here participated more in bodily care, even though they were also responsible for the extended MDS-RAI documentation at this nursing home. In this relational organizational context, there was a less pronounced demarcation between occupational hierarchies, which also affected gender relations.

The staff group at this nursing home was marked by a high degree of racialization, in that most of the women were Black or of Asian descent, but differed from Nursing Home 1 in that most of the employed men were of Asian descent. Also, in clear contrast to Nursing Home 1, teamwork was less emphasized as an organizational norm. Instead, most workers worked

by themselves but cooperated when they needed to, while some preferred to work in pairs. Therefore, the extent of teamwork varied between different shifts. Further, workers did not rotate between the units, so most of them helped the same residents on each shift. The outcome was higher continuity of care compared with that of Nursing Home 1. This produced stronger care relationships between workers and residents.

In our interviews, most care workers, as in Nursing Home 1, commented about feeling time pressure, which is not surprising given the lower staffing ratio. However, in the workers' descriptions of their day, they articulated a higher degree of discretion to vary their routines. This discretion allowed workers to deal with their daily pressure in creative ways that also accommodated resident preferences.

For example, although all residents were usually washed and dressed in time for breakfast, the wake-up time, bedtime, and showers could be adjusted if residents wished, allowing workers to do their work in a less rigid and pressured manner that also made residents more comfortable compared to those at Nursing Home 1. Further, this flexibility depended on communication between residents and workers, contributing to the relational care model to which this nursing home aspired.

> If I see the resident as a number – after you done, I put you in bed, I go to the next. That's no good, you know, because they're human beings. They need the human touch. They need to know that somebody cares. (Man of Asian origin, PSW)

> They [the care workers] try to make the residents feel at home. This is their home, you know. If they want to go up, they go up, whatever they want. (Black woman, PSW)

At breakfast, all care workers were in the dining area, helping to serve and support the residents. Afterward, some residents returned to their rooms, while others were brought to the lounge. The workers often put on the TV or a CD-player and then went to the nursing station to complete documentation and other routine duties. As the nursing station was open to the residents' lounge, care workers were able to monitor and interact with the residents even as they worked on documentation. This was not possible in Nursing Home 1.

Nursing Home 2, while offering care workers more scope for discretion and personalized care, was far from ideal. During our observations and interviews in both nursing homes, we noted that organizational norms and routines were treated and described as more important than individual needs. What differed in Nursing Home 2 was that the care workers reflected on resident needs and preferences, describing and treating the nursing home as the residents' home. Further, a discourse of relational care was incorporated into the organizational culture and norms. During one observation, a woman RPN explained: "I don't like that people sit around at the nursing home after the task is done. Sit, touch, and engage with the residents instead." We also noted that care workers sang, danced, and joked with residents, especially during the evenings. Although time for interaction was scarce during mornings, there was more scope for relational work in the afternoon, time that did not exist at Nursing Home 1.

Organizational Approach: Personalized Care

At Nursing Home 2, the work organization focused on the provision of personalized care for the residents. Unlike the situation at Nursing Home 1, there was no organizational requirement to work in teams. The only general rule was that care workers were not allowed to transfer a resident without assistance. Otherwise, care workers decided together, on their shifts, how to plan and perform the work.

Teamwork emerged not as an imposed work organization but as a pragmatic strategy across occupational boundaries that allowed the work to be accomplished. Less demarcation among the occupations supported a sense of shared responsibility among PSWs and RPNs. Even so, care workers expressed different opinions about teamwork. Some preferred it; others preferred to work alone.

> Actually it depends. Okay, if you had a resident and it's two persons: I wash my resident, dress my resident, and leave my resident in bed until I get help from another staff – if we are working two together, it takes up more time. So if you go ahead and you do one resident, and if I go ahead and do one, we come together later. One is washing faster than if two are washing one resident. (Black woman, PSW)

At Nursing Home 2, the more flexible organizational approach gave care workers leeway to work more independently or more cooperatively, depending on the pragmatic agreements of those on shift.

> We can get along and we help each other. That's a very good thing because our assignment is heavy. Good working environment is more important. Otherwise everybody gets stressed. Teamwork is really important here. People can help each other and talk to each other. (Man of Asian origin, PSW)

It became clear that the definition of teamwork differed from Nursing Home 1. Here, teamwork was viewed as a voluntary strategy to ease the daily work apart from transfers of residents. In Nursing Home 1,

https://doi.org/10.1017/S0714980817000071 Published online by Cambridge University Press

teamwork was a pre-defined organizational norm rather than a strategy based on flexibility. At Nursing Home 2, the work organization was sufficiently left in the hands of the care workers to provide them more discretion. Furthermore, this possibility for worker cooperation seemed important for the notion of men and masculinity as a resource in the everyday life of care.

Men as Care Workers: A Wanted Category

In comparison to Nursing Home 1, the absence of criticism directed at men care workers by their women colleagues was striking. In this home, masculinity was not perceived as a problem, but rather as a complement to feminine caring. Clearly rooted in a normative view of gender relations as a duality composed of masculinity and femininity as separate and complementary genders, these women care workers told us that men could contribute something qualitatively different from what they could contribute.

> I think more men should work anywhere they want, I guess. You know, whatever their preferences are. But it's nice if more men work here because, you know, when the guys [men residents] get hard and they're fighting you can't call a man and say "come and help" because it's all ladies here. So it would be nice to have a guy work on every shift. (Black woman, PSW)

> We need some men because of the energy and power, but some ladies don't want men to touch them, and some women like the men to touch them. Positive thing for them [women residents], and for those men we cannot handle, assign them to men. (White woman, PSW)

Instead of being described as unwanted or problematic by the women workers as in Nursing Home 1, the men care workers were perceived as physically stronger and more capable of subduing difficult residents than the women workers. Men care workers reinforced this image.

> Some male residents – sometimes they don't want to listen to the PSW. They [the woman worker] say, "Okay, you could go in the washroom and wash". They [the residents] say, "Oh no, I don't want to come". They [the women care workers] can't do anything. Then they call a man PSW. (Man of Asian origin, PSW)

> What I observe, if you are a man PSW you can do everything because, I don't know, the man has the force, the strength. […] They [the women workers] always ask the men to work. It's ok. I understand. (Man of Asian origin, PSW)

As in Nursing Home 1, some residents in Nursing Home 2 refused help from men. Yet, in this setting, workers did not describe this as a major dilemma. One man worker said, for instance:

> No, no, no. You can count [those who don't want help from men] by your fingers. No, usually they are fine. It's different now. You can shower everybody. Like [only] two or three people here say they don't like men.

Approaches to Gendered Dilemmas: Flexibility and Integrations of Men Workers

In reviewing our data to find clues to explain the difference between these two nursing homes in terms of how men's care work was perceived and understood, the higher degree of decision-making latitude in Nursing Home 2 allowed individual workers and staff teams to work out issues related to perceptions and prejudices associated with gender, and perhaps of race as well. If a resident refused help from men, the workers could collaborate as they saw fit to switch residents with each other. Both women workers and the manager of the home mentioned this strategy.

> We try to send someone else. My challenge is if I happen to only have male PSWs on that day, you know. So we figure out our workaround for that situation. We'll have the RPN do it or we'll bring another female PSW up from another floor to do that particular part of care or something. (White woman, manager)

> Some residents, if they don't want men to shower them, we take over. So they have preferences. And some residents, they don't want men to go into their room; they say, "Oh no, no, no." So we switch residents. "You take the guy, I will take the lady," you know. (White woman, PSW)

Some men care workers complained that they occasionally felt they ended up being assigned particularly demanding residents. However, this ability to deal with these residents contributed to their high status in the woman-dominated organization. Further, this status was the main reason that they did not resist this assignment.

Discussion

To better grasp the dynamics of gender and care work in these settings, we draw on the work by Connell (2002) to explain that, given the nursing homes' close geographic proximity within the same jurisdiction and their urban locations, gender at the structural level – Connell's "gender order" – is identical for both contexts. But at the organization level, the nursing homes can be seen as two different organizational models: the rigid and the relational. With Connell's conceptualization, we can also see them as two gender regimes that affect gender relations and especially the men care workers' scope for discretion in the everyday life of care.

We know from previous care research that the staff's discretion is crucial for providing good care and to

https://doi.org/10.1017/S0714980817000071 Published online by Cambridge University Press

enable the organization to care for both workers and residents (Daly & Szebehely, 2012; Wærness, 1984). Our key finding is that the workers' discretion is crucial not only for the quality of care but also for how the organization can handle gender diversity. This applies especially in the case of men workers, who constitute a minority in paid care work (Anttonen & Zechner, 2012). In this study, men care workers were reported to be accepted more readily and viewed more positively by their women co-workers and residents if the organization provided workers with a higher degree of discretion to decide how to complete care work.

Scandinavian studies on women's perspectives on men as care workers indicate that they often view the presence of men as positive. However, a general dilemma is that many residents dislike men performing bodily care such as bathing and dressing (Andersson, 2012; Sörensdotter, 2008; Storm, 2013). This in turn creates dilemmas for women workers if the work organization does not allow flexibility and discretion. Our analysis shows that important organizational aspects are (1) whether the workers can determine which worker is to care for which resident, (2) whether to work in pairs or alone, and (3) when to accomplish certain tasks. All of these dimensions of discretion allow workers more opportunity to tailor care to meet residents' preferences and habits.

This discretion was larger for workers in an organization that prioritized relational care over Taylorized modes of efficient work organization and strict occupational divisions. Nursing Home 1 with its rigid organizational structure provided little flexibility and reduced opportunities for relational caring, while also insisting that workers should be interchangeable – essentially, that they should be considered to be all the same. This requirement for interchangeability generated gender-based dilemmas positioning men and masculinity as problematic elements in everyday care work. Here, women and femininity were regarded as the assumed gender position associated with caring skills. The rigid organizational model in Nursing Home 1 affected the everyday interactions and expectations of women compared with men care workers. The men emphasized that they were decent care workers who had overcome residents' rejection by being caring and sensitive. Further, these men drew on masculine metaphors, such as military terms and images, to discuss their work, reinforcing their own association with masculinity and drawing a distinction between themselves and their women colleagues, while at the same time resisting and attempting to reconstruct the norm of feminized care. This suggests that *a rigid organizational model* also contributes to *rigid gender relations* where the challenges of gender prejudices were more difficult to overcome.

In the quiet of evening routines, men care workers had more scope to prove their caring abilities. This was possible because there were fewer co-workers, and because residents seemed to accept them well at this time of day – partly because they did not have access to other, preferred workers. Of crucial importance is the difference in organizational discretion between day and night shifts. On night shifts there were no baths or food deliveries or constant rotation of workers, thus facilitating more time for relational care. With time to get to know the residents and build personal trust, these men on the night shift did not face the same problems as they did on day shifts where the schedule was tight and time for flexibility restricted. Thus, we find that time and discretion are not only prerequisites for good care, but they also ensure the smooth integration of men into the feminized nursing home workforce and, therefore, that gender relations can shift to accommodate changing working conditions.

In Nursing Home 2, where care workers had the discretion to organize their work as a team and with more focus on relational care, the gender relations were different. In this home, care norms were constructed based not on a particular routine or procedure but rather in consideration of both care recipient and worker. The workers' discretion in organizing daily work united the care workers while also having a positive effect on gender relations. In this nursing home, there were fewer restrictions on the organization of teamwork; instead of being dependent on specific co-workers, care workers could ask for assistance from anyone on the shift. This freedom generated a higher degree of mutuality between the care workers. Therefore, the women did not find it problematic to help the men workers by switching residents. Even though the number of employees per shift was slightly lower at this home, there was more focus on the relational aspects of care work and thus more scope for treating residents as individuals. This probably contributed to fewer residents refusing to be helped by men. However, this also strengthened traditional gender relations where men were considered stronger and more efficient than women (see Storm, 2013). Even though these men did not face the same dilemmas and rejection as men in Nursing Home 1, stereotypical assumptions of men and masculinity restricted their scope to provide care. Thus, a flexible organizational model does not necessarily contribute to a flexible understanding of gender positions.

Interestingly, unlike other research on men's nontraditional work in feminized settings (Acker, 1990; Williams, 1995), we did not hear either the men themselves or other workers describe a masculine bonus or privilege often associated with men who do feminized work. Drawing on Sargent's (2004) analysis of

men who work in early childhood education, as well as on Connell's (2005) work on subordinated masculinities, we suggest that the men who come into nursing home care work tend to be from working class, racialized, immigrant, and other subordinated groups, and may not receive such a bonus. Indeed, they may have to walk a narrow line between acceptable expressions of masculinities and required expressions of feminine caring that varies based on social norms related to gender, race, and class. In our research, most of the men employed at Nursing Home 1 were Black men, whereas the men care workers at Nursing Home 2 were of Asian origin. Intersections of racialization and gender may be implicated in the different valuations and normative expectations of men workers in these settings. As Han (2006) noted, men of Asian origin are often described as feminized in western discourses whereas Black men according to Connell (2005) are stereotypically interpreted as hyper-masculine. This could affect both the women workers' and residents' assumptions of these men and could be one reason why the men workers in Nursing Home 2 did not face the same problems as the Black men in Nursing Home 1. This study suggests the need for deeper analysis of the interplay among racialization, gender, and care work under different organizational conditions.

Further, this study has focused on care workers' perspectives on gendered norms and expectations on men workers within the organization of care work. Resident perspectives have appeared only as presented by care workers; consequently, further exploration of the views of residents and families could provide important information about the ways in which gender and work organization are related in nursing home work.

References

Braedley, S. (2006). Someone to watch over you: Gender, class and social reproduction. In K. Bezanson & M. Luxton (Eds.), *Social Reproduction: Feminist Political Economy Takes on Neoliberalism* (pp. 215–230). Montreal, QC: McGill-Queens University Press.

Braedley, S. (2010). Accidental health care: Masculinity and neoliberalism at work. In S. Braedley & M. Luxton (Eds.), *Neoliberalism and Everyday Life* (pp. 136–162). Montreal, QC: McGill-Queens University Press.

Braedley, S. (2013). A gender politics of long-term care: Towards an analysis. In P. Armstrong & S. Braedley (Eds.), *Troubling Care: Critical Perspectives on Research and Practices* (pp. 59–70). Toronto, ON: Canadian Scholars Press.

Braedley, S., & Martel, G. (2015). Dreaming of home: Long term residential care and (in)equities by design. *Studies in Political Economy*, *95*, 59–81.

Acker, J. (1990). Hierarchies, jobs, bodies: A theory of gendered organizations. *Gender & Society*, *4*(2), 139–158.

Andersson, K. (2012). Paradoxes of gender in elderly care: The case of men as care workers in Sweden. *NORA-Nordic Journal of Feminist and Gender Research*, *20*(3), 166–181.

Anttonen, A., & Zechner, M. (2012). Theorizing care and care work. In B. Pfau-Effinger & T. Rostgaard (Eds.), *Care Between Work and Welfare in European Societies* (pp. 15–34). Houndmills, ENG: Palgrave Macmillan.

Armstrong, P., Armstrong, H., & Scott-Dixon, K. (2008). *Critical to Care. The Invisible Women in Health Services*. Toronto, ON: University of Toronto Press.

Baines, D., & Cunningham, I. (2013). Using comparative perspective rapid ethnography in international case studies: Strengths and challenges. *Qualitative Social Work*, *21*(1), 1–16.

Bourgeault, I. L., Atanackovic, J., Rashid, R., & Parpia, R. (2010). Relations between immigrant care workers and older persons in home and long-term care. *Canadian Journal on Aging*, *29*(1), 109–118.

Connell, R. W. (2005). *Masculinities* (2nd ed.). Berkeley, CA: University of California Press.

Connell, R. W. (2002). *Gender*. Cambridge, ENG: Polity Press.

Daly, T., & Szebehely, M. (2012). Unheard voices, unmapped terrain: Care work in long-term residential care for older people in Canada and Sweden. *International Journal of Social Welfare*, *21*(2), 139–148.

Diamond, T. (1992). *Making gray gold: Narratives of nursing home care*. Chicago, IL: The University of Chicago Press.

England, P. (2005). Emerging theories of care work. *Annual Review of Sociology*, *31*, 381–399.

Gerstl-Pepin, C. I., & Gunzenhauser, M. G. (2002). Collaborative team ethnography and the paradoxes of interpretation. *International Journal of Qualitative Studies in Education*, *15*(2), 137–154.

Glenn, E. N. (2010). *Forced to care: coercion and caregiving in America*. Cambridge, MA: Harvard University Press.

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. New York, NY: Anchor Books.

Gubrium, J. F. (1975). *Living and dying at Murray Manor*. New York, NY: St. Martin's Press.

Han, C. S. (2006). Geisha of a different kind: Gay Asian men and the gendering of sexual identity. *Sexuality and Culture*, *10*(3), 3–28.

Jönson, H., & Giertz, A. (2013). Migrant care workers in Swedish elderly and disability care: Are they disadvantaged? *Journal of Ethnic and Migration Studies*, *39*(4), 809–825.

Kanter, R. M. (1977). *Men and women of the corporation*. New York, NY: Basic Books.

Malterud, K. (2009). *Kvaliativa metoder i medicinsk forskning*. [Qualitative methods in medical research]. Lund, SWE: Studentlitteratur.

McGregor, M. J., Tate, R. B., McGrail, K. M., Ronald, LA., Broemeling, A., & Cohen, M. (2006). Care outcomes in long-term care facilities in British Columbia, Canada. Does ownership matter? *Med Care*, *44*(10), 929–935.

Novek, S. (2013). Filipino health care aides and the nursing home labour market in Winnipeg. *Canadian Journal on Aging/ La Revue canadienne du vieillissement*, *32*(4), 405–416.

Price-Glynn, K., & Rakovski, C. (2012). Who rides on the glass escalator? Gender, race and nationality in the national nursing assistant study. *Work, Employment & Society*, *26*(5), 699–715.

Sargent, P. (2004). Between a rock and a hard place: Men caught in the gender bind of early childhood education. *The Journal of Men's Studies*, *12*(3), 173–192.

Silverman, D. (2001). *Qualitative research: issues of theory, method and practice*. London, ENG: Sage.

Stone, D. (2000). Caring by the book. In M. Meyer-Harrington (Ed.), *Care work. Gender, class and the welfare state*. New York, NY: Routledge.

Storm, P. (2013). Care work in a Swedish nursing home. In A. Hujala, S. Rissanen, & S. Vihma (Eds.), *Designing wellbeing in elderly care homes* (pp. 148–162): Aalto, FIN: Aalto University Press.

Sörensdotter, R. (2008). *Omsorgsarbete i omvandling. Genus, klass och etnicitet inom hemtjänsten* [Care work in transition. Gender, class and ethnicity within home care]. Stockholm, SWE: Makadam.

Turpin, L., McWilliam, C. L., & Ward-Griffin, C. (2012). The meaning of positive client-nurse relationship for senior home care clients with chronic diseases. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, *31*(4), 457–469.

Twigg, J. (2004). The body, gender and age: Feminist insights in social gerontology. *Journal of Aging Studies*, *18*(1), 59–73.

Wærness, K. (1984). The rationality of caring. *Economic and Industrial Democracy*, *5*, 185–211.

Whitaker, A. (2007). *Gamla och nya boendeformer för vård och omsorg av äldre: en översikt*. [Old and new residential places for older persons in need for care: An overview]. Norrköping, SWE: Tema Äldre och Åldrande, Linköpings universitet.

Wiersma, E. C. (2010). Life around …: Staff's perceptions of residents' adjustment into long-term care. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, *29*(3), 425–434.

Wiersma, E. C., & Dupuis, S. L. (2010). Becoming institutional bodies: Socialization into long-term care home. *Journal of Aging Studies*, *24*(4), 278–291.

Williams, C. L. (1992). The glass escalator: Hidden advantages for men in the 'female' professions. *Social Problems*, *39*(3), 253–267.

Williams, C. L. (1995). *Still a man's world: Men who do "women's work"*. Berkeley, CA: University of California Press.

Williams, C. L. (2015). Crossing over: Interdisciplinary research on "Men who do women's work". *Sex Roles*, *72*(7–8), 390–395.

Wingfield, H. A. (2009). Racializing the glass escalator. Reconsidering men's experience with women's work. *Gender & Society*, *23*(1), 5–26.