

Negotiating Care of Frail Elders: Relationships Between Community Nurses and Family Caregivers

Catherine Ward-Griffin

Les changements récents dans les modèles de soins aux personnes âgées au Canada, dont le retrait des services officiels de soins à domicile et l'augmentation du recours aux fournisseurs de soins membres de la famille, exigent une analyse critique des relations entre les fournisseurs de soins officiels et non officiels. Le but de cette étude était de décrire et d'analyser la relation entre les infirmières et les membres féminins de la famille offrant des soins à domicile aux personnes âgées frêles. Recourant à une méthode ethnographique critique dans un cadre de travail socialiste et féministe, des entrevues en profondeur distinctes ont été menées auprès de 23 dyades d'infirmières et de fournisseuses de soins membres de la famille. L'analyse des transcriptions des entrevues et des notes prises sur le terrain a révélé que les relations se caractérisaient par l'incertitude et la tension. Alors qu'autant les infirmières que les membres de la famille fonctionnaient à l'intérieur des structures actuelles relatives aux soins à domicile tout en s'y opposant, les parties concernées étaient engagées dans un processus de négociation continu quant aux postulats culturels concernant la prestation de soins « privés » et « publiques ». Les résultats ont mis au jour les conséquences relativement à la pratique, à la formation et aux orientations de la profession infirmière.

Recent changes in patterns of care of the elderly in Canada, including the withdrawal of formal home-care services and increasing reliance on family caregivers, call for a critical analysis of the relationship between formal and informal caregivers. The purpose of this study was to describe and analyze the relationship between nurses and female family members caring for frail elders in the home. Using a critical ethnographic method in a socialist-feminist framework, separate in-depth interviews were conducted with 23 nurse-family caregiver dyads. Analysis of interview transcripts and fieldnotes revealed that relationships were characterized by uncertainty and tension. While both nurses and family caregivers functioned within and resisted current home-care arrangements, they engaged in an ongoing process of negotiating cultural assumptions about "private" and "public" caregiving. The findings point to implications for nursing practice, education, and policy.

Catherine Ward-Griffin, RN, PhD, is Assistant Professor, Faculty of Health Sciences, University of Western Ontario, London, Ontario, Canada.

Introduction

As a result of the combined effects of an aging population, reduced health-care services, and a belief that home care is preferable to institutional care, families continue to experience pressure to assume more caregiving responsibility for the frail elderly. Families and friends have always been the greatest source of in-home support for the elderly in Canada, as high as 90% in the province of Ontario (Ministry of Health, 1993). The movement towards a home-care approach is also driven by the assumption that home care is more cost-effective than institutional care. However, there is considerable evidence that female family members, who assume the vast majority of informal caregiving responsibilities, bear tremendous physical, emotional, and economic costs (Abel, 1990; Baines, Evans, & Neysmith, 1991). Policy-makers rarely take these into account when making decisions about the cost of delivering home-care services.

Another cost-cutting strategy used within home-care systems is the expectation that families will assume an active role in elder care. In Ontario, family involvement is a condition of receiving home-care services through the Community Care Access Centres. Although the relationship between professional and family home-care providers revolves around a shared concern with meeting the health-care needs of elders, family caregivers are increasingly expected to perform complex technical tasks previously carried out by professionals (Glazer, 1990; Guberman & Maheu, in press). Thus, community nurses are expected, more than ever before, to teach, delegate, assign, or supervise the care provided by family members. Since many family caregivers gradually develop a skill repertoire and a store of knowledge concerning the elder's needs, it is inevitable that complex negotiations related to authority, accountability, and values will arise between the two caregiver groups (McKeever, 1994), and that these negotiations will be complicated by ambiguity about role expectations and status.

Although much has been written about how informal and formal caregivers should relate to one another, there has been little empirical analysis of the relationship. This paper aims to provide a critical analysis of the nurse-family relationship in home care. Findings from a qualitative study illustrate how care of the elderly is negotiated between informal and formal caregivers. They illuminate, in particular, how nurses and families reaffirm, accommodate, and challenge existing boundaries of caregiving; how nurse-family caregiver relationships are formed and negotiated within the home-care system; and how cultural ideologies shape the negotiations. The paper concludes with practice, education, and policy implications for nursing.

Literature Review

The literature addressing the relationship between health professionals and families in home care is limited. Most studies that have examined caregiving in the home have focused on family caregivers. Family caregivers of the elderly have been asked about their own caring work and its effect on their lives (Abel, 1990; Dwyer & Seccombe, 1991; Keefe, 1990; Navon & Weinblatt, 1996; Pohl, Collins, & Given, 1995), the caring work of the professionals with whom they interact (Dansky, Brannon, & Wangness, 1994; Pringle, 1982), and their relationships with those professionals (Hasselkus, 1988, 1992; Keady & Nolan, 1995; Nolan & Grant, 1989; Ong, 1990; Pohl et al.). Limited attention has been given to formal caregiving in the home, and those studies that have included this aspect have focused on personal-support workers rather than health professionals. Formal caregivers of the elderly in the home have been asked about their own caring work (Aronson & Neysmith, 1996; Bartoldus, Gillery, & Sturges, 1989; Martin Matthews, 1992; Neysmith & Nichols, 1994; Pringle; Qureshi, 1990), the caring work of the family (Kaye, 1985), and their relationship with the family caregiver (Aronson & Neysmith; Kaye). Both professional and family caregivers have been found to value individualized affective care accompanied by good instrumental care. However, the perceptions of the two groups tend to differ with respect to the particular types of care that should be provided by each.

A few researchers have actively sought to gain insight into how family caregivers and health professionals work together to provide elder care in diverse settings (Fischer & Eustis, 1994; Rubin & Shuttlesworth, 1983; Schwartz & Vogel, 1990) and how that relationship changes over time (Clark, Corcoran, & Gitlin, 1994; Keady & Nolan, 1995). Most of the existing work on the relationship suggests that conflicts may arise when health professionals fail to recognize a family caregiver's expertise (Duncan & Morgan, 1994; Hasselkus, 1988); when roles overlap (Cott, 1991; Kaye, 1985; Schwartz & Vogel); when roles are rigidly defined (Bowers, 1988; Duncan & Morgan); or when there are discrepancies in role expectations, treatment goals, or values (Hasselkus, 1988; Nolan & Grant, 1989; Schwartz & Vogel). Other work describes the relationship as an alliance based on communication and mutual respect (Fischer & Eustis). Few studies, however, have specifically asked why health professionals and family caregivers tend to operate from different assumptions and value systems or have conflicting role expectations. Although many researchers cite the need for collaboration between health professionals and families, few raise the

issue of the power differential between the two groups, or address the difficulties that this power differential can introduce into the relationship.

Less clear and less documented still is the specific relationship between nurses and family members who provide care to frail elders in the home. Although the aforementioned studies emphasize the importance of relationship-building on the part of health professionals and family caregivers, there has been little systematic analysis of how nurses and family caregivers negotiate the care of the elderly and the specific negotiation strategies they use. Moreover, the social context and the consequences of this negotiation process are rarely examined.

Theoretical Perspective

The current study was informed by a socialist-feminist perspective of caring (Fisher & Tronto, 1990; Ungerson, 1990) supplemented by Twigg and Atkin's (1994) typology of family caregivers and Gerson and Peiss's (1985) activist view of negotiation. A socialist-feminist inquiry is particularly useful in conceptualizing caregiving because of two distinctive features: caring work occurs in both the private sphere and the public sphere, which are interwoven; and caregivers' everyday experiences are inextricably connected to the larger political, social, and economic environment. As with other critical theoretical perspectives, a basic principle of the socialist-feminist approach is that caring work cannot be understood in isolation from the social, political, and economic conditions in which it takes place. Research on health-care relationships has tended to focus on the micro process of interaction without taking account of the macro-level social and economic forces in the marketplace and the home. In other words, women's caring work not only is structured by economic relations, but also maintains and reproduces these relations. It is also important that macro-level structures, such as formal home-care policies and administrative rules, be understood in terms of their relationship to the everyday lives of caregivers. The socialist-feminist perspective and its utility have been more fully described elsewhere (Ward-Griffin & Marshall, 2001).

Since Twigg and Atkin's (1994) conceptual model focuses on the perceptions and roles of professionals in responding to family caregivers, it was a useful template for examining the ongoing negotiations between formal and informal caregivers. Twigg and Atkin suggest that the definition of the situation, the conceptualization of need, and the acceptability of the care provided are all subject to negotiation between the professional and the family caregiver. Implicit in this process is a

recognition that both parties are active participants, asking or demanding that resources be shared or reallocated (Gerson & Peiss, 1985). This perspective of negotiation reflects an activist view of human agency: humans are creative and reflexive, capable of adjusting their actions to fit the situation (Giddens, 1993). Supplementing an activist view of agency with a socialist-feminist perspective of caregiving will help to illuminate how caregivers produce and reproduce, but also resist and undermine, current economic and ideological structures. Thus, there is a dialectical relationship between individual meanings and the wider social organization, which is mediated through nurse-family caregiver negotiations.

Method

Purpose and Design

The underlying assumptions of feminist methodologies situate them within a critical approach to research (Neysmith, 1995). The purpose of this study was to describe and explore, using a critical ethnographic approach, the relationship between nurses and female family members caring for an elder in the home. Of particular interest were the forms that this relationship takes and the strategies, conditions, and consequences of the negotiation process. Critical ethnography was chosen because research, in this approach, makes explicit what is implicit in a culture (Thomas, 1993). While conventional ethnography treats the descriptions of cultural traditions as complete in and of themselves, critical ethnography is recognized as "having conscious political intentions that are oriented toward emancipatory and demographic goals" (Quantz, 1992, p. 448). Thus, adopting a critical stance towards assumptions of formal and informal caregiving provides an opportunity to engage in positive social change.

Sample

Using a two-phase sampling frame, registered nurses and family caregivers of elderly individuals were recruited over a 5-month period (August–December 1996). Inclusion criteria were: participants had to speak and understand English; participants had to have interacted with one another on four or more occasions; family caregivers had to have provided regular care (at least weekly) to a frail family member 65 years of age or older; and nurses had to be currently employed full-time or part-time at one of the three non-profit community nursing agencies in southwestern Ontario. All registered nurses ($N = 127$) were sent a

letter inviting them to participate; 43 responses were received (34% response rate). Nurses who met the eligibility criteria were asked to approach family caregivers who met the eligibility criteria to determine their interest. Family caregiving was defined according to Hooyman and Gonyea's (1995) definition, as services provided for the well-being of older individuals who, because of physical or mental disabilities, cannot perform such tasks themselves. This sampling frame may have introduced biases in that some nurses may have avoided "difficult" family caregivers or caregivers who would find an hour-long interview too tiring. However, it was a condition put forth by the participating community nursing agencies, suggesting that this approach may minimize potential coercion by the researcher and safeguard confidentiality of the family.

Purposive sampling led to the selection of 23 nurse-family caregiver dyads (Patton, 1990). The dyads had known one another from 3 months to 14 years, with a mean of just under 3 years. Most saw each other weekly. The average age of the nurses was 47 years. All but one were female. The majority were born in Canada (67%), spoke English as their first language (93%), held a nursing diploma and/or a specialty certificate (53%), and had been practising community nursing 11 or more years (53%). The family caregivers ranged in age from 33 to 82 years; most were over 60 years. None of the family caregivers were employed full-time but three were employed part-time. All were female. The majority were born in Canada (65%) and provided care to their husband (70%) who had a chronic illness (87%). The elders ranged in age from 65 to 99 years with a mean age of 78.9 years. As will be discussed below, virtually all of the elders required continuous, intensively demanding daily care. Family caregivers provided higher levels of care than the general estimate of 5 hours per week (Arber & Ginn, 1990). Due to the complexity of care required by the elder, the majority of nurses made weekly visits (57%).

Data Collection and Analysis

The major sources of data for the study were 38 in-depth interviews and corresponding fieldnotes. Demographic data were collected from the participants at the end of each interview and analyzed using descriptive statistics. Separate in-depth focused interviews (Merton, Fiske, & Kendall, 1990) were scheduled at a mutually convenient time and place for the nurse and family caregiver. Using a semi-structured interview guide informed by socialist feminist assumptions of caring work, participants were encouraged to talk about the paid and unpaid

care provided to the elder, the nurse-family negotiations concerning their caregiving responsibilities, and the conditions (social, political, and economic) and consequences of these negotiations. In response to open-ended questions (e.g., Can you tell me what your experiences have been in caring for X?), most participants discussed their caring work and relationships without further prompting. The interviews averaged 75 minutes. All were audiotaped. Approximately half of the interviews with nurses were conducted in their homes and half in their offices. Interviews with the family caregivers were conducted in their homes; all but one of the caregivers lived with the elder requiring care. Interviews were carried out until an adequate amount of data had been collected. As recommended by Morse (1994), it was anticipated that approximately 30 interviews would be adequate to obtain comprehensive descriptions sufficient for ethnographic research, but additional participants were added to ensure adequacy. Adequacy is attained when enough data are collected to provide a full and rich description of the phenomena — that is, when saturation occurs (no new data will emerge by conducting further interviews) (Morse & Field, 1995).

As recommended by Miles and Huberman (1994), a provisional list of codes was drawn up prior to interviewing based on the study's theoretical framework and research questions. These preliminary coding categories, related to caregiving and informal-formal relationships, were applied to the first set of transcripts and fieldnotes, then examined for fit. This method, situated between the a priori and inductive approaches to coding, helped create codes inductively nested in each general category. Early analysis focused on key phrases and themes that emerged from the data. As common themes emerged progressively, new codes were added, producing numerous and varied codes (Lofland & Lofland, 1995). These codes were inserted into the text by hand and then entered onto NUD*IST (Richards & Richards, 1994). The process of sorting and resorting data to locate patterns between coding categories was facilitated by the software program. (The author can be contacted for details about the techniques used to ensure credibility of the findings.)

Results

Using the coding method described above, an initial index system of 60 codes emerged. Codes were discarded or refined if they were not supported empirically by the data or were overly abstract. The codes were frequently regrouped or revised, resulting in a final total of 35. The index system that emerged from the coded data captured the general

categories of caring work (e.g., physical, emotional, intellectual); nurse-family caregiver relationships (e.g., as friends/family, as co-workers); types of negotiation strategies (e.g., refusing to care, delegating care); and conditions (e.g., age of caregiver, agency policies) and consequences of caregiving (e.g., quality of life for elder, for caregiver). This index system was consistent with and reflected the theoretical framework that guided the study. In particular, the socialist-feminist principle that the organization of caring work is part of the larger social, political, and economic environment was strongly supported by the data.

The findings revealed that relationships between community nurses and family caregivers are complex, multifaceted, and dynamic. Both groups performed all facets of caregiving — physical, intellectual, and emotional — but to varying degrees and for different reasons. Nurse-family caregiver relationships that evolved through caring for an elder at home were of four types: nurse-helper, co-worker, manager-worker, and nurse-patient. Finally, while both nurses and family caregivers collaborated in and resisted existing caring arrangements, they engaged in a process of negotiating cultural assumptions of “private” and “public” caring. It became evident that the opportunities for negotiation were more limited for family caregivers than for nurses, reflecting the powerlessness of an individual whose caring work is not publicly visible. This position of invisibility supports prevailing conservative political ideologies. Indeed, nurses relied on ideologies of “familism,” “fiscal restraint,” and “choice” to transfer caring work between the informal and formal caring systems. Ideologic work by nurses constituted the most powerful, but covert, means of controlling the caring work of family caregivers.

Boundaries of Care

Family caregiving was described by both groups in terms of continuous, demanding, daily care. It consisted of personal care, monitoring, and emotional support. In addition, every family caregiver performed a number of complex technical procedures, such as wound dressing, tracheotomy suctioning, and administration of medication. General perceptions about family caring were similar for nurses and family caregivers, with two notable, interrelated differences. First, nurses described family caregiving mostly in terms of “dirty” hands-on care — unskilled labour that can be easily learned. They rarely acknowledged the importance of emotional and intellectual informal care to the same extent as the family caregivers did. Second, even though it is clear that a family caregiver gradually becomes expert on the elder’s health-care needs,

nurses tended to give less importance to the caregiver's level of knowledge and competence.

Perhaps the failure to recognize the family caregiver's knowledge stems from the importance attributed to the nurse's role as monitor. Both groups tended to describe nursing care in terms of periodic assessment and supervision. Caregivers explained that nurses provided this type of care because of their superior knowledge and expertise: "I couldn't fulfil what Diane does. Her knowledge. Her expertise. Her experience. She uses all that. What I do is provide meals, get the groceries. I have to run the house as well... I don't think we overlap at all. I don't think she could do what I do, because mine is so menial and hers is professional." When nurses provided hands-on care — usually temporarily — it was described as a "technique" or means to an end such as "building trust," "assessing the elder's condition," or "providing relief for the family." Moreover, unlike family caregivers, nurses had choices concerning whether and when to provide hands-on care. Another major difference in perceptions about nurses' caring work concerned the emotional support they provided to both the elder and the caregiver. While nurses saw this as a key component of their role, many family caregivers perceived it as personalized attention and extra effort "beyond the call of duty." Thus, there appears to be a clear division of labour between nurses and family caregivers not only in terms of specific functions, but also in terms of manual and intellectual work.

On closer examination, however, it was apparent that nurses and family caregivers crossed the boundaries separating "manual, unskilled" from "intellectual, skilled" work. Although both groups sought to maintain distinct boundaries between their caring work, the findings revealed that family caregivers gradually provided complex, technical tasks typically seen as professional nursing care. Similarly, if family caregivers were unable to provide hands-on care, particularly when they were ill or too tired or when the elder's condition worsened, some nurses temporarily assumed a greater portion of "unskilled" responsibilities, frequently working longer hours or without pay. It is to these relationships between nurses and family caregivers that we now turn.

Relationships Between Nurses and Family Caregivers

The nurse-family caregiver relationship shifted and oscillated among four interrelated types: (1) nurse-helper, (2) worker-worker, (3) manager-worker, and (4) nurse-patient. A detailed description of these relation-

ships has been published elsewhere (Ward-Griffin, 1999; Ward-Griffin & McKeever, 2000).

In the *nurse-helper* relationship, the boundaries were relatively unambiguous. The nurse took the time to provide and coordinate the majority of care, while the family caregiver assumed a supportive role. At times, family caregivers actively sought out opportunities to be involved, but although nurses acknowledged and supported the involvement of family in the elder's care, they did not transfer their nursing work to the caregiver. Nurses within this relationship tended to assume more responsibilities than assigned by the agency, and resisted agency policies and directives to relinquish this care. Both parties recognized and valued the contributions of the other. While most nurses and family caregivers stated that this was the type of relationship they had had at the beginning of the elder's illness, it was the least common type in this study ($n = 3$).

Although only a few dyads currently functioned in a *co-worker* relationship, most had done so in the past. In contrast to the original nurse-family caregiver relationship, this one was filled with tension, conflicts, and ambiguities. Based on the notion of teamwork, nurses attempted to collaborate with family caregivers in a way that recognized their expertise yet co-opted them. Negotiations focused on family caregivers' growing competence and acquisition of caregiving skills usually associated with nursing. Many nurses downplayed the complexity of these skills while at the same time seeking to gain the family caregiver's trust in order to delegate their nursing work. If necessary, nurses would be careful to give the caregiver time to "get used to the idea" before transferring the work. Although many family caregivers complained of feeling uneasy, overwhelmed, or angry because the task appeared too difficult, they usually agreed, deferring to the nurse's professional opinion and experience. Consequently, nurses were able to gradually reduce the frequency of their visits as the family caregivers were co-opted into becoming informal members of the health-care team.

The vast majority of the dyads ($n = 16$) functioned in the third type of relationship, *manager-worker*. As nurses gradually transferred their actual caring work to the family caregiver, their supervisory tasks — such as monitoring the "coping skills" of the caregiver — increased in importance. These nurses acted primarily as "resource persons," providing information or emotional support. They saw the elder and family caregiver infrequently and sporadically, using as justification the fact that the elder's condition was "stable" and the caregiver was "competent." Although family caregivers had generally accepted increases

in their caring work in terms of complexity and time, many were confused and sad that the nurse had reduced her involvement. A few resisted the nurse's attempts to set limits, but with minimal success.

The fourth type of relationship, *nurse-patient*, occurred almost as frequently as the manager-worker relationship, and as a consequence of it. As a result of their relentless caregiving demands, family caregivers became the nurses' patients. Nurses were faced with contradictory expectations: they were expected to relate to the family caregiver both as worker and as patient/client. Many family caregivers characterized their situation as "living on the edge" or "not having a life of my own." While nurses expressed concern for the health and well-being of the family caregiver in these crisis situations, they claimed that they were doing their best given the current fiscal reality of the home-care system. Only rarely, however, would nurses consider increasing their own or other formal caregiving efforts to ease the family caregiver's workload. Consequently, for many family caregivers the demands of caring induced illness, because they did not have the same opportunity as nurses to delegate their work to others.

Thus, the results show that relationships between nurses and family caregivers in home care tend to be ambiguous and characterized by tension. The findings also suggest that ideologies constitute the most powerful, though covert, influence in nurse-family caregiver negotiations.

Ideologies and Nurse-Family Caregiver Negotiations

An ideology is a set of beliefs and attitudes of a group about a social reality, as well as the practices and motives that embody these beliefs and attitudes (Geuss, 1981/87). Two interrelated ideologies shaped the negotiations between nurses and family caregivers: fiscal constraint and familism. Nurses described constant pressure from management to "cut costs" by finding the least expensive home-care service or reducing the frequency of their home visits. This relentless drive to reduce or eliminate induced a sense of powerlessness in many nurses. Due to heavy workloads, they felt they had little choice but to comply. Moreover, as guardians of the public purse they believed they had a role to play in saving money within the health-care system. Their methods for doing so included: transferring caring work to family caregivers and/or "less skilled" home-care workers; restricting "complete" home-care services to family caregivers of terminally ill elders, who were considered in greater need than family caregivers of chronically ill elders; encouraging family caregivers to pay for private home-care services; and reallo-

cating, in an "equitable" manner, home-care supplies and services from those who did not need it to those who did. These cost-cutting strategies required nurses and family caregivers to continually negotiate the boundaries between skilled and unskilled labour and between public and private costs.

Coupled with the ideology of fiscal restraint, familism played a central role in the negotiations between nurses and family caregivers. Familism — the idealization of what a family should embody — is rooted in the principle of "private" responsibility, which emphasizes self-reliance, privacy of the family home, and freedom from intrusion (Hooyman & Gonyea, 1995). Virtually all family caregivers expressed a duty and obligation to assume the role of caregiver. Caring was regarded as "natural" for women and as a "family duty," particularly for older spousal caregivers. Familism, with its prescriptive assumptions about the "natural" and "right" position of women (and men) within marriage, shaped their experiences and their expectations about the provision of care.

Similarly, nurses' opinions about the degree to which family members "should" care for their elders were shaped by personal values and assumptions based on traditional gender roles, family relations, and the caregiver's age. Nurses openly encouraged younger women to "lead their own lives" — to consider placing their grandmother in an institution, for example. In the case of older women, in contrast, nurses placed a higher value on "love and family care." They particularly admired older family caregivers who were "devoted" and "dedicated," and frequently told them so. Moreover, most nurses placed the onus for caring on the family, viewing home-care services as playing a secondary role. They saw family care provided in the home as superior to institutional care. Interestingly, the majority of nurses assumed that family caregivers were free to choose alternative forms of care, even though they acknowledged that such options were often limited or inappropriate. Although family caregivers rarely questioned the naturalness of family care, they differed from the nurses in their opinions about it as a "choice"; the lack of options led many family caregivers to believe they had no choice but to provide the bulk of care.

Thus, ideologies that view home care as better and more cost-effective than institutional care, and that view women as natural caregivers, sustain the current system of home care and preclude caregiving alternatives both within and outside of the home-care system. Ideologies are invoked by nurses, as guardians of the public purse, in the transfer of economic responsibility for elder care from the public to the private

domain. The power of these ideologies is reflected in the compliant behaviour of family caregivers in assuming the bulk of *work* in elder care and in eventually also assuming the greater portion of *responsibility* for elder care.

Implications for Nursing

The findings of this study provide evidence that relationships between nurses and family caregivers in the home-care system present a particular challenge. They tend to be characterized by uncertainty, tension, and power struggles. While both nurses and family caregivers feel it is important to develop collaborative relationships, they must constantly negotiate care in an emotionally charged "intermediate" domain. Located between the public world of paid work and the private world of the family, Stacey and Davis's so-called intermediate domain (cited in Mayall, 1993) is a contested arena. Negotiation between nurses and family caregivers is impeded by many factors: blurred boundaries between skilled and unskilled caregiving; unequal division of formal and informal care; powerlessness on the part of both nurses and family caregivers; and acceptance of the notion that caregiving is women's work. In the process, alliances of nurses and family caregivers are formed under the guise of partnership, only to be severed and rebuilt to conform with home-care policies and priorities. The questions that this study raises about the relationships between nurses and families caring for frail elders at home have implications for nursing practice, education, and policy.

Previously published discussions of the current findings (Ward-Griffin, 1999; Ward-Griffin & McKeever, 2000) include implications for nursing practice. Briefly, nurses need to: (1) evaluate the negative consequences of transferring care from paid caregivers to the family, (2) acknowledge an ethical responsibility to support family caregivers by providing adequate resources, and (3) ensure that women are not coerced into assuming their "natural" role as family caregivers. In short, the time has come for nurses to advocate for and with family caregivers, as a first step in the development of a genuine partnership.

Given these implications for practice, all health disciplines may need to make curricular changes, in order to prepare practitioners in the building of collaborative relationships with family caregivers. Educators are challenged to adopt creative teaching strategies with the ultimate goal of enabling future practitioners to effect social change — to reform rather than to reproduce gendered power relations (Ward-Griffin & Ploeg, 1997). Nurse educators may have to examine their

current teaching methods and opt for a more collaborative learning approach (Boughn & Wang, 1994). What is needed is an environment that fosters shared leadership in the classroom and in clinical settings, with students learning to identify areas that require social change, to examine their role in effecting change, and to identify sources of support for social change (e.g., the Ontario Nurses Association). Nursing students must be given opportunities to examine the power dimensions of their professional relationships with families and to identify collaborative political strategies such as coalition-building. Nursing faculty must critically examine the training and indoctrination of students into the profession to determine whether they promote the ideologies of familism and essentialism (i.e., woman as nurturer). All of these strategies might equip future practitioners to address some of the inequities in the home-care system.

Partnerships with family caregivers are important in the political arena as well. The future well-being of family caregivers depends, in part, on the development of sound, socially relevant policies to correct inequities in the home-care system. If this goal is to be met, partnerships will have to be fostered among all caregivers, both formal and informal. Individual health professionals, and their provincial and national organizations, will have to join in the efforts of other caregivers. The recent establishment of the Canadian Coalition of Caregivers represents an opportunity for nurses and family caregivers, along with other key stakeholders, to jointly identify and prioritize caregiving issues. This multi-sectoral coalition is an important first step in recognizing and addressing the powerlessness common to all caregivers, by working together in equal partnership with community members, professionals, volunteers, and care recipients. By lobbying policy-makers and key decision-makers at the provincial and national level they can contribute to policy change and the development of a new paradigm for caregiving in Canada. Significant changes must be made not only in the workplace but also in government policies that constrain both families and health professionals in their caregiving efforts.

Finally, the findings of this study are consistent with those of Hooyman and Gonyea (1995), that we need to challenge the pervasive ideologies of familism that undergird implicit and explicit policies and to envision alternative models of care. For instance, the community-oriented approach suggested by various authors (Guberman & Maheu, in press; Neysmith, 1991) situates the ultimate responsibility for caregiving with the community as a whole. This could be the new paradigm for caregiving in Canada. In the social-care model, care of the elderly is

seen not as a "problem" for individual families to resolve but as a social responsibility warranting a collective response by all concerned stakeholders. The central tenets of the social-care model are: genuine choice for individuals about whether to assume family caregiving; access to a guaranteed minimum level of services for all disabled persons; and caregiver/care recipient participation in policy development at all levels of the health-care system (Guberman & Maheu). In the social-care model, nurses and family caregivers enter into a relationship that is unambiguous, for the purpose of building a genuine, equal partnership.

In conclusion, the results of this study demonstrate that the responsibility for elder care is unequally distributed between nurses and family caregivers. Of particular concern is the evidence that current home-care practices and policies create or intensify problems for family caregivers. The ideologies that inform both nurses and family caregivers serve to exploit female family members by coercing them into taking on the bulk of care. As governments seek more and more ways to cut health-care costs, it is reasonable to predict that in the future families will experience even greater difficulties in caring for the frail elderly. These inequities will not necessarily be sustained, however, if nurses take the opportunity to seriously look at what they do and the outcomes they want to achieve (Fisher, 1990). Policies that constrain and work to the detriment of both formal and informal caregivers must be changed. Nurses must join other professional and lay organizations in lobbying for radical alterations to structures and ideas that perpetuate the unequal division of labour between private and public caregiving. Only when policies reflect the principles of primary health care, including equity, empowerment, and multi-sectoral collaboration, will there be a genuine partnership between nurses and families in home care.

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Author's Note

This study was made possible by the following funding resources: Health Canada (NHRDP) Research Training Award (#6606-5125-47), a Canadian Nurses Foundation Research Grant, and a Helen Glass

Research Award (Sigma Theta Tau Nursing Society, Iota Omicron Chapter).

The author wishes to gratefully acknowledge the guidance and skilled advice of Drs. Victor Marshall, Patricia McKeever, and Ann Robertson throughout the research project, and to thank the reviewer for helpful comments, which greatly enhanced the clarity of the article.

Comments or queries may be directed to Catherine Ward-Griffin, School of Nursing, Faculty of Health Sciences, University of Western Ontario, London ON N6A 5C1 Canada. Telephone: 519-661-2111, ext. 86584. Fax: 519-661-3928. E-mail: <cwg@uwo.ca>.