

# **The Material and Social Predicaments of Home: Women's Experiences After Aortocoronary Bypass Surgery**

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Plusieurs auteurs prétendent que la vie des femmes est conditionnée par des circonstances sociales telles que la classe, la race, l'ethnie, l'âge, les capacités, la maladie ou l'incapacité chroniques. Il se crée des modèles d'avantages et de désavantages, de domination et d'oppression, qui constituent le terrain de la santé des femmes. Une ethnographie institutionnelle a été élaborée afin de suivre les expériences de 18 femmes qui ont réintégré leur domicile à la suite d'un pontage coronarien. Utilisant les récits de trois femmes comme exemples, l'auteure se concentre sur les activités quotidiennes des femmes au cours du premier mois de leur retour à la maison. L'auteure décrit les circonstances dans lesquelles se produisent ces activités et examine les relations sociales révélées par ces descriptions. À partir de cette analyse, on affirme que la recherche et le travail de fond bénéficieraient d'une compréhension plus critique de l'expérience différente des femmes relativement à la maison et aux soins à domicile.

Several authors argue that women's lives are conditioned by social locations such as class, race, ethnicity, age, and chronic illness or (dis)ability. Patterns of advantage and disadvantage, domination and oppression are formed which constitute the groundwork of women's health. An institutional ethnography was designed to follow the experiences of 18 women on their return home following aortocoronary bypass surgery. Using the narratives of 3 women as examples, the author highlights the everyday activities pursued by the women in the first month after their return home. The author describes the circumstances under which the activities occurred and discusses the social relations reflected in the descriptions. From this analysis it is argued that research and substantive work would benefit from a more critical understanding of women's different experiences of the home and of home care.

In Canada in 1999, women comprised 46% of the paid labour force and 68% of all mothers in two-parent families were employed (Statistics Canada, 2000). In the same year, women performed a disproportionate 65% of all unpaid labour (including volunteer work), a share that has remained stable since the early 1960s despite sharp increases in women's participation in the paid labour force. Women with children under age 19 and full-time employment spend from 1.5 to 2.5 more hours daily on housework than do their partners (Jackson, 1996;

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Statistics Canada). In 1999, women missed an average of 7 working days because of family responsibilities, compared to an average of 1 working day missed by men for similar reasons (Statistics Canada). These figures may actually underestimate the amount of time and effort women devote to homemaking and family care: the invisible labour involved in providing emotional support, maintaining links with health-care providers and educational systems, and coordinating social relationships with friends and neighbours are activities that escape the notice of time-usage surveys (Angus, 1994, 1996; Duncombe & Marsden, 1995; Luxton, 1997). In Smith's (1990) words, women's everyday lives consist in part of "localized activities oriented toward particular others, keeping things clean, managing somehow the house and household and the children — a world in which the particularities of persons in their full organic immediacy...are inescapable" (p. 20).

Statistical observations suggest that women may confront barriers when their own health requires time and attention. The literature on women's recovery from cardiovascular surgery and myocardial infarction is replete with references to resumption of homemaking tasks (Boogard, 1984; Fleury, Kimbrell, & Kruszewski, 1995; Hamilton & Seidman, 1993; King & Jensen, 1994; Sutherland & Jensen, 2000). Women are described in these studies as inextricably linked to homemaking by discursive concepts such as control, guilt, gender roles, and household responsibilities. However, these explanations do not acknowledge the ways in which women are differently constrained by social locations such as gender, class, race, ethnicity, age, and chronic illness or (dis)ability, or the myriad ways in which these locations articulate. Indeed, recognition of the deeply heterogeneous nature of women's material situations, identities, and experiences of health has marked a new approach to theorizing women's health (Clarke & Olesen, 1999; Doyal, 1995; Ruzek, Olesen, & Clarke, 1997). Scholars who draw our attention to the patterns of advantage and disadvantage, domination and oppression that condition individual women's experiences also would encourage us to consider how these patterns enter into everyday experiences of health and illness (Bannerji, 1995; Clarke & Olesen; Collins, 2000; Meekosha, 1998). Many Canadian authors draw attention to these patterns in their work on women with chronic health problems or (dis)abilities, and they consider how the relations of health care enter into the textures of their experiences (see, for example, Anderson, 1998; Anderson, Blue, & Lau, 1991; Dyck, 1995; Dyck, Lynam, & Anderson, 1995; Thorne, McCormick, & Carty, 1997).

With the above referents in mind, I will discuss the findings of an institutional ethnography of women's experiences on their return home

following aortocoronary bypass surgery (ACBS). Although many aspects of care, such as diagnosis, surgery, and post-surgical care, take place on the professional ground of doctors' offices, diagnostic laboratories, and hospitals, shorter hospital stays have resulted in an emphasis on the home as a location of recovery from surgery. I was interested in learning how women attend to their own health needs in a location where they are accustomed to arranging the conditions of health and well-being of others. In this paper, I consider how gender, age, class, and immigration configure illness experiences within the material and social context of home.

### **Analytic Framework**

The tenets of institutional ethnography (Smith, 1987, 1990, 1999) formed the analytic and methodological ground for this study. Smith explains that institutions are functional complexes comprising multiple locations wherein various activities are pursued by diverse actors (Grahame, 1998). The health-care system is a functional complex spanning locations such as hospitals, research institutes, government ministries — and homes. Potential difficulties inhere in the coordination of activities across these locations, yet individuals are able to proceed in collaboration despite distance, dissimilar foci, and a range of expertise. A fundamental assumption of institutional ethnography is that activities within institutions are discursively organized, and that discourse itself is textually mediated, or present in written materials, audiovisual media, and other forms of communication. Activities within the homes where women recover from cardiovascular surgery may be linked to the health-care system because of information conveyed at the time of discharge or through the presence of home-care providers.

Hence, people are discursively active in different places and in different ways. They remain embodied participants in discursively organized social relations within these various social positions. There are "differences in the possibility of knowing that relate to the knower's location and everyday/everynight work" (Campbell, 1998, p. 59). There are also some possibilities for the construction of codified knowledge which inevitably divest concepts of their underpinnings in the everyday. Hence, according to Smith, there are two modes of knowing. One arises in the local and particular world of embodied activity and the sensory organization of immediate experience. The other passes through or derives some elements from the local world but enters the more conceptual and generalized order of discourse. Concepts such as "gender role," which connects gender with the work of homemaking, are markers of the second mode of knowing.

Institutional ethnography is concerned with examining discourse or discursive practices and explicating the work or embodied activities that people pursue in the course of everyday life. The aim is to describe the social relations that are evident in how these local activities are linked and coordinated with work processes in other diverse sites (Grahame, 1998, p. 353; see also Smith, 1987). In this paper, I highlight the everyday activities pursued by women in the first month after their return home after ACBS. I describe the circumstances under which these activities occur and discuss the social relations reflected in these descriptions. I conclude by comparing these observations with the discourse on homemaking and gender which is evident in the nursing literature.

### *Study Design*

Experiential approaches to data collection are essential features of institutional ethnography because they enable the researcher to directly learn from the experiences of participants (Campbell, 1998). Hence, 18 women who were recovering from ACBS were purposively selected from the client group of the cardiovascular surgery department of a teaching hospital in a large metropolitan centre. These women were interviewed twice: once after they had been home from hospital for 4 weeks, and once after 4 months. The interviews followed an unstructured narrative format and were audiotaped and transcribed. Transcriptions were entered into the NUD\*IST software package for coding. Analysis closely followed the three-stage process reported by Kasper (1994), which she developed with reference to the tenets of institutional ethnography. The first stage of the analysis was completed by the respondents in their selection and interpretation of anecdotes or examples from a large repertoire of experiences. In the second stage, each woman's account was condensed into a biographical case study with attention to embodied activities and sensory perceptions as well as interpersonal experience. Luken and Vaughn (1997, 1999) use a similar comparative approach to biographical accounts. Review of these case studies led to development of a system of codes in the third stage of analysis, so that corresponding statements within transcribed interviews could be indexed, retrieved, and further compared.

Four distinct periods in the women's encounters with heart disease and treatment were evident in their narratives: diagnosis, hospitalization for surgery, the first month after surgery, and 4 months after surgery. Each point was suffused with social and bodily displacements or relocations. Diagnosis marked entry into the social category "women

with heart disease," which was connected to assumptions of moral responsibility for developing heart disease. Hospitalization removed the women from the familiar social context of home and close others, and embedded them within social relations that effected a sense of bodily dispossession. Homecoming was an occasion of relocation within a division of responsibility which was poorly designed to meet their needs and in which they were still responsible for the needs of others. In the months following their homecoming, the women struggled to situate themselves at the intersection of two, often conflicting, discourses: the discourse of homemaking and the discourse of self-care. For these women, illness and health care dislocated the binary spatial opposition of public and private, disrupting and rendering problematic the assumptive ordering of the home. Here, I focus on the women's initial period of relocation to the home after discharge from hospital.

### **Home: A Location of Healing for Women?**

On return to the site of their everyday world after hospitalization, respondents were confronted with a dilemma: their bodies and their physical health needs did not always align with the conditions and practices associated with home. This local world evoked biographical patterns of support for others, yet the moral responsibility to protect themselves and their own health presented a conflicting set of objectives. The women's physically healing bodies were a source of disturbing and sometimes mysterious sensory experiences that inhibited resumption of habitual activities. Instruction by health professionals, as well as information available through personal contacts, the media, or self-help books, had indoctrinated some of the women into a discourse of heart health that featured principles of risk modification and self-care. Yet the immediacies of home and the inescapable requirements of particular others presented another set of concerns. This was emphatically not simply a conflict of meaning; it was a material predicament centred on physical activity and the coordination of everyday life. Material and social circumstances influenced the range of possibilities available to each woman.

Thus, these women were no longer "at home" in their own bodies. Furthermore, they returned to everyday material and social conditions that provided varying degrees of convalescent support. Some were therefore more "at home" in activities that promote healing and recovery than others. They occupied an interstitial space created by the embodied and discursive intrusions of illness and health care into the assumptive world of the home, and it was their task to resolve the



resultant tensions. I turn now to discussion of how these conditions contoured the possibilities open to the women as they pursued care of their healing bodies in their own homes. Following Luken and Vaughn (1997, 1999), I will examine the narratives of individual women to illustrate that what each knew and could tell about managing the home in the early weeks after surgery was different, because each of the knowers occupied a different social location. The narratives of three of the women form the basis of this comparative analysis.

### *Social Relations of Homemaking After Surgery*

The activities of homemaking are extensive, and they do involve physical labour and exertion (Wilke et al., 1995). In the convalescent period following cardiovascular surgery, the women were advised to avoid heavy housework. They were instructed against lifting small children or otherwise placing tension on their healing sternums. Prior to discharge, their situations were assessed to determine the need for home-care support. Two women who lived alone with very limited assistance from their families were sent to convalescent settings for an additional week of care. Two of the 18 women received home-care services, including homemaking, upon returning to their own homes. But neither home care nor the presence of cohabiting family members ensured that the women were free to rest and pursue their own health needs. Their experiences were uniquely configured by their unique social locations.

*Eva.* A 75-year-old woman with arthritic joint deformities, Eva lived in a rented seniors' apartment with George, her 84-year-old husband of 2 years. She had been born and raised in Canada and was of European extraction. When Eva was admitted for surgery, George was also hospitalized, with thrombophlebitis. He was discharged home on anticoagulant therapy at the same time she was, and the couple received home-care services, which included nursing care for George, physical therapy for Eva, Meals-on-Wheels, and a homemaker to assist with personal care, cleaning, and laundry. However, it was Eva who coordinated her own and George's medications and health regimens, and it was she who called attention to his inflamed leg 1 week after discharge. He was immediately readmitted, and Eva's care regimen was interrupted by a new routine of hospital visits.

*Eva:* Okay, so there was also...a [physical] therapist was supposed to come in for me. [chuckles] And, um, I told her I wouldn't be able to see her that week because I had to go up to the hospital every day and walk through that tunnel...I got all the walking I needed. [chuckles]

Interviewer: Oh?

Eva: *And back home again... I stayed 4 hours with him and came back again at night... And when I was at the hospital I was up and down getting things for him. I thought I was getting enough exercise! She says, "You're right, you are! But we just want to show you how to walk." And I said, "Well, I've been through all that before."*

One week later, George was again discharged home and Eva described the embodied rigours of spousal caregiving. She found that her discomfort in the early weeks at home was in part associated with her responsibility for physical care.

Eva: *There was just, I think, the constant running... And then of course putting on those elastic stockings for him.*

Interviewer: *Oh, you put those stockings on for him?*

Eva: *Oh, yeah, and it was a struggle. Especially, it caught me all down here. [indicates sternal area]*

Her comments reflected careful coordination of George's many appointments for blood tests and assessment, as well as responsibility for his medication dosages:

*He has to have blood tests every solitary Monday they told him. And they always call me back... Last week I had to reduce his pills by two. I cut out Wednesday and Thursday. I'm expecting probably that they'll call me later on and tell me to do it again. And maybe he has to have the whole seven this week. He's on Coumadin.*

It was clear that the same attentiveness did not go into her own self-care efforts:

*I put the letter [from the cardiovascular surgeon to the family doctor] in my purse...and come to think of it I haven't given it to him yet.*

Here, gender and age intersect to create a position of disadvantage. Eva's story illustrates the consequences of a pattern of heterosexual bonding in which the woman is typically younger than the man. As both partners age, the wife often becomes involved in providing or coordinating health care for an older husband. Furthermore, older women's biographical experiences may facilitate development of considerable expertise in family caregiving. Eva, for example, had cared for her first husband when he developed severe coronary artery disease in middle age, and had nursed him after a subsequent stroke. In widowhood, her extensive experience with health professionals as she required treatment for arthritis and coronary artery disease further prepared her to assume responsibility for the care of her second husband, George. Her competence and ease with the language and practices of health care, as well as her eagerness to return home with her husband

regardless of the circumstances, may have led health professionals to view Eva as a candidate for home care rather than admission to a convalescent setting (Twigg & Atkin, 1995). In her narrative, George is described as more vulnerable than she, and he was not expected to provide care for her or to perform homemaking tasks.

*Margaret.* Younger women have different challenges and advantages. Fifty-three-year-old Margaret, like many women of her generation, worked outside the home for most of her adult life, and she raised her two sons to independent adulthood. Like Eva, she was Canadian-born and of European extraction. With her husband, Reg, she owned a large detached home in an upper-middle-class neighbourhood as well as a thriving family business. Her class location meant that Margaret was able to exempt herself from some of the activities of homemaking; she could afford the weekly services of a "cleaning lady." Margaret and Reg lived alone, and Reg was unable to stay home for lengthy periods to attend to her needs because their business was already short-staffed in her absence. Female family members were a constant caregiving presence during her first week at home:

*Well, my sister was here for a week with me. And Reg, he's fairly good at doing things, you know. And I have a cleaning lady come in once a week. So I had no problems, not really. And I had a daughter-in-law who was really, really great. Anything I needed she was there. They were always there when I needed — in fact, they were sometimes here too much and I'd tell them to go. [laughs]*

However, 5 weeks after her surgery Margaret returned to work. One facet of the business involved attending shows where some of their items would be displayed for sale. Reg and her eldest son had to attend one such show in another city and Margaret was left for a week to run the business with an employee:

*I went in with her...maybe from 12 to 5. I did it for the full week. I was kind of tired. I was really quite tired.*

Despite this pressure to maintain the viability of the business, Margaret insisted that she had the discretion, as co-owner, to decide which hours she would work. Consequently, she was able to develop a routine that included time for self-care:

*I exercise every morning. I walk. I always get up about a quarter to seven, half-past six, and I find I do like it. I've sort of got the house to myself and I do my exercise, my walking, in the morning, and I have my breakfast and I sit and really relax at this point. I don't go to the store until 11 o'clock so I can do a load of washing, whatever I have to do...I find*



*that first thing in the morning is my time, and that 3 hours, 4 hours, I just — my most important time is in the morning.*

Although this protected time included homemaking tasks such as laundry, Margaret did have the opportunity to read books and pamphlets about nutrition and, consequently, to experiment with her diet. She proudly reported her progress:

*I eat properly. I don't take sugar any more, I don't put salt in my food. I use herbs, and I don't eat anything that's fat. I stay away from the fats, although I try to have the good fats, which I should have. And my cholesterol has been good, and my blood pressure is fine, so I guess I'm fine for a while. [chuckles]*

Margaret's class location brought advantages and disadvantages. She could afford to pay to have her house cleaned, and she could, to some extent, determine her own working hours to suit her health needs. She lived in a large, comfortable house in a safe and quiet neighbourhood. Yet she was also bound to the staffing demands of her family business. Margaret's experiences were also embedded in social relations that were marked by the continuing devolution of caregiving work from paid providers to unpaid family members — in her case, a sister and daughter-in-law. These female relatives were a continuous presence during her most vulnerable period so that her husband could attend to the family business. Her use of the phrase "I have a cleaning lady" was a further reference to social relations that configured her experience but that were not immediately apparent in her everyday world. The phrase is a code that conceals with its simplicity the relations of purchasing house-cleaning services from another woman at affordable rates. Both instances disrupt the boundaries of public and private, formal and informal, paid and unpaid, and reveal the entanglement of the local world of home with extralocal relations.

**Olga.** A 50-year-old self-declared housewife, Olga told a story that differed from Margaret's, despite their similar ages. When she was 18, she met and married her Latino husband in her native Germany. The first of four children was born a year later, and the family moved to Canada when she was 22. She became unwell in her mid-40s but found it difficult to engage the attention of her family physician to the sensory experiences, which she interpreted as severe fatigue and, later, shortness of breath.

*Instead of finding out why I was complaining, he told me to find a job. Then finally he eventually did find out that I had diabetes. I had no idea. And so this is the same story now — he kept on saying, "Oh, there's nothing wrong with you." I was somehow in the background of my mind*

*always worried...thinking of my father [who died of heart disease]. That always worried me. That might be something there with the heart. And also he told me to stop eating sausages. [laughs] Maybe because I'm German he thought I eat morning, night, and all day long sausage.*

Olga's social locations as a housewife and an immigrant entered into the diagnostic process. Because she was a housewife with a nearly empty nest, she was presumed depressed and in need of a diversion. Because she was an immigrant, her dietary patterns were imputed by her physician to be culturally distinct and problematic, yet her physical symptoms were not investigated.

Olga confided at the beginning of our first session that she was embarrassed by her accent and had occasional problems selecting or understanding English words. Although she could fluently speak and read the language, she told me that it was difficult for her to write in English and this had impeded her efforts to secure and retain the kind of employment that interested her. Eventually she had given up her search for work outside the home. She explained that these linguistic issues also constituted a barrier to her obtaining information. Indeed, our discussions were punctuated with her pauses as she tried to identify or define the appropriate term:

*I mean, we are immigrants...we didn't even know that word, and so we never used it.*

Olga: *And then he explained that day before the surgery where they take the vein, you know, this... [pause] But still, I'd like to know more about that. And I've never heard about this, what's it called — memory...?*

Interviewer: *The mammary artery?*

Olga: *I'd never heard about that, and I just can't picture how this all works... I'd like to know about these things.*

These statements describe the constraints Olga encountered in her efforts to gather information about her treatment, but they also remind us that the interview is, among other things, "a site of identity negotiation" (Dyck, 1998, p. 26), whereby participants "place" themselves and one another within a social framework. Olga's comments and our discussion identify her as an immigrant and me as somewhat representative of the health professionals who possessed the linguistic skills and information to which she had limited access. Her efforts to learn the vocabulary associated with her diagnosis and treatment underscore the exclusionary power of language and the fact that the construction of shared social worlds is mediated by shared terminologies (Smith, 1999). Unlike Eva, with her long history of communicating with health pro-

fessionals, and Margaret, with her effortless reading of publications on cardiovascular risk reduction, Olga struggled to interpret the implications of her illness for her personal care.

Olga described other conditions that limited her possibilities. Her husband was the sole wage earner, and his working-class location as a lathe operator made the couple vulnerable to a competitive global climate in the industry in which he worked. Periods of intense labour resulted in overtime and increased income, but layoffs were also common:

*Until a few months ago, from about late summer last year, they had so much work to do that he had to work 7 days a week. And that never, ever happened. Until that all stopped — not so wonderful for the pocket, you know, not at all. [laughs] And we never learn. When there are times of plenty, you don't put some on the side. And now suddenly there is this big bang, and there is not enough. But that's life.*

Her husband was called back to work when Olga was ready to be discharged from hospital:

*My husband was willing to stay home with me but we just totally couldn't afford it. I don't know how to pay the bills after if he had, because he's paid by the hour. And the week before the surgery he hadn't been working.*

In the traditional division of domestic responsibility in Olga's household, an adult son who was still living at home was not expected to provide homemaking support. Instead, her daughter returned home from university studies in another city to care for her mother for a brief period before taking a scheduled trip to Europe:

*She was here for a while and then she got an occasional 2-week job, and she really needed that because Europe is very expensive right now. So she went for that job... That's when I started to do all the housekeeping here again, but this is even though I got the shouts from my husband: "What are you doing? You're crazy, don't do it!" But nobody else did it, so what are you going to do? And he is tired...he's even more tired now than when he worked 12 hours a day. So who else is going to do it? I think all these things are better for men because they get served anyway. But women...things totally get screwed up if they're not — if you're not in charge, you know.*

As Olga pointed out, a vacancy existed within her home. There was no other person present who was consistently able or willing to run the household while she recovered from her surgery. Indeed, in the uncertainty associated with extralocal influences on their income, she was concerned to ensure that her husband was able to rest after his day of labour. Such homemaking ensures the continuous availability of a func-

tioning labour force. Hence, Olga was bound by her financial dependency on her husband to her position as an unpaid participant in social relations that support and constitute the economy. She could not find the office or retail work she favoured because, as an immigrant, she was unable to write English. Her schooling and vocational preparation had been terminated by early marriage and motherhood, further limiting her options.

These case studies illustrate the importance of beginning analysis from the standpoint of women's embodied activity within their everyday worlds, but also of attending to the ways in which experience is conditioned by interlocking social locations such as gender, age, class, and immigration. These locations did not determine experiences, but interacted to present barriers or opportunities as the women managed tensions arising from the embodied and discursive intrusions of illness and health care into the assumptive order of the home. The women's accounts permit us to glimpse the local manifestations of the social relations of health care, which articulate with gender, age, class, and immigration. When women are deemed in need of home care, services are purchased by the state from providers of personal care and homemaking, while residual needs are fulfilled on an unpaid basis by family members or the women themselves. Women who are not considered candidates for home care either rely on the assistance of family members or purchase cleaning and caregiving services with their own resources. Yet some women, despite their own health concerns, are economically dependent on spouses who require rest at the end of a day's labour, or must attend to the residual unmet needs of older, frailer others. In such instances, the women become not only their own caregivers, but homemakers and caregivers to others. Furthermore, it has been noted that access to the information needed to make decisions about personal care may be severely limited by language barriers and hierarchical relationships between immigrant women and health professionals (Anderson, 1998). Such relations exacerbate tensions within the home and result in differential access to health care.

### **Conclusions**

Although shorter hospital stays are intended to result in financial savings for governments and hospitals, this solution ignores persistent gender inequities in the distribution of domestic work. It evades the problem of providing care, homemaking assistance, and financial support to the family caregiver who is ill herself. It presumes that other family members will know how to "take over" for her, and will be

available and willing to do so (England, Keigher, Miller, & Linsk, 1994). But gender inequities perpetuated in home-care policies and practice are not the same for all women. Various social and material circumstances contoured the patterns of advantage and disadvantage experienced by the women who participated in this study.

There is a lack of cross-pollination between the social sciences literature on housework and the health sciences literature on women and cardiovascular disease. In the social sciences, there is an evolving understanding of how the politics of gender are enacted in the everyday work of homemaking. Doyal (1995), for example, casts this problem within the framework of the global politics of women's health. She argues that the health of all women is affected in various ways by the demands of home and family. Although North American women do not need to spend hours in a physically exhausting search for food, fuel, and clean water, their health is affected by the "double burden" of paid employment and homemaking. This burden results in drastic limitations on the amount of time available for rest, leisure, attention to personal health, and pursuit of information about healthful activities. Efforts to "shift" that burden by employing others inevitably rely on the exploited labour of other women, who are remunerated at minimal rates for their undervalued work.

Authors writing from a health sciences perspective seem less certain about the problems involved in housework: "Clearly, in this study women were engaged in fairly strenuous household duties (eg., bed making, laundry, and sweeping), within 4 weeks after experiencing an AMI. Whether this is beneficial or harmful has not been investigated" (Hamilton & Seidman, 1993, p. 313). Some do venture further into the discussion: "Although domestic functions are of high value to women in perception of self, they are poor choices of cardiovascular activity for women" (King & Jensen, 1994, p. 104). Successful engagement in homemaking tasks is very easily, but tautologically, construed as constitutive of gendered identity because these tasks are incorporated within an assumptive and persistent "natural" gender division of labour. Furthermore, the problem is often discursively elaborated in the health sciences literature as one of cardiovascular exertion. Within this idiom, the question becomes one of exercise, not equity, and the subtly inscribed dynamic is one of "choice." This is a seductive perspective, for it leads us away from the challenges associated with confronting the fundamental structures of social life. It obscures from our view how very few choices some women have and — more distressingly — how we may, with the best of intentions, participate in social relations or professional activities that further limit these choices or obscure the



scarcity of options. We are thus spared the difficulties of figuring out how we, as nurses, are to respond to the very real effects on health of the intersecting conditions associated with gender, class, race, ethnicity, age, and (dis)ability.

We can begin by considering homemaking as something more than simply an example of "gender role" performance or identity, although many aspects of the everyday construction of selfhood reverberate within these ideological codes. A home is a place where all the immediacies of material and social continuity intersect for all of its inhabitants. Our attention needs to be focused on these intersections and how they are experienced by particular women as they struggle with the conflicting demands of physical discomfort and infirmity, learning new personal-care regimens and coordinating contact with various facets of the health-care system. Our teaching interventions might then go beyond instructing women to "say no" to housework after surgery and become an attempt to learn the reasons why they actually may be compelled to resume this work. Discussion about cardiac risk modification might then expand into a dialogue about "the hazards of hearth and home" (Doyal, 1995, p. 27) which takes into consideration the possibility that the same home may be a very different place for its various occupants.

As Olga points out, men and women may have very different experiences of the purposes and responsibilities inherent in being "at home." Her observations make it clear that we nurses cannot assume that we necessarily share our patients' experiences of home. The home is a crucial location as it becomes more and more entangled within the institutional complex of health care, and it is a problematic location in that its metaphorical significance distracts us from the very real social and material conditions that intersect within it. It is vital that we increase the complexity of our theoretical approaches to the home as we enter this sphere in our research and practice endeavours.

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