

Offprint 4

On the wards

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Depending on ward size, there are usually three or four domestic assistants on each of the two day shifts and two on the evening shift, providing domestic cover from 7.30 a.m. until 8 p.m. Although the two-tier domestic grading of 'orderly' and 'domestic' is now obsolete, the domestic assistants continue to make distinctions between 'tops' and 'bottoms' work. Those who do 'tops' work clean the 'clean dirt' i.e. the top surfaces including the patients' lockers and ward sinks, and give out drinks to the patients. 'Bottoms' clean the 'dirty dirt', i.e. the 'bottom' surfaces, like floors and lavatories. In the past, 'bottoms' work was of slightly lower status and the pay a little less than that of the 'tops' or orderly. It was my impression that one or two of the older women who had been orderlies resented having to do bottoms work but younger women, although they used these terms, did not make associations of this kind. For example, one woman in her early twenties explained that she preferred 'bottoms' work because she found the patients less demanding than when doing 'tops'. Although the formal occupational structure has changed since the days of 'orderly' and 'domestic', informally the distinctions have become part of every-day usage, subtly resisting management attempts to introduce greater flexibility into work practices by making tasks interchangeable.

Because they work around patients cleaning lockers and beds, 'tops' tend to have more direct contact with patients than 'bottoms'. Domestic assistants are often asked to find things in the patient's locker, to pour drinks or help someone sit up. Although the latter is strictly a nursing duty, experienced domestics will sometimes lift a patient if a nurse is not readily available. 'Tops' begin the day by preparing the kitchen, the drinks trolley and the patients' dining room and then give out breakfasts and drinks under the direction of the nursing staff. After breakfast the empty trays are collected and stacked on the trolley which goes to the central kitchen. Teacups and beakers are collected, washed, and dried. Then a trolley is made up with cleaning materials which the 'tops' pushes around the ward damp-dusting the patients' lockers and beds, emptying and replacing the rubbish bags attached to each locker. Sinks, taps, surrounds, and mirrors are cleaned and paper towels and other disposables replaced. The patients' drinking water is changed and the ward made generally tidy. The ward kitchen floor is mopped clean twice a day, and there is washing-up to do (teacups and glasses), work surfaces and sinks to clean, and the fridge to be cleaned and occasionally defrosted. There is also the patients' day room to keep clean, ashtrays to empty, and plants to water.

'Bottoms' vacuum all ward areas, adjoining offices, corridors, and landings. Floors are sprayed with a liquid polish and buffed with an electric polisher (sometimes referred to as a 'bumper'). Ward floors are vacuumed, mopped, and polished and throughout the day spillages of blood and urine cleaned up. Lavatories, bathrooms, and sluice are cleaned thoroughly every day. Waste bins are emptied, disposable towels, soap, and toilet rolls replaced and walls and doors cleaned as

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necessary. The domestic on 'bottoms' work has literally to work around other people on the ward, carefully controlling the powerful polisher as she cleans under and around beds and chairs. Both 'tops' and 'bottoms' recognise that they do more than required in their job description, a fact which prompted a work-mate to remark that 'one day soon with privatisation patients will become things to dust around'. Underlying this point a routine health check had found that some domestic assistants who worked on wards where patients were receiving radiotherapy treatment registered radiation levels which, though safe, were nevertheless higher even than those of the nursing staff on the ward. Investigations revealed that these domestics had far more close contact with patients in the course of their work than their job actually required.

Domestics who work on the wards, whether as 'tops' or as 'bottoms', have contact with patients in the course of their daily round. By dealing with patients as 'ordinary people' and not just 'an illness', some of the domestics I talked to quite consciously saw themselves as providing something for patients which they felt the nurses, with their specialised interest, could not. One woman described how a male patient who was very ill with cancer of the pelvis had discussed his illness with her and shown her the open wound. One day she told him truthfully that he looked much better. She felt that this meant more to him than if she had been a doctor or a nurse – 'he really brightened up' – because they had established an ordinary, everyday friendship in which they could chat openly to each other.

[...]

Although, at the hospital where I worked, domestic assistants were not supposed to spend any time talking to patients, they nevertheless did so as they went about their work. On one ward my two work-mates kept the patients entertained with jokes and friendly jibes as they wiped the lockers and beds. As the following extract from my own notebook shows, domestics can care for patients by simply keeping a friendly eye on them:

We refer to one of the patients, the gentle, baby-pink old man who's always asleep, as 'Shirley's boyfriend'. 'He's lovely', she says and does his tea especially, keeping him awake while he drinks it, holding the beaker for him as if he were a child.

Older domestics who had worked at the hospital as orderlies or who had many years' experience of ward life were quite confident in their dealings both with patients and nurses: (domestic to elderly man) 'I'll come and smack your bottom if you don't eat that food!'; (domestic quietly to staff nurse with a nudge) 'Quick, move that [used] syringe [left lying about], the nursing officer's coming'. These commonplace exchanges help to create a friendly atmosphere on the ward, a degree of comradeship between domestic and nurse, and, particularly on the male wards, engender the kind of 'leg pulling' that I have often seen take place between male and female work-mates. In addition, the domestic assistant is able to extend the control she exercises over her work environment by encompassing within it 'patient care'. Thus, she is able to exert some control over the patients themselves by involving them in a social way in her work tasks. Only occasionally did I see a domestic assistant becoming short-tempered with the patients, but this does not mean to say that underlying tensions did not exist. For example, some domestics said that they much preferred working on male wards because female patients were less good humoured – a view I have also

heard female nurses express. On one occasion, a black domestic drew my attention to the way white patients left blood-stained pyjamas around for her to pick up, commenting that it was these 'little things' that built up over the years and caused trouble between black and white. Another time, when I was working alone, a white male patient in a side ward asked me if my 'ethnic friends were sitting in the kitchen'. The negative attitudes that some patients brought into the hospital thus influenced the way they treated the domestic staff, making the relationship a two-way one.

[...]

Longer-serving domestic assistants had begun their working lives at the hospital when the domestic or orderly was an integral part of the ward hierarchy, answerable directly to sister and above her to matron. Among other things, changes in work organisation and nursing structure have gradually undermined the domestics' formal role in patient care. But even younger women new to the job and those who have worked at the hospital for only a few years seem also to feel the ambivalence of their situation. Despite the ever tighter restrictions of their job description, and the increasingly sharp demarcation between specialised nursing and domestic tasks, they find themselves becoming involved in their ward ... Some of the domestic assistants I talked to were motivated ... to move into auxiliary work:

I'd like to be an auxiliary, since I've worked here and had my own ward because of watching them. And also [to work-mate] don't you get an awful lot of patients asking you to help them and you're not supposed to? It's not your job and you feel embarrassed.

Having made the step they find the job more satisfying:

Auxiliary: I love this job!

Self: What do you like about it?

Auxiliary: You've got contact with people and it's nice to feel that you're doing something really useful. I know how Gladys [domestic assistant] feels now mopping that floor and someone walks on it. The domestics say it's a step up being an auxiliary but I don't feel that. Responsibility I've got mate! If they need a bedpan I've got to make sure they're sitting on it properly!

[...]

Almost unconsciously the domestic assistants responded to the hospital environment by developing a knowledge of illness and also a personal strategy for dealing with the more distressing aspects of the work. Over time, domestic assistants become sensitised to the presence of death. This heightened sensitivity becomes part of the store of knowledge which the domestic unconsciously acquires with experience. One domestic in her late twenties told me that the third floor of the hospital, where the cancer wards are situated, was always colder than elsewhere, death making it so. Although I was working with her, it did not feel any colder to me – maybe because I had not worked there long enough to become sensitised to the cold. For instance, one work-mate explained that she had trained with an older woman, who had worked at the hospital for years, who asked her one night if she could smell something 'sweet and rotten' and she could not. Then the older woman said 'I can smell death. Someone on this ward is going to die soon', and a few minutes later someone on their ward did die. Some weeks later the

younger woman was walking along a corridor when she suddenly became aware of something which smelled 'sweet and rotten'. This time she knew what it was – 'As she turned the corner the porters were bringing the box along [with the dead body in it]'. Encounters with dying patients can also leave lasting impressions on the domestic. As one woman explained:

One evening a male patient caught my arm as I was clearing his locker and said 'I'm thirsty, can I have a drink?' I said 'No, it says not above the bed' [i.e. Nil by Mouth]. He looked at me and said 'Does it matter!' So I went to find and ask a nurse. An hour later that man died. I will never forget it. He held my arm and I can feel it now, and the look on his face because you can see it, see death. You look into the face of death and you can see it. In the eyes – it's though they're not human, not here any more, but very, very distant.

[...]

No proper recognition is given to the fact that domestics, like nurses, may be affected by the conditions under which they work. Nurses at this hospital told me that they were encouraged to cry as a necessary safety-valve for their feelings. Yet domestics have to shut themselves up in the lavatory, ward kitchen or, like one woman, the kitchen store cupboard to have a 'good cry'. Unlike many nurses, once a domestic assistant is allocated to a specific ward, she tends to stay on it for a long time, decades in some cases. In this way the domestic becomes a familiar anchor point for patients in a constantly changing sea of nursing and medical staff. In interviews about their early training midwives and nurses have commented that sister would virtually ignore a first year student nurse – the 'lowest form of life on the ward' – yet she would chat to, and even confide in, an established domestic who had learned from experience 'how sister likes things done'. Even today familiarity with ward routines and sister's likes and dislikes puts the domestic at an advantage over other nursing and medical staff who are new to the ward. In addition, the domestic gets to know the nurses and is able informally to establish a way of working with them.

[...]

Domestic staff also get to know the patients' visitors. Working evenings with one of the older domestics, I observed that one group of visitors waited anxiously for her to come round with the tea so that they could find out how their relative had been that day. The significance of the domestics' unofficial role in relation to patients' relatives was vividly highlighted by a recent legal case, which the Ealing Health Authority lost, which was reported in the *Guardian* (7 January 1986). A man whose mother was in hospital being treated for cancer learned from a domestic while he was in the hospital canteen that she was in fact dying. The domestic told him that an emergency had happened and he returned to the ward to find his mother dead. Medical staff had not told him of the actual serious state of his mother's illness, so that he was quite unprepared for her death.

[...]

Note

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