NOTE TO USERS

Page(s) missing in number only; text follows. Page(s) were microfilmed as received.

239-242

This reproduction is the best copy available.

UMI
HOME IS WHERE THE HEART IS:
WOMEN'S EXPERIENCES OF HOMEMAKING AND SELF CARE
AFTER AORTOCORONARY BYPASS SURGERY

By

Janet Elizabeth Angus

A thesis submitted in conformity with the requirements
for the Degree of Doctor of Philosophy
Graduate Department of Community Health
University of Toronto

© Copyright by Jan Angus 2001
The author has granted a non-exclusive licence allowing the
National Library of Canada to reproduce, loan, distribute or sell
copies of this thesis in microform, paper or electronic formats.

The author retains ownership of the
copyright in this thesis. Neither the
thesis nor substantial extracts from it
may be printed or otherwise
reproduced without the author’s
permission.
ABSTRACT

Home Is Where the Heart Is: Women’s Experiences of Homemaking and Self Care After Aortocoronary Bypass Surgery
Doctor of Philosophy, 2001
Jan Angus
Graduate Department of Community Health
University of Toronto

Several authors argue that women’s everyday lives are structured in ways that limit their access to the resources which create and sustain health (see for example, Annandale & Hunt, 2000; Clarke & Olesen, 1999). How do these features of women’s lives interact with the relations of health care in the diagnosis and ongoing management of particular health problems such as heart disease? The purpose of this institutional ethnography (Smith, 1987, 1999) was to examine the social relations reflected in women’s experiences after aortocoronary bypass surgery (ACBS). Eighteen women were interviewed twice after ACBS: once after they had been home from hospital for four weeks, and once after four months. Eleven health professionals participated in the study as informants.

Four distinct periods in the women’s encounters with heart disease and treatment were prominent in their narratives: diagnosis, hospitalization for surgery, the first month after surgery and four 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’ and assumption of moral responsibility for self care. Hospitalization removed the women from familiar social contexts and embedded them within social relations which 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 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.

I conclude that a new approach to cardiovascular health education is required. This approach would of necessity place the learner in the position of expert participant and informant (Anderson, 1998; Tang & Anderson, 1999). I further argue that the contractionist discursive foundations of home care policy evade the problem of finding care, homemaking assistance and financial support for the family caregiver when she is ill herself (McKeever, 1996).
ACKNOWLEDGMENTS

"The heart has its reasons that reason knows not of..."
– Blaise Pascal, *Pensées*

"probably all the passions of the soul are associated with the body – anger, gentleness, fear, pity, courage and joy, as well as loving and hating; for when they appear, the body is also affected."
– Aristotle, *De Anima*

My years as a doctoral student brought many extraordinary people into my life and I consider myself truly fortunate. With all of these wonderful associates, I have learned the great pleasure of exploring the social world. Predictably, language fails me at this moment, yet I must attempt first to express my deep appreciation to the women who participated in this inquiry, because they opened their hearts to me and generously shared the complexities of their everyday lives. I hope that in writing this thesis I have extended our discussions in a manner that remains faithful to the worlds they graciously permitted me to enter. Several health professionals also shared their experiences and insights, and these helpful contributions expanded my understanding and contributed to my analysis. I am most grateful for their input.

It has been a great privilege to work with each member of my doctoral committee. Dr. David Coburn, my doctoral supervisor, profoundly influenced my unfolding career as a student with his integrity as a scholar. He unfailingly encouraged me to read widely, question critically and engage in debate about new analytic perspectives. Dr. Patricia McKeever - a dear colleague, mentor, and friend - provided constant encouragement, a steady flow of articles, opportunities to engage in qualitative research and animated
consultation over bowls of soup. Dr. Dorothy Smith offered this novice institutional ethnographer the considerable benefit of her experience, carefully considered critique and an analytic framework which, while often challenging, spoke eloquently to me of the circumstances of my life as a nurse, a scholar, and a mother. I am indeed grateful for her participation in this work.

To the members of my examining committee I extend warm thanks for their insightful and constructive reviews of my work. It was a great honor to be examined by Dr. Joan Anderson of the University of British Columbia, Dr. Linda Muzzin of OISE/UT, and Dr. Joan Eakin of Public Health Science, UofT. Their exciting ideas will inspire much thought in future endeavours!

I owe a special debt of gratitude to Dr. May Yoshida, who introduced me to the issues encountered by women with heart disease and who generously offered her time and suggestions in the early stages of my research. Through her, I began to grasp the actualities of life with heart disease, and it is a source of pleasure and comfort to realize that her voice still speaks within the fabric of this document.

Many colleagues and friends contributed their support and suggestions along the way - and their interest sustained me at all stages. I have received strong and continuous support from Dr. Dorothy Pringle, former Dean of the Faculty of Nursing. I am indebted to Dr. Gail Donner, current Dean of the Faculty of Nursing, for her steadfast encouragement and enthusiasm. My friends and colleagues Francine Wynn, Kate Hardie, Denise Gastaldo, and Ivy Bourgeault have all shared readings and dialogue.

I gratefully acknowledge partial funding by the Heart and Stroke Foundation of
Canada, in the form of a Nursing Fellowship. This generous assistance enabled me to complete the early phases of my inquiry.

Finally, my beloved children, Stephanie and Michael, have graciously endured much throughout my years as a student and have provided countless moments of enjoyable diversion and involvement in their projects and progress. They are closest to my heart and the source of boundless pride. What joy to at long last share completion of my doctoral studies with them!
# TABLE OF CONTENTS

Chapter 1: Introduction

- The Problem: Health And The Everyday Lives of Canadian Women ........................................ 1
- Women and Homemaking ............................................................................................................. 3
- Women’s Experiences With Homemaking And Self Care After ACBS:
  - An Institutional Ethnography ................................................................................................. 7
  - Summary of Major Results and Conclusions ........................................................................... 9
- Overview of Thesis ....................................................................................................................... 11

Chapter 2: Locating Women in the Literature on Heart Disease

- Women in the Literature on Recovery from Cardiovascular Events ........................................ 15
  - Physiological Differences Between Men and Women with CAD ........................................... 17
  - Return to Paid Employment and Activity Following ACBS ..................................................... 18
  - Women Helping Men Recover From MI or ACB ..................................................................... 21
  - Women's Recovery from MI and ACB .................................................................................... 25
- Issues in the Health Sciences Literature on Women and Heart Disease ................................... 28
- Discussion ..................................................................................................................................... 36

Chapter 3: Analytic Framework

- Critique of Traditional Health Sciences and Sociology .............................................................. 47
- Cartesian Science and the Embodied Subject .............................................................................. 50
- Sex, Sex Roles and Gender in Research ....................................................................................... 55
- Women’s Work, Men’s Analytic Models ...................................................................................... 60
- Institutional Ethnography ............................................................................................................ 69
- Critique and Discussion of Dorothy Smith’s Analysis ................................................................. 80

Chapter 4: Research Methods and Procedures

- The Study Purpose and Research Questions ............................................................................... 87
- The Study Questions ..................................................................................................................... 87
- Institutional Ethnography ............................................................................................................ 88
  - The Social Relations of Ethnography ....................................................................................... 91
- Validity of the Research .............................................................................................................. 98
- Research Design .......................................................................................................................... 101
- Sampling Methods ..................................................................................................................... 102
- Data Collection ............................................................................................................................ 104
  - Interviews with women after ACBS ....................................................................................... 104
  - Key informant interviews with health professionals ............................................................... 107
  - Analysis of Data ....................................................................................................................... 107
- The Study Participants ............................................................................................................... 103
- The Institutional Setting .............................................................................................................. 118
- Summary ..................................................................................................................................... 122
Chapter 8: Situating Women With Heart Disease: Between the Home and the Endangered Heart

Case Studies: ................................................................. 310
  Olivia............................................................................. 312
  Cookie........................................................................... 315
Situating the Self............................................................... 321
  Situating Hearts Within Women’s Active Bodies............. 321
  Situating Self................................................................. 331
Learning The Situation: Consulting With Health Professionals.. 339
Situating Self Care Within Homemaking................................. 345
  Self Protection............................................................... 345
  Self Care......................................................................... 345
    Learning....................................................................... 351
      a) Doing Diet............................................................ 354
      b) Exercise............................................................... 359
    Resuming Paid Employment....................................... 365
    Homemaking.................................................................. 368
Situating Self With Others.................................................. 376
Discussion....................................................................... 387

Chapter 9: Conclusions.......................................................... 394
Discussion of Major Findings.............................................. 395
  How Women Described Their Experiences....................... 395
  The Discourse of Homemaking....................................... 402
  The Discourse of Self Care........................................... 410
  The Social Relations of Displacement.............................. 421
Limitations of the Study.................................................... 429
Implications of the Findings................................................ 431
  Implications for Health Care Practice.............................. 432
  Implications for Health Policy....................................... 438
  Implications for Theory and Research............................ 440
Conclusion....................................................................... 445
Tables
1: Demographic Summary for Participants in Study ........................................ 115
2: Participants in Study Arranged in Ascending Order of Income .................. 117

References ........................................................................................................... 450

Appendices
A: Information Sheet for Clinic Representative .................................................. 472
B: Information Sheet for Participants ................................................................. 473
C: Consent Form for Participants ...................................................................... 475
D: Schedule of Questions and Prompts for First Interview .............................. 476
E: Schedule of Questions and Prompts for Second Interview ......................... 478
F: Information Sheet for Key Informants ........................................................... 480
G: Consent Form for Key Informants ................................................................. 481
H: Schedule of Questions and Prompts for Key Informants .............................. 482
I: Questionnaire for First Interview ................................................................. 484
J: Questionnaire for Second Interview .............................................................. 497
CHAPTER ONE

INTRODUCTION

Maxwell (1994) wrote that "nurses can advance the cardiovascular care of women by critiquing cardiovascular science from a feminist perspective" (1994, p. 26), arguing that there was more at stake than simply comparing men’s and women’s patterns of etiology, manifestation and response to various treatments. Cardiovascular disease is the leading cause of death in Canada; heart disease and stroke, the two major categories of heart disease, rank as the first and second as diseases causing mortality in Canadian women (Heart & Stroke Foundation, 1997). However, women's experiences with cardiovascular disease were, until recently, neglected in the research and texts which guide health care practice. This presented a considerable challenge to practitioners in all health disciplines who struggled to diagnose and treat heart disease in female clients (see for example, Hawthorne, 1994; Legato & Coleman, 1991; MacKenzie, 1993; Maxwell, 1994). Awareness of this problem is reflected in an expanding literature on women's experiences of such events as myocardial infarction (MI) or aortocoronary bypass surgery (ACBS). However, much of this literature does not expand the scope of inquiry to consider how the social relations of health care and women’s everyday lives interact to limit the extent to which women can pursue activities which are thought to improve cardiovascular health.

The Problem: Health And The Everyday Lives of Canadian Women

Health is embedded in the activities of social life. It is “created and lived by people in the settings of their everyday life, where they learn, work, play, and love” (Ottawa
Charter for Health Promotion, 1986, p. 427). For women, the activities wherein health is created are conditioned by social inequality. Women with heart disease are typically older than their male counterparts, and are more likely to live alone with fewer caregiving resources (Hawthorne, 1994; Heart & Stroke Foundation, 1997; Rankin, 1989). Most importantly, it is widely acknowledged that the home is a work setting for most women, as opposed to a recuperative setting for men. Women are responsible for the majority of household chores, health oriented activities, and emotional support of family members (Armstrong & Armstrong, 1994; Bowlby, Gregory & McKie, 1997; Conway, 1990; Delphy & Leonard, 1992; Duncombe & Marsden, 1995, 1998; Hochschild & Machung, 1989; Kahn, 1991; Luxton, 1997; Wilson, 1991). This structure of household obligation is constitutive of the material context of women's social lives, and while it may be enacted in countless idiosyncratic patterns, the idiom of homemaking remains constant.

Furthermore, in seeking treatment for symptoms related to CAD, women enter the intersection between their own embodied, local knowledge and the abstract, objectifying knowledge and practices of health professionals. Health professionals work with diagnostic and treatment schema that have accepted the male experience with CAD as the standard. Only recently have they begun to study and incorporate the patterns exhibited by women (Legato & Coleman, 1991; MacKenzie, 1993; Maxwell, 1994). It has been noted that communications between health professionals and clients are conditioned by social relations that are configured by the gender, ethnicity, socioeconomic status, and education of the participants (Roter, Hall, & Katz, 1988; Street, 1991; Waitzkin, 1989; Webber, 1990); these features pervade all aspects of professional knowledge and
discourse (Smith, 1990a, 1990b). However, professionals' (mis)interpretations of the structure and particularities of women's everyday lives may further obscure and sustain barriers to health (Gerbert, Johnston, Caspers, Bleecker, Woods & Rosenbaum, 1996; Safran, Rogers & Tarlov, 1997; Thorne, McCormick & Carty, 1997). Textual records of research and theoretical developments in specific fields of practice are imbued with a systematic bias that is informed by ideological understandings of women's lives (Smith, 1990a, 1990b, 1998; Thorne, 1990; Thorne, McCormick & Carty, 1997). Yet women occupy social positions in relation to others which are intensely problematic in terms of the opportunities they find to pursue activities designed to better their own health (Angus, 1994, 1996a).

Women and Homemaking

Women's participation in paid labour has increased markedly in recent decades. According to the results of the 1992 General Social Survey (GSS) of Canadian families, in 1990, 71% of all couples with children under age 19 in the household were dual earners. Only 30% of similar couples were dual earners just over 20 years ago (Marshall, 1993). Although some women have become successful in nontraditional occupations, Jennings (1992) argues that the bulk of women's paid activities are similar in character to their supportive work in the home. At present, approximately 80% of Canadian women in the labour force still act as "social homemakers" (Jennings, 1992, p.132) in their gender-segregated roles as health care workers, teachers, service workers, and clerical workers (Armstrong & Armstrong, 1994; Duncombe & Marsden, 1998; Phillips & Phillips, 1993).
Despite the trend towards dual income families, homemaking is still largely the responsibility of women. While there is evidence that women are doing less housework than in previous decades, an imbalance persists (Bernier, Laflamme & Zhou, 1996; Fox, 1993). The 1991 GSS reported that Canadian women spent an average of 4.5 hours per day doing unpaid work in the home, in contrast to the 2.6 hours spent by men (Devereaux, 1993). This discrepancy of approximately two hours a day means that over the course of a year, women do the equivalent of one full month more work in the home than men. This inequity is not reflective of the fact that many women restrict their employment patterns to part time jobs so they can devote more time to their family responsibilities. In the dual income families where both spouses were employed full time, the women were solely responsible for housework in 52% of the families, the women were mostly responsible for housework in 28%, responsibility was equally shared in 10%, and the men were solely or mostly responsible in 10% (Marshall, 1993). Furthermore, older women (those who are at higher risk for heart disease) appear to bear disproportionate responsibility for household work, attesting to generational variations. Again in dual income families, the percentage of women who were solely responsible for housework was 47% in the under 35 age group, increasing to 53% between ages 35-44 and 69% between ages 45-64 (Marshall, 1993).

The division of household tasks was also linked to income: sole responsibility for housework was held by 67% of women whose incomes were under $20,000 in contrast to 53% of those with incomes over $40,000. In couples where men earned less than $20,000, 39% of the women took full responsibility for housework, while 45% took full
responsibility when husbands earned over $40,000 (Devereaux, 1993). Similar patterns have been observed in the United States, where there is a negative relationship between a woman's wages and time devoted to household chores (Hersch & Stratton, 1997).

However, this relationship is mediated by other considerations. Brayfield (1992) found that unemployed Canadian men did no more than 40% of the housework regardless of their spouses' employment status. This observation is paralleled in the United States where economic dependency on their wives and participation in housework are negatively related in unemployed husbands (Brines, 1994).

Women are also usually responsible for the care of sick or aging family members. Neysmith (1991) observes that the notion of community based care, which has become a prevalent feature of health policy in recent years, merely transfers economic responsibility for care to the family. Yet normative gender expectations place familial responsibilities squarely on the shoulders of women (Anderson & Elfert, 1989; Neysmith, 1991; Ursel, 1993). Gallop, McKeever, Mohide, and Wells (1990) reviewed the research on family caregiving and found that in most studies, "70 per cent or more of the caregivers are women" (p.9). Anderson & Elfert (1989) found in a qualitative study that responsibility for managing the care of chronically ill children rested primarily with mothers. McKeever (1994) found that among a sample of biological and foster mothers of children with disabilities, 30% of the married mothers reported that their spouses gave no assistance with the child's care, while another 25% had assistance from their spouses for less than one hour daily. The majority of the women were also solely responsible for household chores. In both studies, the women were deeply involved in interactions with health
professionals to exchange important information about the children's care.

Thus there is little doubt in the minds of several authors that women's everyday lives are fundamentally different from men's and that they are structured in ways that limit their access to the resources that create and sustain health (see for example, Armstrong & Armstrong, 1994; Doyal, 1995; Roberts, 1990, 1992; Ursel, 1993). Of interest is how these features of women's lives interact with the relations of health care in the diagnosis and ongoing management of particular health problems such as heart disease. In recent years, two related developments in health care have brought this issue into sharp relief. Hospital admissions for elective surgeries have been reduced in response to fiscal concerns. To meet the need for the follow up health services thus generated, publicly funded home care programmes have expanded markedly in the past decade.

Home care programmes rely largely on what is euphemistically called "family caregiving" work. Contractionist health policies have resulted in the transfer of formerly hospital-based, paid activities to the home where unpaid, predominantly female, family members provide most care and household assistance (England, Keigher, Miller & Linsk, 1994; McKeever, 1996; Neysmith, 1991). These policies obscure gender inequities, for they are based on the premise that both genders will be equally able and willing to provide care for family members. They are based on the assumption that home is the same place and holds the same meanings for both genders. The present study was intended to address this problem, with attention to the needs of women who undergo ACBS.
Women’s Experiences With Homemaking And Self Care After ACBS: An Institutional Ethnography

To respond to Maxwell’s (1994) call, a theoretical approach was required which would remain as attentive to the extralocal influences on everyday social life as it was to the material predicaments of individual embodiment and activity. Dorothy Smith’s (1987, 1999) Institutional Ethnography formed the analytic and methodological foundation of this work. Smith argues that discourse organizes and is organized by social processes. She calls attention to the ways that people are discursively active. However, Smith also reminds us that people are discursively active from different locations and in different ways. They remain embodied participants in discursively organized social relations within these various social positions. There are, therefore, “differences in the possibility of knowing that relate to the knower’s location and everyday/everynight work” (Campbell, 1998, p. 59). Hence, it is important to begin inquiry from the everyday, embodied position of those who are active at various phases of discursively coordinated activity.

This point of entry is particularly appropriate for study of women’s experiences of homemaking and self care after ACBS, because it is derived from the understanding that “activity or practices are ‘sensuous’, done with or in the body” (Smith, 1987, p. 144).

The study was designed to focus on one overarching question:

What social relations are reflected in women’s accounts of their experiences with heart disease and aortocoronary artery bypass surgery (ACBS)?

Four subquestions were derived from this major focus:

1. What are the daily activities of women as they recover from ACBS?
2. What kinds and sources of knowledge do women require in this process?
3. What are the material and social conditions under which experiences with heart disease and ACBS occur?
4. What activities do health professionals pursue in facilitating recovery for women at various stages of their encounters with the health care system?

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, eighteen women who were recovering from ACBS were purposively selected from the client group of the department of cardiovascular surgery at a teaching hospital in Metropolitan Toronto. These women were interviewed twice: once after they had been home from hospital for four weeks, and once after four months. The interviews adopted an unstructured narrative format and were audiotaped and transcribed. In addition, eleven health professionals were invited to participate in the study. These informants were all involved in the care of women who undergo ACBS. These interviews were also audiotaped.

For the purposes of analysis, the participants' words were not "cleaned up" or paraphrased during transcription, although less relevant passages were summarized for later reference to the audiotape if necessary. Transcriptions were entered into NUD*IST for coding. Analysis closely followed the three stage process developed by Kasper (1994), which was developed with reference to the tenets of institutional ethnography. In the present study, as in Kasper's (1994) work, the first part of the analysis was, in effect, accomplished by the respondents as they selected and interpreted anecdotes or examples.
from among a large background repertoire of experience. The second stage of the analysis progressed from detailed examination of each participant’s narrative to comparison of the accounts provided by all respondents. The final step in the analytic process involved a search across interviews for organizing relationships, contradictions, and similarities (Hammersley & Atkinson, 1983; Kasper, 1994).

The results of analysis are presented within four chapters that correspond to temporal points which featured prominently in the respondents’ narratives. These temporal points were: the events leading up to diagnosis of heart disease, hospitalization for ACBS procedures, the first weeks at home after surgery, and the fourth month at home after surgery. There were many differences noted in the women’s stories, depending on biographical background, age, class, education and ethnicity. These differences are highlighted by comparing selected case studies at the beginning of each chapter. Results are also discussed in sections which correspond to the four research subquestions.

Summary of Major Results and Conclusions

Four distinct periods in the women’s encounters with heart disease and treatment were prominent in their narratives: diagnosis, hospitalization for surgery, the first month after surgery and four 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’ and assumption of moral responsibility for self care. Hospitalization removed the women from familiar social context and embedded them within social relations which 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 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.

The discourse of homemaking provided a framework from which participants could interpret their own activities and comportment, and those of others. Activities pursued within this framework comprised part of what Smith refers to as “a complex of social relations specifically defining femininity and organizing, in and across actual local sites of people’s lives, the homogeny of gender difference” (1990b, p.160). Gender and heterosexuality were created and maintained in the activities of homemaking. On the other hand, the discourse of self care is imbued with the assumption that people have considerable influence over their own health and are capable of changing activities which contribute to ill health. The women’s narratives revealed their understanding of a moral subtext to this discourse; no rational person would choose to damage their own health or risk death (Kaufert, 1996; Lupton, 1993; Morgan, 1998). This framework individualized responsibility for health, but it was incompatible with the discursive underpinnings of homemaking, which emphasises women’s active involvement in providing conditions which facilitate health in others.

I conclude that, because the tenets of institutional ethnography (Smith, 1987, 1990a, 1990b, 1997, 1999) demand the inclusion of sensuous, active embodiment, the materiality of health and illness can be understood from a position that is often obscured
in the health and social sciences. This emphasis on the materiality of the body permits elaboration of sensations, emotions and personal practices associated with illness, the home and social life. It is through this description that disjunctures indeed become revealed; in this study, bifurcations were noted between professional and lay versions of such issues as homemaking, diet and health education. These bifurcations revealed areas where the underpinnings of home care policy, health education theory and interventions, and research ought to be more closely examined. For example, I argue with Anderson (1998) and others that a new approach to cardiovascular health education is required. This approach would regard the learner as an expert contributor to the process by negotiating objectives and providing information about her bodily experiences and everyday practices (Anderson, 1998; Lather, 1991; Tang & Anderson, 1999).

This study shows how actual women encounter material conditions influenced by the discursive foundations of home care policy problem. It illustrates the problems of finding care, homemaking assistance and financial support for the family caregiver when she is ill herself (McKeever, 1996). Although shorter hospital admissions are intended to result in fiscal savings for governments and hospitals, there are personal health costs for individual women. Hospital cardiovascular programmes could articulate with home care services to develop educational and supportive follow up to patients after discharge with particular sensitivity to the needs of women regardless of their living arrangements.

Overview of Thesis

In this introductory chapter, I contextualize the research problem by examining issues in women's unpaid labour in the home and changes in the social context which
contribute to inequities in home health care for women. I discuss the framework and design of this institutional ethnography and outline the major findings and conclusions.

In Chapter Two, I review selected literature which deals with cardiovascular disease and its treatment in women. In this review, I analyze several apparent perspectives on women and cardiovascular health. I explore the two-sidedness of the heart as it appears in professional and lay usage.

In Chapter Three, I examine critically some of the theoretical frameworks offered by the health sciences and sociology. I review and discuss theoretical positions on Cartesian science and the embodied subject; sex categories, sex roles and gender in research; and women's paid and unpaid work. I then discuss the work of feminist sociologist Dorothy Smith (1987; 1990a; 1990b; 1997; 1999), which forms the basis of this thesis.

In Chapter Four, I elaborate on the design of this institutional ethnography. I discuss the implications of Smith's work for the conduct of this inquiry and describe the ensuing techniques of data collection and analysis. I also elaborate on matters related to the validity of the study, as well as ethical conduct of study procedures. I present demographic descriptions of the study participants.

In Chapters Five, Six, Seven and Eight, I describe the four temporal points in the women's narratives about their experiences: diagnosis, hospitalization for surgery, the first four weeks after return home, and four months after surgery. At each point, I examine the issues of embodied selfhood, activity and social relationships that arise at each point. In Chapter Five, I describe how the women engaged with health
professionals to identify or name a problem which began and persisted in the concrete, sensuous world of their active female bodies. This process of diagnosis was a search for a world in common, mediated by a unique lexicon (Smith, 1999). Diagnosis displaced or socially repositioned the women as ‘women with heart disease’.

In Chapter Six, I discuss the women’s experiences in the hospital as they underwent ACBS, a response to the problem of heart disease. I draw attention to the ways in which the women were profoundly displaced in a location coordinated by technomedical discourse. They were no longer in full possession of their own bodies, which were anaesthetized, sedated, invaded by tubes and marked by incisions. These dispossessed bodies were the problematic sites of repair and reconstruction, but ceased to be the familiar locus of feminine comportment. Within this context, the women were further indoctrinated into a medicalized discourse of self care which promoted adherence to specific practices associated with diet, exercise, activity resumption and stress management.

In Chapter Seven, I explain how the women’s homes presented extraordinary challenges as sites of their own health care. When they were relocated to their homes after hospitalization, many women encountered a prominent vacancy: there was an absence of someone able and willing to coordinate and execute the activities of homemaking. Less available was the caregiving support of others who could interpret for the women and assist them to implement the fundamental activities of self care. Simultaneously the women were responsible to learn and operationalize the principles of self care. Policies and procedures governing home care services organized assistance in a
fragmented manner which penalized women who ostensibly had family "help" and obliged the few women who did receive services to coordinate or complete the work themselves.

In Chapter Eight, I examine the issues identified by the women four months after surgery as they relocated themselves at the intersection of the discourses of homemaking and self care. It was important to health professionals and close others that they visibly demonstrate accountability for self care, yet care of others and coordination of the home were concurrent requirements. I uncover the actual practices associated with learning therapeutic regimens. Activating the texts which deal with self care was contingent upon considerable translation into sensuous, embodied terms.

Chapter Nine concludes this dissertation with a discussion and synthesis of the major findings. I identify implications for health care practice, theory, future research and health policy.
CHAPTER TWO

LOCATING WOMEN IN THE LITERATURE ON HEART DISEASE

For decades, women's experiences with cardiovascular disease were neglected in health care research and practice. In the late 1980's and early 1990's this omission was represented in the techno-medical literature as a considerable challenge to practitioners in all health disciplines who applied existing knowledge to the ongoing care and treatment of female clients (see for example, Hawthorne, 1994; Legato & Coleman, 1991; MacKenzie, 1993; Maxwell, 1994). Information gradually became available about women and coronary artery disease (CAD) (Eaker, Chesebro, & Sacks, 1993; Glazer & Hurst, 1987; Jadin & Margolis, 1998; Tomas & Braus, 1998; Wenger, 1998), women and cardiovascular risk factors (Bass, Newschaffer, & Klag, et al, 1993; Blair, Kohl & Barlow, 1993; Daly, Vessey & Hawkins, 1996; Kannel & Wilson, 1995; Kawachi, Colditz & Stampfer, 1993) and women and diagnostic or treatment modalities (Eaker, Packard, Wenger, Clarkson, & Tyroler, 1987; Khan, Nessim, Gray, et al, 1990; Maynard, Litwin, Martin, et al, 1992; Wenger, 1990). Yet as attention turned to the project of developing an understanding of cardiovascular health in women, it was noted that particular approaches to the researching the problem were likely to solve some problems, yet obscure or produce others.

Maxwell (1994) suggested that "nurses can advance the cardiovascular care of women by critiquing cardiovascular science from a feminist perspective" (1994, p. 26). She was one of several feminist practitioners concerned about the predominant approach to resolving deficiencies in the knowledge base on women's cardiovascular health. This
approach consisted of replicating with female samples studies which had previously been conducted using all-male samples. It was a strategy that, although likely to yield useful information, implicitly held men's physiological experiences with cardiovascular disease as the gold standard to which women's experiences were compared. It failed to consider or seek out ways that women's lives are conditioned by social and material conditions that differ from men's. Finally, the intense focus on pathophysiology, diagnosis and treatment can, ironically, erase the particularities of the sensuous, embodied, social facets of illness (Griffin, 1999).

These problems are evident in the research literature on women's recovery and lifestyle adjustments following such events as myocardial infarction (MI) or aortocoronary bypass surgery (ACBS). Events such as these form epiphanies in the lives of women where the actualities of their everyday lives and activities intersect with their altered health requirements. "Home" for many women is not a place of leisure, but a site of activities and obligations which are not evident in the techno-medical literature (Angus, 1994, 1996a, 1996b). Yet it is at home where most women may expect to recover and learn new health behaviours.

Smith (1987, 1990a, 1990b) argues that there is a disjuncture at the intersection of the public world of socially constructed knowledge and the private world of everyday life. The existence of a knowledge base in a given area of study exerts premature closure on the search for alternative perspectives, ensuring that "the determinations of our everyday experienced world remain mysterious by preventing us from making them problems for inquiry" (1990, p. 41). The standpoint of women's experience has thus been obscured in
many areas of health and health care, but attention has recently turned to this issue and the challenges it presents for research.

In this chapter, I review the substantive health sciences literature that deals with cardiovascular health and women's paid and unpaid work to examine current ideas about the experiences of women who are recovering at home following heart surgery. The issues and problems encountered by women during recovery from MI or ACBS have not been fully explored in the cardiovascular literature, and there is growing recognition of this deficiency. Many studies compare the physiological trajectories of recovery for men and women, while others examine the social issues of recovery such as support, caregiving, and resumption of daily routines and activities. In past years, heart disease was constructed as a man's disease, and until recently the bulk of the available literature has focussed on recovery from an androcentric perspective. In this chapter, I will present the literature on recovery from MI and ACBS.

**Women in the Literature on Recovery from Cardiovascular Events**

CAD is a leading cause of morbidity and mortality for both men and women in Canada (Statistics Canada, 1995). Acknowledgement of gaps in knowledge about the trajectory and treatment of the disease in women has been slow, but considerable attention has recently turned to the study of women's cardiovascular health. Previous studies were designed with all male samples, or when female subjects were included, data were grouped and comparisons were not made (Jadin & Margolis, 1998; Tomas & Braus, 1998). The health sciences literature contains increasing references to women's unique physiological responses to CAD and treatment, psychosocial markers of recovery such as return to
working following MI or ACBS, women's responsibilities as caregivers for men with CAD, and women's social experiences during recovery from MI and ACB.

**Physiological Differences Between Men and Women with CAD**

Some authors have studied physiological differences in recovery trajectories for men and women. This literature is useful in planning some aspects of treatment and establishing prognoses, but it reveals little about the actual experiences of women who have suffered an MI or have undergone ACBS. Heart disease was the leading cause of death for women in 1992 and its incidence increases sharply with age (Statistics Canada, 1995). For some time, it was thought that heart disease took a more benign course in women than in men. However, recent analyses of epidemiologic data revealed that mortality rates are similar between age matched men and women after onset of anginal chest pain (Jadin & Margolis, 1998). Women have a poorer chance of surviving MI than men, and uncomplicated recovery occurs less often in women (Jadin & Margolis, 1998; Johansson, 1989; Young & Kahana, 1993). Differences in early mortality following ACB varies from almost twice as high in women as in men (Hammar, Sandberg, Larsen, & Ivert 1997; Kindwall, 1989; Penckofer & Holm, 1990; Wenger, 1989), to almost nil (King, Clark, & Hicks, 1992; Mickleborough, 1994). Investigators are quick to point out that the risk of mortality is low in both sexes; for example, Hammar et al (1997) found that early mortality was 3% in women and 1.7% in men.

Several authors note that risk factors for heart disease are similar for men and women, although there are differences (Jadin & Margolis, 1998; Murabito, 1995; Thomas & Braus, 1998). Age is the major factor for both men and women, with the onset of heart
disease occurring ten years later in women than amongst men. The presence of
comorbidities such as diabetes or renal disease narrows this difference considerably. First
MI occurs twenty years later in women than in men. The effect of estrogen on
coaulation and cholesterol profiles protects premenopausal women from heart disease
and provides the strongest explanation for the age gap between onset of heart disease in
men and women. Hence, menopause without hormone replacement therapy is a major
independent risk factor in women. Hypertension is a risk factor in both men and women
although its incidence is higher in men until age 70, when the incidence in women begins
to overtake and steadily surpass that in men. Smoking is a well known risk factor in both
sexes, but women over thirty who use oral contraceptives and smoke are under the
greatest threat. Elevated triglyceride levels and low levels of high density lipoprotein
(HDL) identify women at risk for heart disease, while the pattern for men at risk consists
of elevated total cholesterol and low density lipoprotein (LDL) levels.

There is evidence that men's and women's symptoms of CAD differ and that their
responses to treatment may also vary (Jadin & Margolis, 1998; Kindwall, 1989; Wenger,
1989). The Framingham Heart Study revealed that women (54%) more commonly
experience angina than men (38%) do as the major presenting indicator of heart disease,
but recognized MI is seen less often by women (18%) than men (30%) as the initial
presenting indicator (Murabito, 1995). Typical angina is characterized by substernal chest
pain that is precipitated by exercise and is relieved within ten minutes by rest or
nitroglycerine. Women have more atypical symptoms such as nausea, vomiting, or neck
or shoulder pain (Jadin & Margolis, 1998). Women with typical or atypical angina are
less likely than men with either category of angina to demonstrate significant CAD on angiogram although this difference decreases with age (Jadin & Margolis, 1998). The likelihood of CAD is lowest in premenopausal women with atypical angina, and one or no risk factors, whereas postmenopausal women with typical angina and multiple risk factors are considered at highest risk (Jadin & Margolis, 1998).

Some investigators have suggested that women receive less aggressive treatment than men for CAD even when medical indications are similar (Ayanian & Epstein, 1991; Wenger, 1990). The lack of correlation between angina and the extent of occlusive disease in women renders the diagnosis of CAD more complex in women than in men. Therefore some argue that the responses of clinicians to atypical signs in women depends as much on awareness of the disparate patterns of presentation seen in men and women as on degree of gender bias (Glazer & Hurst, 1987; Jadin & Margolis, 1998; Thomas & Braus, 1998). The rate of coronary artery bypass surgery (ACB) in Ontario increased by 31% between the years 1981 to 1989 with a male:female ratio that remained at approximately 3:1 throughout that period (Ugnat & Naylor, 1993). The physiological outcomes of the procedure for men and women have been compared with varying results. Higher operative mortality rates and poorer relief of angina symptoms following ACB in women have been attributed to women's smaller stature and smaller blood vessels, although age and an accompanying higher incidence of comorbidity with diabetes and hypertension have also been implicated. It has been suggested that outcomes for women may have improved considerably in recent years because of advances in surgical management and technique (King, Clark, & Hicks, 1992; Mickleborough, 1994).
Return to Paid Employment and Activity Following ACBS

Recovery from ACBS was initially studied from the problematic of return to work and productive activity in an effort to justify the treatment in economic terms; however, findings were contradictory and inconclusive. Sociohistorical influences may be as involved in the decision to return to work as level of physical recovery and vigour. As Radley pointed out:

"The awareness has grown that the outcome of CABGS [or ACBS] is shaped by socioeconomic factors that lie well beyond the medical framework...In recent years this has become evident in the form of the effects of economic recession upon the working lives of disabled people generally, including those who suffer from heart disease. When jobs are not available it becomes a palpable nonsense to gauge recovery solely (or mainly) in terms of employment status" (1988, p.7).

For example, layoffs and plant closings in one region resulted in fewer men than women returning to work following ACB (Anderson, Barboriak, Hoffmann, Mullen, & Walker, 1985). Brezinka and Kittel (1995) reviewed literature on return to employment following MI or ACB and found that most samples included only men or were mixed but with very few women, therefore there is very little information about women’s employment patterns on recovery. Many authors have found a negative association between age and employment status following MI or ACB (Bryant & Mayou, 1989; Crosby, Chiang, Jordan, Mentzer, Kron, Kaiser, & Craddock, 1985). Education and income are positively associated with return to work (Almeida, Bradford, Wenger, King & Hurst, 1983; Stanton, Jenkins, Denlinger, Savageau Weintraub & Goldstein, 1983) while anxiety and depression are negatively associated with employment (Mark, Lam, Lee, Clapp-Channing, Williams, Pryor, Califf & Hlatky, 1992, 1994; Maeland & Havik, 1987). Finally, the type
of occupation has a strong influence on return to employment. Factory and unskilled workers are less likely to return to work than professional or clerical/skilled workers (Caine, Harrison, Sharples, & Wallwork, 1991; Gehring, Koenig, Rana & Mathes, 1988; Zyzanski, Stanton, Jenkins, & Klein, 1981).

There is some evidence that women are less physically active than men following surgery and that fewer women return to paid employment after bypass than do men (Almeida, Bradford, Wenger, King, & Hurst, 1983; Boogard, 1984; Zyzanski, Stanton, Jenkins, & Klein, 1981). It has been suggested that women are less likely to return to work because they tend to develop heart disease later in life than men, they may have husbands who provide financial support or they may have activity limitations (Wenger, 1985). Women tend to earn less than men, therefore some authors argue that there is less financial incentive to resume employment (Brezinka & Kittel, 1995). Zyzanski, Stanton, Jenkins and Klein (1981) found that women who were forced to retire after ACB demonstrated poor psychosocial adjustment and reported that they had been poorly prepared for return to work by their physicians. Ameida, Bradford, Wenger, King & Hurst (1983) found that more women than men were advised not to return to work.

When homemaking tasks are included as indicators of activity or employment, the incidence of postoperative activity and return to work is found to be equivalent between men and women (Barnes, Ray, Oberman, & Kouchoukos, N., 1977; Niles, Vander Salm, & Cutler, 1980; Westaby, Sapsford, & Bentall, 1979).

Radley (1988) further argues that "the problem of coping with heart surgery remains part of the continuing development of medicine in which the features of
technological advance on the one hand and social care on the other are brought into fresh relief" (p.13). Although improvement in physical capacity does not necessarily predict return to work following bypass surgery (Allen, 1990), the resumption of paid employment is a profoundly social act that reflects striving for a healthy place within the experience of illness. The crisis of heart disease and surgery may well represent for some people an opportunity to examine their social lives and activities in order to establish some sense of coherence; this period of reflection would necessarily take place within a larger material and social context. At such junctures, the decision to retire early from an unsatisfactory working life could represent a more healthful scenario than would the decision to return to an unhappy work experience when retirement is not financially feasible. Interestingly, the latter scenario could count in some studies as an indicator of a positive outcome following surgery. For example, risk of CAD is increased in female clerical workers with unsupportive employers, regardless of other risk factors (Eaker, 1989). Return to the same working conditions following surgery might jeopardize the beneficial effects of treatment. There is a need to study women's experiences on return to the service work or caring work that prevails within female-dominated occupations. These occupations may or may not involve challenging levels of physical activity, but they frequently involve hierarchical social relations and emotional labour (Armstrong & Armstrong, 1994).

Penckofer and Holm (1990) found a general failure to fully conceptualize the nature of housework in existing studies. Given the multifaceted nature of the work women perform in the home, one immediately notes that early studies defined housework
as merely a type of physical activity, such as tidying, doing laundry, and vacuuming or sweeping; there is no mention of coordination of the home, emotional work or attending to caregiving responsibilities. The question of 'choice' is also not explored; some workers with pensions or disability benefits may choose not to return to the labour force, but the conditions under which women might chose not to do housework are unclear. Indeed, the isolation associated with homemaking may provide working conditions as unhealthy as those experienced by female clerical workers with unsupportive employers. In a 20-year follow up of the Framingham Study, it was found that housewives who had complained earlier of loneliness during the day and lack of social ties demonstrated significantly higher CAD and coronary mortality rates than women with better supportive ties (Eaker, Pinsky & Castelli, 1992).

Complex differences among the experiences of those who return to work may well be obscured unless the relationships among work activities, class, gender, race, and ethnicity are carefully studied. Anderson and her colleagues (1993) have shown that immigrant women with chronic illnesses are less able than Euro-Canadian women to restructure their employment situations to accommodate their health needs. The immigrant women struggled with language barriers, inflexible work environments, limited employment opportunities, and pressing financial situations. Lack of educational qualifications hampered their searches for more favourable employment settings as well as their efforts to understand their own health requirements. Rather than treating return to paid employment as a marker of recovery for women, research is needed that treats employment as a health issue for recovering women.
Women Helping Men Recover From MI or ACB

The process of recovering from and making sense of the crisis of ACB or MI has more recently been examined within the context of marital, family, and social relationships, although most authors place the greatest emphasis on supportive aspects of spousal or family relationships. Interestingly, the 'spouse' of the recovering person in many studies is female, and her psychological state is considered by some investigators to be an important determinant of recovery for her husband (see, for example, Beach, Maloney, Pocica, Sherry, Weaver, Luthringer, & Utz, 1992). In reading the findings of these studies, one finds an intricate description of women's caregiving work and of the entanglement between women's own emotional wellbeing and that of their family members.

Emotional work is a prominent theme in many studies. Recovery is not merely a matter of physiological healing. Many investigators have found that preoperative levels of functional status are unchanged postoperatively or may deteriorate further regardless of the extent of physical impairment (Allen, 1990). Depression and anxiety have been associated with lack of improvement in functional status, poor social outcomes and mortality (see, for example, Frasure-Smith, 1991; Ladwig, Kieser, König, Breithardt & Borggreve, 1991; Ladwig, Lehmacher, Roth, et. al., 1992) therefore some researchers have studied influences on the psychological wellbeing of the recovering person (Allen, 1990; Bryant & Mayou, 1989; Channer, O'Connor & Britton, 1988). A lack of social and community ties has been associated with higher mortality due to coronary artery disease (Ruberman, Weinblatt, Goldberg, & Chaudhary, 1984), while married men and women have exhibited significantly better long term survival rates following MI than do the
unmarried (Chandra, Szklo, Goldberg, & Tonascia, 1983; Williams, Barefoot, Califf, et al., 1992). Recurrence was significantly higher in the six months following a first MI in persons who lived alone than in those who lived with a spouse or others, although marital disruption did not constitute a risk for recurrence (Case, Moss, Case, McDermott, & Eberly, 1992). These and similar observations have been cited frequently in terms of the support available to those with spouses, yet the manner in which social support influences survival is unclear. Unfortunately, the more focussed studies which deal with this issue answer the question from one perspective: that of the man with CAD.

Some investigators, using data from all-male samples, have advanced the hypothesis that social support exerts a buffering effect on the long term health consequences of coronary-prone personality traits such as Type A behaviour pattern (Blumenthal, Burg, Barefoot, et al., 1987; Orth-Gomer & Unden, 1990). Others have found that supportive marital relationships are negatively associated with depression, and marital conflict is positively associated with anxiety during recovery from MI (Waltz, Badura, Pfaff, & Schott, 1988). O'Reilly and Thomas (1989) found that men who had managed to maintain a change in lifestyle patterns and lower their calculated cardiac risk scores had significantly higher informational, emotional and appraisal support scores than men who did not adhere to prescribed lifestyle changes. Most named their spouses as the primary source of support. Similarly, Ben-Sira and Eliezer (1990) noted that the spousal support offered to men recovering from a first MI played an important role in recovery by enhancing self-esteem and mastery.

O'Reilly and Thomas (1989) as well as Riegel (1989) caution against assigning to
wives the burden of responsibility for the emotional and physical wellbeing of men with CAD and urge health care workers to consider the emotional needs of the women themselves. Gillis (1984) found that the spouses of men who underwent ACB reported higher stress than did their husbands and that they felt overwhelmed by the burden of caring for their partners. While it was initially thought that including spouses in cardiac rehabilitation programmes might increase the predisposition to offer support to the recovering person (Dracup, 1984), it later became apparent that people with cardiovascular disease and their families have different experiences and concerns (Gillis, 1991). While the person with CAD tends to focus on daily progress, families and spouses tend to worry about the future and about their effectiveness in providing care and support (Bramwell, 1986; Gillis, 1991). Some women may experience emotional problems such as clinical depression in the months following their husbands' bypass surgery (Goldschmidt, Fulcher, Baird, & Tennant, 1984; Langeluddecke, Tennant, Fulcher, Baird, & Hughes, 1989) or MI (Hilbert, 1993).

One source of the emotional distress experienced by caregiving women is their perceived need for information about how to care for their husbands. After MI or ACB, it is well known to laypersons that a programme of comprehensive lifestyle change may forestall further damage. There is angiographic evidence that adherence to such practices may result in a reversal of atherosclerotic lesions (Ornish, et al, 1990). Often these lifestyle changes, particularly dietary restrictions and stress management, fall within the normatively perceived domain of women's domestic responsibility. Several authors have found that women feel responsible for managing these changes in their husbands' health.
habits following an MI or ACB, and the psychological health of the women may be strongly influenced by their access to appropriate information (Hentinen, 1983; Mayou, Foster, & Williamson, 1978; Nyamathi, 1987; Orzech & Stanillo, 1987; Thompson & Cordle, 1988).

These studies provide evidence that women take their caregiving responsibilities seriously and that there is a social expectation that they do so. Furthermore, these findings indicate that personal commitment to the wellbeing of others may result in emotional sequelae for caregivers themselves. While it is useful to recognize the challenges women face in helping men recover from MI or ACB, the remarkable proliferation of studies in this area obscures the issues faced by women with CAD. If the existing gendered division of labour is as powerful as the above literature would appear to indicate, what happens when the genders are reversed in this scenario? Only recently have some researchers begun to recognize that the social and material conditions of recovery from MI or ACB may be different for women, because women's paid and unpaid work is structurally different from that of men.

Women's Recovery from MI and ACB

When the designated family caregiver becomes ill, several issues arise. Young and Kahana (1993) followed for one year a group of 246 older persons who had suffered a first MI; one third of this sample consisted of women. Several disadvantages were found among the women, including less aggressive medical care and less caregiving assistance from significant others. Mortality was higher in the women than in the men at one year: 20% of the women had died after one year as opposed to 12% of the men. The women
were significantly less likely than the men to have a spouse who could act as an informal caregiver, and women who had little assistance were more than twice as likely to die in the follow up period. The authors also note that married women were three times more likely to die in the year following MI than were married men, and that marriage was not synonymous with caregiving support. It has been suggested that because women tend to marry men who are older, their husbands may well be chronically ill themselves and unable to provide assistance to their wives.

Additionally, women may receive different family care depending on whether that care is provided by a husband or a daughter. Young and Kahana (1987, 1989) studied the problem of caregiver strain in families giving informal care to members with cardiovascular disease. In particular, they note that the care provided and the experience of caregiving may vary according to gender and kin relationship. In their study of 183 caregiving dyads, two thirds of the caregivers were spouses and 80% were female. The women caregivers gave more assistance and the type of care varied by gender; meal and laundry assistance were linked to care by women, while men performed handiwork and gave transportation assistance.

Rankin's (1992) study of recovery from ACB in 69 couples included comparison of male and female spouses. Male caregivers were significantly less likely to be stressed by the dual responsibilities of employment and caring for their wives and less likely to feel that their relationships with others were affected negatively or that their health had suffered as a result of caregiving. The men were also significantly more likely to state that they could do an adequate job of caring for their wives, and that "life had gone on as
normal" (Rankin, 1992, p.275). Their approach to care was less expressive and more task oriented. Rankin does not report on differences between the self care activities of men and women as they recovered from ACB, so it remains unclear whether life went on as normal for the male spousal caregivers because their wives assumed some responsibility for self care and household chores.

Powell and colleagues (1993) studied the psychosocial predictors of mortality in 83 women in the years following a first MI. After 8.5 years, the most significant predictors of mortality were being divorced and being employed without a college degree. Employment without a college degree may be accompanied by poor working conditions, hierarchical work relationships, and poor income. Therefore material as well as social conditions are implicated in this model, but not overtly studied. Interestingly, the inverse of Type A behaviour pattern was also predictive of mortality in this sample. Women with an absence of time urgency and absence of emotional arousability exhibited higher rates of mortality. The authors speculate that this pattern indicates depression, thus supporting the hypothesis that depression is associated with morbidity and mortality in heart disease.

Several investigators have compared psychosocial adjustment in men and women, but most studies are flawed by disproportionately small numbers of women (Brezinka & Kittel, 1995). For example, Frasure-Smith, Lesperance & Taljic (1993) compared 173 men and 49 women after MI, and found that women were marginally more likely to be depressed than men. Conn, Taylor, & Abele (1991) compared 117 men and 80 women after MI, and found that after 1 and 2 years, the women reported significantly more days of reduced activity than the men, although the authors note that the average age of the
female subsample was higher than that of the males. Schron, Pawitan, Shumaker and Hale (1991) compared 1234 men and 264 women after MI and found evidence of a significantly worse social and emotional quality of life in women. Rankin (1990) compared 93 men and 24 women one and three months after ACB and found no differences in psychosocial markers such as sexuality, recreation or return to employment. Interestingly, women demonstrated significantly lower levels of mood disturbances than men in this study.

Some authors have explored the interface between the normative expectations of a 'good' homemaker and the recovery experiences of women. Boogaard (1984) compared ten women and ten men three to six months after MI. She used a semi structured interview format to elicit information about return to physical activity, psychosocial aspects and family relationships. The women almost immediately resumed household activity and felt guilty about having others assume their responsibilities, while men reported no guilt feelings and a more leisurely programme of resting, relaxing, and walking in the house. The women did not view homemaking as work and were unlikely to think of it in terms of energy expenditure. Family members perceived both male and female respondents as ill and showed willingness to provide assistance. Men accepted this help, but women resisted it, particularly when help specifically related to normal household chores. Half of the men in Boogard's sample enrolled in rehabilitation programmes, while only one woman did.

More recently, MacKenzie (1993) described women who had returned home after hospitalization due to ischemic heart disease as initially testing their physical limits and then changing their activities or help seeking patterns to accommodate their apparent
physical capacities. The women retained primary responsibility for household tasks, but lowered their standards and paced themselves carefully while doing housework. In another study, older women with heart disease reported greater limitation in their ability to complete housework and more resultant stress than did older men (Sharpe, Clarke, & Janz, 1991). The authors compared 189 men and 134 women using a telephone interview format. The women experienced significantly more cardiac symptoms and greater severity of symptoms than the men and more functional limitation on the Sickness Impact Profile.

Although both men and women reported similar patterns of adherence to medical advice about medication and diet regimens, men were significantly more likely to adhere to exercise programmes than women.

Hamilton and Seidman (1993) compared recovery from acute MI in 20 women and 42 men, using a descriptive mailed survey approach. There was no statistically significant difference between women and men related to return to work, however women received less counselling from health professionals about their return to work. Nineteen of the 20 women were responsible for household chores at the time they experienced MI while only 28 of the 41 men held responsibility for housework. Within four to six weeks of MI, fifteen of the women (75% of the female subsample) had resumed responsibility as opposed to 14 of the men (33% of the male subsample). The women engaged in significantly more cooking, dishwashing, bed making, laundry, dusting and sweeping. Men engaged in significantly more outdoor work. The authors remark that if counselling about return to work included attention to resumption of unpaid homemaking activities, women would have been advised about the strenuous nature of activities such as
bedmaking, laundry and sweeping.

King and Jensen (1994) used a grounded theory approach to study the experiences of ten women who had undergone cardiac surgery. Seven of these women had ACB surgery, while three had repair of cardiac anomalies. They found that identity and sense of self was profoundly affected by the surgery; women struggled to maintain "role related" activities and personal relationships in order to preserve a sense of self. The women defined progress in terms of the household chores they were able to accomplish. Some experienced frustration and impatience with the amount of time it took to evolve a revised "normal" self and responded by returning to activities their doctors had warned them against. Younger women were particularly prone to feelings of vulnerability in relation to others' judgements about their role performance. The degree of trust embedded within relationships with helpers made the difference between 'losing control' and 'relinquishing control'. Technically successful surgery did not correlate with perceived success by patients. Their markers of successful outcomes included making sense of the experience, normalizing perceived changes in functional ability and developing a sense of control over the experience. These elements contributed to a sense of self preservation.

Hawthorne (1994) compared women's and men's perceptions of ACB in a qualitative study. Three influences on gender-related dissimilarities in these perceptions were found:

"(1) differences in life span development, (2) differences in world view, and (3) differences in roles and associated life experiences" (p. 78).

While the men viewed ACB as an event that generated a life transition where personal
goals were evaluated, women were more concerned with establishing a balance between their altered needs in the postoperative period and the requirements of significant others. Patterns of passivity and deference were evident barriers to communication and information exchange between the women and their physicians, and there were indications that the women received less information from nurses about personal care and resumption of activity following surgery. The men conformed to professional advice on activity levels in the recovery period while the women, who were less informed at the outset, approached activity resumption with a stronger orientation towards family and home responsibilities than to specific instructions from health professionals or physiologic cues.

These studies indicate that it is difficult for women to give up responsibility for work in the home. Although others may demonstrate reluctance to help out due to lack of time, experience, or inclination, the women themselves may feel compelled to resume housework through guilt or feelings of inadequacy. Even when others are readily available and eager to help, women may feel uneasy with this assistance because it undermines their sense of identity (see also, Aronson, 1991). King and Jensen (1994) and Hawthorne (1994), in particular, suggest the intricate juxtaposition of personal identity, homemaking activity and quality of relationships with close others. These elements resurface in studies of women's attendance in cardiac rehabilitation programmes.

According to some authors, proportionately fewer women than men enter cardiac rehabilitation programs, and their attendance may be sporadic or even terminated because of family responsibilities (Hawthorne, 1994; Murdaugh & O'Rourke, 1988; Schuster & Waldron, 1991). Others have found no difference in men's and women's attendance.
(Hamilton & Seidman, 1993). Young and Kahana (1993) found that men received significantly more information about heart disease than women, and were significantly more likely to be referred for cardiac rehabilitation programs and diagnostic angiograms. Women who did not receive cardiac rehabilitation had a greater chance of reinfarction within the year, as did women who had fewer follow up visits to a physician.

Moore (1996) used a focus group method to examine the patterns of women’s participation in cardiac rehabilitation programmes. Ten women who participated in a coed cardiovascular programme were interviewed in two focus groups using a semi-structured interview guide. The participants identified several positive aspects of the rehabilitation programme: the safety of being monitored during the programme, feeling better, friendly programme personnel, belonging to a group, obtaining nutritional information, relaxed atmosphere, convenience and flexibility. Negative features included: lack of choice in exercise options, lack of emotional support from staff, few opportunities to socialize with other participants, a ‘men’s club’ atmosphere which gave preferential times to working men, feeling rushed and crowded, and getting weighed on a frequent basis. Support for attendance in the programme came from spouses and adult children. Some said that these close others were a motivating force to get better; they wanted to avoid precipitating emotional upheaval in their loved ones. The findings of this project underscore the extent to which cardiac rehabilitation programmes have been designed from an androcentric perspective. For example, solitary exercise on a stationary bicycle or treadmill does not seem to meet women’s needs for social interaction, nor do rapid turnover times in length of sessions or programmes.
Although some authors have studied gender differences in referral and treatment patterns for CAD (Ayanian & Epstein, 1991; Bickell, Pieper, Lee, Mark, Glower, Pryor, & Califf, 1992; Krumholz, Douglas, Lauer, & Pasternak, 1992; Ugnat & Naylor, 1993), the manner in which recovering women interact with health professionals to obtain information and advice has not been studied to date. Moore’s (1996) findings suggest that in at least one area of treatment, cardiovascular rehabilitation programming, an androcentric pattern persists. Although there is growing awareness that the physiological responses of women with CAD may vary from those of men, the health sciences seem poorly prepared to recognize the social and material conditions that configure women’s attempts to live with chronic illness. Ironically, while there are many rich descriptions of women’s attempts to assimilate the information given by health professionals into their care of husbands who are recovering from MI and ACB (Gillis, 1984; Radley, 1988; Simons, Cunningham, & Catanzaro, 1992), there is little research that deals with women’s patterns of self-care or assisted self-care (Sharpe, Clark, & Janz, 1991). In the final section of this chapter I discuss this problem in greater depth.

**Issues in the Health Sciences Literature on Women and Heart Disease**

The above discussion suggests that health professionals play a pivotal role in the recovery of women from MI or ACB. As Smith (1987, 1990a, 1990b) points out, the assumptions of health professionals and researchers about social life are incorporated into the knowledge base used in practice. Ultimately, the bulk of what health professionals ‘know’ about recovery from MI or ACB is based on comparisons between an extensive foundation of knowledge about men and a smaller but rapidly growing field of knowledge
about women. Smith further argues that what we regard as 'knowledge' may serve to perpetuate inequities within a system of social relations. An incomplete understanding of recovery from MI or ACB serves as an organizer of gender inequities in cardiovascular care. Knowledge about the particularities of the lives and activities of women is required to provide more effective care and informational support.

The problem of who is to perform homemaking and family care tasks while a woman recovers or deals with exacerbations of chronic illness is an increasingly familiar one. Help from family members or home care services is often arranged, but these are temporary measures bound by time and energy constraints in the former case and fiscal restraints in the latter case. The assumption prevails that the recovering woman will return to her customary duties as soon as she is able, and this expectation is perhaps strongest in the woman herself. There is a need to recognize, however, that some women have workloads that are incompatible with their own health needs. While, as Hawthorne (1994) found, a man might interpret an MI or ACB as a signal that a major reorganization of his activities and priorities was in order, this transition is not as apparent in women. Furthermore, King and Jensen (1994) point out that being able to participate in housework is central to the gender identity of many women.

There is a remarkable 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 identity are enacted in the everyday work of homemaking. Doyal (1995) has recently cast this problem within the framework of global politics for women's health. She
argues that the health all of women is affected in various ways by the demands of home and family care. Although many North American women need not spend hours in physically exhausting searches 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 regimens, and pursuit of information about healthful activities. Authors writing from a health sciences perspective are often 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)

King and Jensen (1994) come closer to defining the problem:

“Although domestic functions are of high value to women in perception of self, they are poor choices of cardiovascular activity for women.” (p. 104)

It is apparent these authors understand that women engage in homemaking as a construction of identity, but the problematic is framed within the issue of cardiovascular work capacity. Within the idiom of cardiovascular science, the problem becomes one of exercise, not equity, and the subtly inscribed dynamic is one of ‘choice’.

This perspective is illustrated in one recent study which appears in The American Journal of Cardiology. Wilke, Sheldahl, Dougherty, Hanna, Nickele, and Tristani (1995) document “the energy expenditure for (oxygen uptake [VO₂]) and hemodynamic responses to housework of women with stable CAD” (p. 670). They compared responses to housework in 26 women with stable CAD and 10 age-matched normal women.
women were required to perform specific housework tasks in a standardized laboratory home-like setting: washing dishes, scrubbing pots, ironing clothes, unpacking groceries, sweeping floors, vacuuming a carpet, mopping a floor, changing a bed, and washing a floor. In determining energy expenditure, the investigators calculated oxygen use in terms of METs, the number of millilitres of oxygen used per kilogram of body weight per minute during specific activities. One MET is the amount of oxygen used at complete rest, or 3.5 ml/kg/min. As work becomes more difficult, the MET level increases, so that a woman who is exercising at 5 times the resting energy cost is expending 5 METs of energy. Levels of exercise are classified according to the number of METs used: light exercise requires 2-4 METs, moderate exercise expends 6-8 METs, and heavy exercise uses 10-12 METs. The MET concept is used to develop individualized recommendations for activity after MI or ACB. Treadmill tests are conducted under medical supervision to determine which levels of exercise are safe for individuals with heart disease.

Wilde (1995) and her colleagues found that the energy requirements for common household tasks range from 2 to 4 METs. They concluded that women who were able to safely achieve 5 METs or more on a treadmill test should be able to perform most homemaking activities. They further argued that by working more slowly at strenuous tasks and periodically monitoring their pulse rates, women should be able to decrease energy expenditure and fatigue. Conditioning exercises to strengthen arm and leg muscles was also suggested. Finally, the authors noted that many tasks raised VO$_2$ and MET values in the participating women to within the range recommended for aerobic exercise. This finding led to speculation that housework would be a useful "adjunct to an aerobic
exercise training program" (1995, p. 673), but should not be considered the only source of exercise. Because the authors believe that some women do not resume housework activities due to low self efficacy after cardiac events, they note ways in which their findings can be used to encourage women to participate more fully in everyday household routines. However, there are limitations to the generalizability of their findings.

First, housework activities were tested in a laboratory setting, although efforts were made to make the work as realistic as possible (eg., by scattering sawdust to be swept up, having women move furniture while vacuuming). The unique topography of each woman's home could not be simulated, so interpersonal contact, material context and embedded emotional activity were stripped from the analysis. Second, each task was performed for 8 minutes, except for vacuuming and unpacking groceries which were performed for 6 minutes. Only four tasks were done at a time, so testing for each participant took place over a two day period. This means that each participant performed no more than 20 to 24 minutes of work at a time in contrast to the average of 4.5 hours per day that Canadian women report (Devereaux, 1993; Jackson, 1996). Third, there is no way of knowing how the workload of shopping for groceries, transporting them to the kitchen, and then unpacking them compares with the energy expenditure required for the study activity of unpacking four bags of groceries for six minutes. Furthermore, it is difficult to extrapolate from these findings the effects of juggling childcare (or eldercare) and several additional household chores simultaneously.

This study, and others like it, conceptualize housework as an isolated physiological event. This conceptualization rests on the assumption that household tasks are parcelled
as discrete sets of activities, each of which require muscular coordination and strength. produce metabolic demands, and result in increased cardiac output for the duration of that activity. When each activity is completed, it is assumed that the body returns to a resting state in which as little as one MET is required to sustain survival. Intervening effects of financial worry while shopping are not considered here, nor are the emotional consequences of the implicit or explicit judgements of others about the quality of the completed labours. Indeed, we learn nothing about the costs of emotional work, for here work is assumed to be the domain of the physiological heart, not the metaphorical or social heart.

**Discussion**

Elliot (1995) argues that

"...conception of the etiology of coronary disease requires a model of health which goes beyond the biomedical model of disease to a socioecological model of health and well-being which involves an interactive set of relationships between individuals and their social, cultural, and physical environments." (p. 112)

Biomedical studies which emphasize physiological measures of cardiac function obscure pressing issues about the suitability of certain environments for healthful recovery. No reputable hospital would discharge a man directly to his place of employment following ACBS. There would certainly be extreme concern if, after establishing his ability to handle a cardiac workload of 5 METs or better, he announced his intention to resume not one, but two jobs. Further, there would be scathing criticism of studies that suggested this overtime work might provide a useful adjunct to a programme of aerobic cardiovascular exercise. Yet men and women are sent home after ACB with little thought that recovery
is not undertaken on a level playing field in that location. Employed men and women are advised that they are fit to return to their jobs after treadmill testing establishes suitable tolerance for moderate activity. Hawthorne (1994) found that men reconsidered their working lives and career goals after ACB; some changed careers or modified their workloads to reduce stress and improve quality of life. Women were less inclined to make these revisions, and continued to pursue their double workloads.

Elliot's (1995) call for a more socioecological model of health would encourage us to critically examine the social relations that relegate such disparities to the realm of an assumptive order. Why, for example, would it seem reasonable that research about the cardiovascular demands of housework tasks should take place in a laboratory, not a house? And how, in this research, did particular aspects of housework become the logically acceptable proxy variables for the full range of activities which comprise homemaking? Clearly, there are conventions and relations associated with the conduct of research, development of theory and generation of knowledge that have the power to exclude or demarcate certain aspects of human experience. Traweek remarks on the problematic associated with knowledge development when it is undertaken from different geographic locations (home, laboratory, or office spaces) and social positions (gender, class or linguistic positions) from that of the object (or subject) of study:

"...for many of us it is our job to separate objectivity and subjectivity, our public and our private, the social and the personal, universals and particulars, the third person masculine generic and the first person singular. To be on one side of the line is to be in the right place to make knowledge and facts and methods and theories; to be on the other side is to be at home. We rarely ask ourselves what would happen if we were to theorize at home and with a different grammar." (1999, p.190)
Traweek invites us to consider that knowledge is situated, and that ontological as well as geographical locations can determine what and how we know.

One of the many possible observations that could be made of the literature reviewed in this chapter is that it was constructed from a particular situation. Indeed, the creation of this knowledge was an ongoing project that located very specific aspects of women’s bodily existences within particular fields of endeavour. The project was not located within the bewildering complexities and actualities of women’s lives. The information thus constructed served certain purposes and answered questions that were posed for distinct reasons. For the sake of expediency, utility and parsimony, the purposes and questions that guided the project converged on what needed to be known to understand, diagnose, and treat heart disease in women.

Yet the project was also undertaken by individuals who studied women’s cardiovascular health from a variety of disciplinary perspectives, including nursing, medicine, exercise science, physical therapy and social work. All of these disciplines are engaged in activities that bring them into contact with women who have heart disease, and they have an interest in providing the most effective care possible for these women. The information gleaned from the project of learning about women’s cardiovascular disease was meant to be used in the care of women with CAD. The actual intent was not to exclude certain aspects of women’s experience, but to help in the ways that were possible within the boundaries of activity that constitute professional practice.

All of the health professions that are concerned with women’s cardiovascular health coordinate their efforts around a common understanding of what a heart is. Within
this realm of understanding, the heart is a muscular organ,

“approximately 12 cm. long from its base at the beginning root of the aorta to the left ventricular apex, 8 to 9 cm. wide transversely at the widest part, and 6 cm. thick anteroposteriorly” (Woods, Froelicher & Motzer, 2000, p. 6).

The heart of an adult woman weighs approximately 250 grams, depending on age, body size, frequency of exercise and presence of CAD. The heart muscle is continually active. To remain viable, it requires patent coronary circulation to ensure a constant supply of oxygen and metabolic substrates as well as removal of carbon dioxide and metabolic wastes. Coronary artery disease compromises coronary circulation. Occasionally, occlusion of the coronary arteries is so severe that it results in myocardial infarction, the damage or death of a portion of the heart muscle. This in turn may compromise cardiac functioning, depending on the location and severity of injury. In serious cases, cardiac function is not adequate to maintain life and the person who has suffered MI will die.

Yet the heart also is the bearer of complex metaphorical significance. It holds more than blood within its muscular walls. The heart is considered the sensuous container for many emotions: love makes it swell, fear makes it shrink, sorrow makes it heavy, joy makes it light and disappointment makes it sink. The pain of grief and loss is heart-rending. In contemplation of the future, the heart is filled with hope. Hearts are torn by indecision and are the locale of intense emotional suffering. In reminiscence, all of these sensations, all of these emotions, are evoked and reviewed within the heart. It is the seat of conscience and remorse, and has a place in everyday language: “I didn’t have the heart to tell her”, “it did my heart good”, “she has a heart of gold”. The heart is the locus of many purposes and experiences. It is bounded by its muscular walls but it metaphorically
extends itself to others in empathy and shared experiences: "My heart went out to her".
“our hearts beat as one”. It is also situated or *located* within particular perspectives:
“Home is were the heart is”, “She has her heart in the right place”, “I searched my heart”.
There is a poignant vulnerability and courageous endurance about the heart, for it
continues to beat, never resting, despite all of the turmoil it contains. And all of its
perspectives, all of its sensuous emotional experiences, end when the heart dies.

The language of the heart forms a discourse of emotion describing a realm of
experience that is uniquely human - but it is absent from the techno-medical literature I
review above. The heart as functioning organ seemingly diverges from the sensuous,
emoting heart. In heart disease, however, the two purviews converge around one
ominous possibility: mortality or death. Many techno-medical articles on heart disease
begin by citing morbidity and mortality rates establishing heart disease as the most
common cause of death in men and women. It is this central issue that drives a complex
of research and health care funding allocation, intensive development of diagnostic and
treatment technologies, and efforts to improve practical approaches to prevention.
diagnosis, treatment and rehabilitation. The activities of many health professionals are
coordinated around the project of avoiding death from heart disease. Hence the literature
cited in this chapter is concerned with assessing, repairing and sustaining the physiological
heart. There is an accepted base of understanding about heart disease. It is caused by a
variety of “risk factors”, many of which are deemed avoidable. When heart disease is
detected, the ideal outcome is not only to repair the heart, but to revise practices which
create risk. Danger is managed. Death is forestalled.
Women’s actual experiences with heart disease are also situated, and also focussed on the terrible prospect of death. With the pain of angina, they are reminded of this peril and suffer pangs of fear. The emotional and physical labour that they do for others, as well as their emotional experiences, burdens vulnerable hearts. The proximity of death is the crux of the world in common they share with the health professionals they turn to for help. Symbols and concepts unite these disparate understandings of the heart. The diagnostic category, “heart disease” identifies those with CAD. The category “women with heart disease” identifies a group who pose or endure specific problems. Their lives and sensuous experiences are abstracted in the text of these articles (which in turn have been abstracted by me for the purposes of this review). The present research was undertaken to understand recovery from ACBS from the perspectives of women involved in the experience. In order to undertake this task, an analytic framework was required which encouraged an understanding of women’s embodied experience as embedded within a sociohistorical context of gendered inequity. In the next chapter, I review feminist (and other) criticisms of health and social sciences, then discuss the analytic framework used in this study.
CHAPTER THREE
ANALYTIC FRAMEWORK

This ethnography takes as problematic the conflicts and contradictions arising for women at locations where several situations and demands intersect: women’s own health needs and their everyday/evverynight domestic activities; professional discourse and the female body; the local and the extralocal. Knowledge, decisions and action are exigent at each point of convergence, consequently each point is the locus of social relations and negotiations. Analysis of the complex interweaving of this social web must remain as attentive to individual agency as it is to the social conditions influencing and influenced by action. Sensitivity to political and historical context is also an integral part of this work.

Women’s heavy responsibilities in the domestic sphere restrict their access to prerequisites of health such as time for personal growth and leisure, adequate income, and equity (Doyal & Gough, 1991; Ottawa Charter for Health Promotion, 1986; Pascall, 1993). Doyal (1995) and Doyal and Gough (1991) suggest that social relations and policies ought to be judged according to their adequacy in meeting common human needs and observe that, in comparison to men, many women’s basic needs are poorly met in all societies. Full citizenship for women means “the equal recognition of needs - for shelter and food, personal space and time, for social acceptance - and the construction of rights and obligations within such a framework of needs” (Pascall, 1993, p.115). Evidence cited in the previous chapter suggests that many prerequisites for physical and mental health are not satisfied for some women as they recover from MI or ACBS. Yet these women are
apparently accessories to their own lesser citizenship, for they retain responsibility for most homemaking tasks, even when physically incapacitated. The analytic framework for this research must therefore attend to the negotiation of conduct and activities without reducing women to passive victims or becoming focussed on individual meanings.

Finally, this work requires an analytic framework that recognizes the human body as the location of our involvement with the social and material world (Diprose, 1994; Leder, 1990, 1998). This materiality acknowledges our "inescapable physical locatedness in time and space, history and culture, which shapes and limits us" (Bordo, 1998). Connection between the embodied subject and the world is achieved through directional activity or motility (Diprose, 1994; Straus, 1966). The world is incorporated in the body through development of corporeal schema, tastes, or mannerisms characteristic of identification with social categories such as gender, class or ethnoracial membership (Diprose, 1994; Smith, 1990b). Therefore, sexed identity, or gender, is constituted in an active, intersubjective process of recognition and identification of bodily comportment (Diprose, 1994; West, 1993).

These specifications evoke consideration of structure and agency. Is one of these two social moments the appropriate point of analytic convergence or departure? Canadian feminist and sociologist Dorothy Smith argues that analysis of the particularities of women's engagement with the world begins from the standpoint of women and extends outward to encompass social relations at the intersection of the local and extra-local (1987, 1990a, 1990b, 1999). Her grounding of social life in the material draws attention
to the sensuous, embodied activity of women, as well as the historical and economic context in which activity is situated. In this chapter, I precede a discussion of Smith’s work with a feminist critique of traditional health sciences and sociological positions on women’s health and work. I demonstrate how, as the analytic framework for the present research, Smith’s work takes up these shortcomings as a problematic and permits extension of analysis beyond the traditional perspective. Finally, I raise recent questions and critiques regarding Smith’s arguments as they present opportunities for and limitations to the present study.

**Critique of Traditional Health Sciences and Sociology**

There are inequities in the gendered division of labour within Canadian households, and men and women experience different trajectories of recovery from aortocoronary bypass and myocardial infarction. More is known about the diagnosis and treatment of heart disease in men than in women because sampling procedures have tended to exclude women. The majority of the studies cited are quantitative, thus they conceal some particularities of social life. Investigators who acknowledge the importance of social relationships to health outcomes, rely on “proxy variables”, such as social support or stress, which decontextualize and reduce social experience. Studies of women’s unpaid domestic work and paid labour in the work force have also neglected subtle, almost imperceptible functions such as emotional labour and coordination of activities.

Feminist and other theorists have criticized the health sciences and social sciences on a number of conceptual fronts related to the above observations. First, the “medical
model" of health and illness has relied on a Cartesian model of science that divides body and consciousness, and fragments the body into a series of organs and systems. This model has permitted the universalized masculine perspective to prevail, and has facilitated biological determinism. Second, health and social sciences researchers have tended to approach the conceptualization of difference in a reductionistic manner, often conflating sex, class, gender and patriarchal social relations. Third, traditional theories and models of work are inscribed with the "malestream" perspective of the sociological founding fathers. This perspective emphasizes the economic and social relations of paid labour, thus devaluing and obscuring women's unpaid domestic activities. I will discuss each of these problems in turn.

**Cartesian Science and the Embodied Subject**

Since the seventeenth century, the human body has been identified as a material object of study, scientifically inscribed with mechanistic functional properties (Calhoun, 1990; Leder, 1990; Smith, 1993). Enlightenment philosophers such as Descartes pursued universal truths by rigorously adhering to standards of detached objectivity. This position enabled, and was enabled by, the conceptualization of a detached or objective consciousness unconstrained by spatial and temporal coordinates. In contrast, the situated body was affiliated with nature, the object of consciousness, to be studied and dominated by human will. Control of illness, and hence the body, became a possibility and later, an actuality. However, the separation of consciousness and body facilitated a fracturing of the social and the physical. The study of illness became a search for physiological causes
and remedies, not social ones.

Women, too, became affiliated with nature in an essentialist logic that promoted distinctions between the anatomic and functional properties of sexed bodies. The bipolar categories male and female, as well as the markedly corporeal attributes of the activities of reproduction and child rearing, undergirded an evolving association of women with nature (Harré, 1998; Smith, 1993). The history of women’s exclusion from higher education, the professions and the cash nexus was marked by allusions to their irrationality, fragility and categorization as “other” than men (Diprose, 1994; Calhoun, 1990; Smith, 1993; Witz, 1992). The evolving conventions of detached scientific observation and textual inscription, combined with the exclusion of women from the ranks of the learned, orchestrated a dual erasure of women’s experience. First, the very dissociation of the scientific writer from the corporeal conditions of existence concealed a masculine bias that permeated the academic enterprise and its evolving language. Second, women’s exclusion suppressed voices that could describe women’s perspective, and curtailed development of linguistic structures that reflected their experience of the world.

Hegel, and later Marx, introduced a critique of the hidden privileging of hegemonic assumptions inherent in the Enlightenment ideal of the “universal man” (Calhoun, 1990). Although Hegel’s master and slave, and Marx’s bourgeoisie and proletariat were imbued with a male perspective, their analyses advanced the suggestion that the “social and material position of every knower (and by extension, every culture, every generation, every class, and even every sort of scientifically trained researcher) makes some
knowledge possible even while it inhibits or precludes other knowledge.” (Calhoun, 1990, p.171). This particularism was taken up by feminist standpoint theorists like Nancy Hartsock (1983, 1997), Patricia Hill Collins (1990, 1997), and Dorothy Smith (1987, 1990a, 1990b, 1997, 1999) who argued that an androcentric bias in the social construction of facticity and knowledge has suppressed the various experiences and voices of women. They called attention to the social relations of oppression, insisting that these could only be understood if investigation began from the position of the oppressed.

The ontological materialism of standpoint theory directs attention to the primacy of embodied social experience as constitutive of and constituted by consciousness. In the phenomenological view, the self is not merely consciousness deposited in a body, but the body is the self and consciousness projected into the world in directional activity or an intentional arc (Diprose, 1994). Standpoint theorists, in their various approaches, would not dispute this, but would add that the body is sexed and subject to social practices, ideas, and prescriptions regarding gendered comportment. Embodied expression of identity both incorporates and acts upon these norms to simultaneously validate and alter them (Bordo, 1998; Harré, 1998; Smith, 1990b). Failure to consider the interaction between embodied subjects and social relations of dominance and oppression is the by-product of a fragmenting Cartesian discourse. For example, when it was discovered that relatively little was known about women and heart disease, researchers hastened to replicate with female samples previous studies done with exclusively male samples. Few called for a close examination of the social relations among health sciences research.
funding bodies, health care, and academia that contributed to the exclusion of women from research samples or appropriate diagnosis and treatment (Maxwell, 1994; McKinlay, 1996). (There was no concern about what implications these flawed relations might hold for the accuracy of the knowledge already gathered about men with heart disease.)

Finally, within the health sciences, the predominant focus on understanding and controlling the workings of the human body has contributed to a depoliticization of the determinants of illness. Theories relating personality variables such as Type A behaviour pattern, hostility or coronary prone behaviour and development of CAD implicitly direct attention to the individual as the author of her or his own misfortune (Radley, 1984). Radley argues that development of such behavioural styles "is embedded in particular uses of the body and in particular forms of social relationships" (1984, p. 1227). The social, historical and economic context of these embodied social relationships is overlooked in the search for personal risk factors or noncompliance with medical regimens, as health professionals and patients engage in what Benner refers to as the "discourse of suspicion" (Benner, Janson-Bjerklie, Ferketich & Becker, 1994, p. 252).

Centuries of Cartesian science have deeply entrenched the assumption that the preeminent seat of reason is consciousness or the mind, which is located within but distinguishable from the body (Leder, 1990; Van Maanen, 1995, 1996). Abstract knowledge is the fruit of conscious thought and is claimed and constructed by an intelligentsia that possesses educational capital or credentials to support their privileged social position. Separation of the body from the creation of knowledge is characteristic of
the Cartesian tenet of objectivity. The body locates understanding within a particular spatiotemporal position, hence it is the locus of subjectivity. Thus, to positivistic health science, the body is rarely considered the locus of knowledge, despite grudging acceptance of its role in enacting knowledge as skilled activity (Attwell, 1990). In contrast, ethnomethodologists propose that all human activity is highly complex (Garfinkel, 1969). "Walking, crossing the road, and carrying on a conversation are amazing accomplishments requiring a complex coordination of perception, movement, and decision, a myriad of choices, and a multitude of skills." (Attewell, 1990, p. 429). Van Maanen (1995, 1996) notes that embodied knowledge of the world enables us to move, preoccupied, through daily routines, fulfilling the need for practical, habitual and tactical perception of situations without conscious deliberation. Leder (1990) reminds us that the amazing internal operations of the visceral body are intricately regulated beyond our control or awareness.

The mundane work of women in the care and service of others is grounded in an embodied intelligence which facilitates the more abstract, highly valued work of others (Smith, 1987, 1990a). However, women’s situated knowledge is less valued and their work is deemed less skilled than those of workers in male-dominated occupations (Armstrong & Armstrong, 1990; Gaskell, 1985). Although abstract reasoning requires considerable conscious attention, many domestic skills become entirely somatized through countless repetitions, requiring little concentration. Paradoxically, while many embodied skills available in the labour force are highly valued and compensated, an expert
homemaker’s embodied skills are considered natural feminine attributes or instinctive actions. In health care, the restoration of health is defined in narrow terms; it is the practice of correcting pathological deviations from normal physiological function, rather than the process of restoring the self reproduction inherent in the conduct of somatized daily, even mundane, routines (Diprose, 1994; Williams, 1984).

In summary, the fragmentation, reductionism and essentialism inherent in Cartesian philosophy has led to an erasure of women’s embodied experience and knowledge from scientific reasoning and practice in the health and social sciences. Detachment of the diseased body from a social, historical and economic context conceals “pathological” properties of social structures and relations. In the next section, I examine the conceptualization of sex and gender in this scientific milieu.

Sex, Sex Roles and Gender in Research

Elliott (1995) notes the shortcomings of the biomedical model as a theoretical apparatus for understanding the etiology of cardiovascular disease in women. She calls for a socioecological model which explores “relationships between individuals and their social, cultural, and physical environments” (p.112). Unfortunately, many studies cited in the previous chapter proceed from a perspective that implicitly presupposes sex differences are the explanation for discrepancies in domestic responsibilities or health outcomes, rather than the analytic starting point of a more comprehensive deliberation of gendered social relations (Fenstermaker, West & Zimmerman, 1992; West, 1993; West & Fenstermaker, 1993). Krieger and Fee note that biological determinism obscures the
dialectical relationship between the body and society, because "usually ignored are the many ways that gender as a social reality gets into the body and transforms our biology" (1994, p. 18). In this section I explore how the conceptualization of sex, sex roles and gender in research can limit or bias findings.

West and her colleagues offer a critique of prevailing conceptual devices in research on gender and health. Research in health and social sciences commonly compares findings on certain outcome variables between males and females. This is a manifestation of an analytic system orchestrated by the search for predictive alignments among variables. While on a superficial level, a linkage between the independent variable "sex" and the dependent variable "mortality in the year following ACB" may seem plausible, sex is no more than a crude proxy variable representing profound physical, personal, and social differences in the lived experiences of women or men. The sweeping essentialism of reducing the scope of analysis to the sex category severely limits understanding of gender inequality (Fenstermaker, West & Zimmerman, 1992; West & Fenstermaker, 1993). While assignment to a sex category may initially be made with reference to biological criteria, everyday identification as "woman" or "man" is maintained through social comportment and management of sexed bodies in ways that indicate membership in one or the other category.

Regarding gender as a role or status is equally problematic:

"...actual performance of a role turns on a specific social position, and a situated set of social actions. One problem with this view is that no concept of role can specify such actions a priori. The potential omnirelevance of gender in human affairs means that when paired with the concept of role, the result is like 'the happy
drunk' Connell describes (1983, p. 198): 'the more it tries to take in, the more incoherent it becomes' (Fenstermaker, West & Zimmerman, 1992)

Here the authors refer to the challenge posed by gender to role theory since gender is a master status or overarching identity. Gendered comportment becomes entangled with and competes with behaviours attached to other roles rendering impossible the analysis of conduct within discrete role boundaries. Within such a framework, gender remains a trait or property of the individual (for example, indices are available to measure how feminine or masculine an individual is), not a process of social interaction. The persistence of masculine and feminine behaviors is usually attributed to socialization, but this allusion to acquired personal conduct forecloses analysis of social relations of power, conflict and inequality.

Butler (1998) argues that particular behaviors are considered appropriately feminine because of the proximity of the biological category "sex" to the socially constructed category "femininity". Femininity or masculinity are constructed as natural because they rest on a biological foundation: female or male sex categories. Harré (1998) observes that even this seemingly innocuous dichotomization bears its own difficulties. Although assignment to one category or the other is rarely difficult, is it to be based on the presence of chromosomal, hormonal or gonadal evidence? Are secondary sex characteristics to be included? If so, what are we to make of hirsute women or men with high-pitched voices? Why then, is the variable "sex" considered at the categorical, and not ordinal or interval level of measurement? From this inquiry, it is only a short step to Butler's (1998) assertion that the category "sex" is, in itself, a social construct anchored
by its apparently indisputable origins in nature: "One way the internal stability and binary frame for sex is effectively secured is by casting the duality of sex in a prediscursive domain" (p.30). There is a socially constructed, tautological linkage between the notion that there are appropriate sex roles or behaviors and the impression that sex categories are self-evident. West and Fenstermaker (1993) argue for similar reasons that analyses based on sex roles are plagued by the same essentialism that flaws those considering sex categories.

Goffman’s (1976, 1977) work on gender display is the foundation of West and Zimmerman’s (1987) assertion that gender is not entirely what one is, but what one does. Goffman conceptualized displays as two-part ritualized exchanges articulated with and through the more mundane features of social interaction. Displays serve to establish relative social location: symmetry or asymmetry, deference or dominance. Calhoun (1990) would argue that these conventions are infused with nuances of identification and recognition, as West and Zimmerman suggest in their subsequent extension of the analysis to include the concept accountability. Building on Heritage (1984), they argue that much of everyday social life is subject to descriptive accountings which

"name, characterize, formulate, explain, excuse, excoriate, or merely take notice of some circumstance or activity and thus place it within some social framework (locating it relative to other activities, like and unlike)." (West& Zimmerman, 1987, p.136)

Activities are subject to comment and, by extension, are designed with the consequent accounts in mind. The omnirelevance of gender includes it as a circumstance of all activities, hence all activities are accountable to prevailing discursive standards of
gendered comportment.

Accounting for one's behaviour holds moral connotations, and it implicitly connotes compulsion to act in a manner that is recognizable - to oneself as much as to others - as appropriately female or male. At stake is one's social competence, yet tactics will vary, for social relations of gender are as much embedded in institutional structures as in the subtleties of human interaction. West points out that gender accountability "draws its idiom from the institutional arenas in which social relationships are enacted" (1993, p. 59), an observation which connects the local to the extra-local. Bodily comportment, material conditions, biographies, and social consciousness are all shaped, altered, truncated, and facilitated by the shifting idioms - and social relations - of gender accountability. This ethnomethodologically inspired view of gender is not exclusively devoted to explaining the impact of inequality on individual, or groups of, women. Rather, this framework invites consideration of how inequities are orchestrated in arenas and by actors distanced from the lived experiences of affected women (Calhoun, 1990; Smith, 1993).

The premise that health outcomes can actually be measured using sex categories or sex roles as independent variables thus obscures relations of power, inequality and dominance which have relevance to health. Furthermore, we see in this instance how scientific inquiry reduces (indeed transforms) the biological body from a sensuous, active, contextually embedded entity into an abstraction. Indeed, the more gender becomes a performance, the less visible is the sexed body. Yet even the above discussion about the
problematic notion of measurement distracts us from a more central consideration. The focus on bodies as, for example, assignable to one of two sex categories - or as actively engaged in enacting gendered schemas - is but one example of how bodies are socially relevant, but are entered into discourse in carefully demarcated ways. The biological, visceral body may be a social construct, but it is simultaneously a material condition of particular social experiences. These experiences may directly or indirectly disturb the countless, extraordinary biological processes of life. Sex in and of itself is not a determinant of health, but the embodied and social experience of belonging to a particular gender is. Conceptualization and measurement of variables involves exclusion as well as inclusion of experience, a recurrent theme which will be repeated in the following section on women’s work.

**Women’s Work, Men’s Analytic Models**

Throughout the 1970s and 1980s, the domestic labour debate raged as feminists attempted to conceptualize unpaid household labour and women’s oppression. Many discussions were grounded in Marx’s labour theory of value, because this framework “...enables us to look behind market relations and superficial money flows at the real social relations of production; that is, to see which groups contribute by their labour to social production and which groups are in a position to appropriate the labour of others.” (Gardiner, 1976, p. 110)

However, Marx gave women’s oppression as paid or unpaid labourers little more than passing mention, and his constructs emanated from an androcentric world view. The dual systems frameworks developed in the attempt to locate an interface between the feminist concept “patriarchy”, with the Marxist concept “capitalism”. Hierarchies of oppression
were weighed in publications with informative titles: *Beyond sexless class and classless sex: Towards feminist Marxism* (Armstrong & Armstrong, 1983), *The unhappy marriage of Marxism and feminism: Towards a more progressive union* (Hartmann, 1981), *Beyond the unhappy marriage: A critique of the dual systems theory* (Young, 1981).

Interestingly, by 1996 Johnson still asks “whether the existence of class relations necessitates the continuing subordination of women.” (1996, p. 194)

Johnson’s (1996) question is understandable considering the unresolved status of the debate. While Hartmann (1981) concluded that an intellectual linkage between the two frameworks was possible, Barrett (1980) and Young (1981) argued that the concept of patriarchy ought to be collapsed into the overarching concept of capitalist oppression. Working from Delphy’s (1984) assertion that Marx’s analysis of the capitalist mode of production is but one instance of the many possible analytic applications of historical materialist methodology, Walby (1990) explored several spheres of patriarchal relations: domestic work, paid work, the state, male violence, sexuality and cultural institutions. Insofar as men exploit the domestic labour of women, Walby (1990) considers the home to be the locus of the patriarchal mode of production. Kynaston (1996) supplements Walby’s analysis and concludes, with considerable historical and contemporary empirical support, that women are subject to a dual oppression by the capitalist and patriarchal modes of production. Johnson’s (1996) question might therefore be answered with a qualified “yes” that invites her to further consider the existence of patriarchal relations.

The surfeit of writings that comprise the domestic labour debate draws attention to
the importance of domestic work to the family and to the capitalist economy, and take
issue with accounts that devalue homemaking skills. They also attest to the intellectual
difficulties intrinsic to projects involving adaptation of patricentric frameworks to feminist
perspectives. Traditional conceptualizations of work are imbued with an emphasis on
tangible products, evidence of physical or intellectual exertion, claims to an abstract
foundation of knowledge (or at least mastery of a valued skill), and payment (see for
example, Armstrong & Armstrong, 1994; Kynaston, 1996; Smith, 1987, 1990a; Walby,
1990; Witz, 1992). This, in addition to the historically shifting nature of household
activities, is a cue to adopt a more generous definition of the term "work" (Smith, 1987).
For example, Fox (1993) provides evidence that women currently spend less time than
ever before on activities related to cleaning, but a prevailing ideological emphasis on
maternal responsibility for the intellectual, social and psychological development of
children contributes to an increasing apportionment of available time to childcare. Much
of this activity goes unreported in housework surveys, and as Armstrong and Armstrong
(1994) point out, it often overlaps with and occurs simultaneously with other tasks.

One subtle conceptual issue inherent within this discussion centres on definition of
the home. As Moss (1997) cogently points out, conceptual power is lost when the home
is regarded as simply a house - a container or physical locale. The interpretation of
women's domestic work in such a medium literally becomes housework, and converges on
the predominantly physical labour of household maintenance. In contrast, Moss offers a
definition of the home as relational space which bears metaphorical and generalized
meanings:

"In such a conceptualization, then, home environment is constitutive of all the actions taken by individuals which have been circumscribed by the routinized behaviours of a set of the many actors involved in, for example, the maintenance of domestic space, the organization of neighbourhood, and the provision of health care services, as well as the multiple sites within which these actions take place." (p. 25)

Homemaking activities extend beyond the physical location of a household, and are relational as well as physical in character. They intersect with social institutions and involve interaction with professionals and bureaucracies. They are subject to idealized discourses about leisure, aesthetics, cleanliness, privacy, family, and femininity.

Homemaking encompasses all the activities of “doing home” and “doing family” and is interpenetrated with social and personal meanings associated with the home (Bowlby, Gregory & McKie, 1997; Gurney, 1997). But homemaking activities often lack a tangible product, are conducted in an apparently effortless or even imperceptible manner, do not require educational credentials, and are financially unrewarded.

If women’s unpaid domestic work is composed of undervalued, concrete physical tasks and mostly unrecognized relational activities, similar issues abound in the feminist analyses of paid employment. Women’s concentration in a narrow range of service industries where their clerical, service, sales, teaching, and health care jobs emphasize the needs of others, positions them as social homemakers who do the nation’s physical caregiving and relational work (Armstrong & Armstrong, 1994; Belle, 1982; Hochschild, 1983; Phillips & Phillips, 1993; Wilson, 1991). In industries where work is vertically divided according to gender, women perform the concrete and interpersonal tasks
necessary to facilitate the better rewarded abstract or technical work of male dominated occupational groups within the job hierarchy (Armstrong, Choiniere, & Day, 1993; Butter, 1985; Cuneo, 1990; Duncombe & Marsden, 1995; Smith, 1987).

Women’s proximity to consumers, as well as the relational and physical contact involved in their work may further devalue their labour. Abbott (1988) noted, for example, the phenomenon of "professional regression" whereby the presence of a profession at the level closest to the client group is maintained by the most junior, degraded members of the group. The most elite members of an occupational group are absorbed in activities, such as research, which permit more distance from consumers. Since the work of these elites provides the intellectual capital supporting that group’s claim to a distinct and valuable field of expertise, their contributions are more highly rewarded than those of the less senior members. Abbott’s discussion of professional regression fails to explicate the social processes through which this phenomenon is enacted, nor does he explain why proximity to clients is relegated to the lower echelons of a professional group. Feminist writers have considered these issues in greater depth.

Historically, the designation of women to the category of "cheap labour" is related to the social construction of gender and the delegation of technical skills to women is often justified on the basis of driving down the cost of labour (Steinberg, 1990; Wajcman, 1991). The notion that people are paid on the basis of their skills obscures the very nature of skilled work as a socially defined and socially evaluated set of characteristics that varies according to the gender, ethnicity, and power of workers, as well as with historical and
economic context. In short, the designation of skill is the product of struggle (Armstrong & Armstrong, 1990; Atwell, 1990; Gaskell, 1985).

In Ontario, the difficult wording of recent Pay Equity legislation placed the onus on women's groups to expend considerable time, money, and energy in the pursuit of its implementation (Cuneo, 1990; McDermott, 1992). As Drover and Kerans (1993) point out, the claims of dominant groups are rarely challenged because these assertions are already aligned with prevalent attitudes and norms. On the other hand, the claims of subordinate groups challenge this established order by demanding a new system of social identity. In struggling for fair implementation of Pay Equity, groups such as the Ontario Nurses' Association were forced to deal with the inscription in legislation of the socially embedded, androcentric definitions of such terms as work, skill, and knowledge. These biased definitions permeated the very measurement scales used to compare and assign value to the work done by men and by women (Armstrong & Armstrong, 1990; Butter, 1985).

Research in women's work and health is interpreted from a partial understanding of women's experiences in the labour force. For example, Theorell (1991) reported on a Swedish survey that examined relationships between the occupations of 600,000 men and 400,000 women and their risk of becoming hospitalized for MI within one year. Women in occupations where overtime was common had a greater risk of MI than other women, but there was a negative relationship between overtime and risk of MI in men until levels of overtime became excessive. Theorell correctly suggests that women's extra workload
at home may be an influence behind this difference. Many investigators have already argued that women do an extra shift of housework when their hours of paid employment come to an end (Hochschild and Machung, 1989). However, recent analysis of the invisible relational and emotional work involved in domestic and social homemaking suggests that a third shift is intertwined with the activities of the first two (Duncombe & Marsden, 1995). This work stems from the emotional bonds inherent within intimate relationships, but it does not include those bonds themselves. Thus, Duncombe and Marsden (1995) would not claim that love is “work”, but they would suggest that managing conflict between family members or supporting loved ones through personal difficulties is work that requires considerable skill.

But Theorell (1991) found that while work in nonlearning and hectic occupations was predictive of hospitalization for many illnesses (including MI) in men, it had no predictive value for any diagnosis among women. Theorell (1991) further noted that social support at work had a greater protective effect on the incidence of cardiovascular disease in women than in men, and marked class influences were noted. Blue collar women, such as waitresses, reported higher levels of support on the job than did white collar women, such as physicians. The combination of high work demands and lack of social support was particularly predictive of cardiovascular symptoms in women, although in men this relationship varied by class.

Theorell's findings suggest several things. First, the class differences noted in the availability to women of social support at work may be linked more with the gender-
typing of certain occupations than with class. As Armstrong and Armstrong (1994) note, the workforce is markedly segregated by gender; women in less traditional occupations are less likely to "fit in". Waiters in Theorell's study reported less support than did the waitresses, again indicating that the interaction between the gender-typing of an occupation and the gender of the worker may be an important determinant of the amount of support available. Frankenhaeuser (1991) and her colleagues likewise found that female managers at a Volvo plant had lower levels of perceived support at work than their male co-workers while female clerical workers reported much higher levels of perceived support than did male clerical workers; in this situation, the female clerical workers were operating in a more traditionally feminine work role, while the female managers were not.

Second, the finding that the combination of hectic and nonlearning work is not predictive of cardiovascular disease in women while it is in men may represent a form of gender bias in the definition of what constitutes learning. As noted above, women's work is associated with an embodied, tacit form of knowledge that is learned and imparted in ways that remain unrecognized and unvalued. In addition, many of women's work activities are difficult to classify as skills in the traditional sense because their components have not been fully articulated or understood, even by the women who perform them.

Indeed, the very nature of women's paid employment may provide women with protection; Barnett and Marshall (1991) found that in a sample of 403 female nurses and social workers there was less psychological distress in conditions of work overload when high rewards from helping others were present. If the provision of support is one facet of the
paid and unpaid work of women, the woman who perceives that she has effectively helped someone despite high work demands is the antithesis of the alienated worker.

Finally, the above discussion leads us to question whether models such as Karasek's (1990) construction of the influence of work demand, control, and social support on the health and job satisfaction of workers apply in the same manner to women as to men (Barnett & Marshall, 1991; Frankenhaeuser, 1991). Indeed, Theorell's finding that moderate overtime constitutes a risk factor for cardiovascular disease in women but not in men indicates that work demand for women cannot simply be measured in terms of hours of paid employment, if indeed, quantification was all that was required. The temporal boundaries between social homemaking and family homemaking are remarkably ambiguous.

Models such as Karasek's (1990) exclude any concern with patriarchal relations because they are narrowly constructed to reveal the relations salient to the capitalist mode of production. The notion that workers may receive satisfaction and comfort from providing social support is foreign to an archetype that hinges on assembling a tangible product. Social homemaking is conditioned by different contextual features, such as lack of time for personal growth and leisure, inadequate income, and inequity (recall Doyal and Gough, 1993; also Pascall, 1993). Intrinsic rewards such as helping others cannot improve one's material lot, but they do provide recognition that one's efforts do indeed have value, despite androcentrically informed evidence to the contrary.

In summary, traditional health and social sciences research cannot fully represent
women's health and work experiences because conceptualizations of the body, gender, and work are biased and inadequate. Smith's (1987, 1990a, 1990b) work recognizes these shortcomings, yet she does not urge us to correct these models and continue in a similar mode of inquiry. Rather, she directs attention to the textually mediated social relations that permeate the conduct of research and its interpretation in practice. In the section that follows, I elaborate on her analytic approach.

**Institutional Ethnography**

Interpretive theorists would argue that individuals make sense of life events through reflection about two sources of understanding: those that are culturally defined, and those that are experientially acquired (Denzin, 1989; Kasper, 1991, 1994). Bourdieu (1989), also posits that social structures and relations are maintained in part by their internalization as a complex of culturally defined, experientially acquired and practised understandings. People act according to their understandings about their social positioning or habitus within a situation or field. Distinctions are readily apparent cues which participants use to interpret their "places" relative to one another as interactions unfold; sex serves as one distinction to which social actors attach expectations for embodied comportment. Similarly, Zimmerman and West (1987) argue that people physically present themselves as women or men through patterns of comportment which are experientially learned and conveyed by cultural and institutional idiom. In these formulations, the authors seem to regard the body as pre-eminently social. It is entered into negotiations with others, it is comported in ways that signify gender or social status,
even sensuous experiences are represented as socially constructed into such markers of social standing as “taste” (Bourdieu, 1989). The biological body as a material condition of social life is absent from these discussions.

For women, culturally derived norms and expectations about womanhood form one source of meaning, but their embodied and material experiences form a second, more personal source. The classical interpretists such as Mead and Schutz assumed that these two sources of meaning converged in a coherent manner; only Berger suggests that conflict between the two loci of understanding might be possible (Kasper, 1991). However, feminists, especially Smith (1987), argue that public or cultural meanings attached to femininity may conflict with actual personal experiences, thus creating a bifurcation of consciousness. That these personal experiences involve material embodiment is an important development, for it enters the sensuous, or biological body into the discussion. In her study of women who had recovered from mastectomy, Kasper (1991) found that many grappled with the contrast between culturally prevalent ideals regarding feminine physiognomy and the feminine identities they had acquired through caring social relationships and activities. Cancer represented an actual biological threat to continued existence. This threat justified drastic removal of a uniquely female feature of the biological body; thus, mastectomy became a material and social predicament. Thorne (1990) found that mothers with chronic illnesses struggled with experiential conflict between cultural and medical expectations of them as “good mothers” and as “good patients”. Sensory experiences such as pain and fatigue posed material barriers to the
activities of motherhood.

Inquiry in all of these instances treads the boundary between the subjective realm of meaning and the material realm of the social relations and activities which construct meaning and worlds in common. When West (1993) and her colleagues treat normative conceptions as the organizing principle of gendered activity, they implicitly accept these conceptions as a given and they direct inquiry towards the manner in which these understandings inform people's activities and accounts. Kasper (1991) and Thorne (1990) subtly shift the emphasis when they examine the intersection between the everyday worlds of sensuous embodiment and the institutionalized world of health care. The importance of seeking this alternate position is elaborated in the writings of Dorothy Smith (1987, 1990a, 1990b, 1999).

As mentioned earlier, Smith emphasizes women's standpoint as organizing a method of inquiry that begins in the actualities of people's experience. That is, people and their subjective meanings are not the objects of investigation; instead, their standpoints or experiences are the point of entry into an investigation or exploration of the social. Hence, investigation can begin with anyone's local situation as it is experienced and told. Smith (1987, 1990a) observes that the standpoint of women is unique in its almost complete exclusion from the creation of the intellectual and cultural discourses that comprise ideology. Women's social and family homemaking activities are positioned at the margins of discursively or textually mediated relations of ruling. Women "have been assigned and confined predominantly to mediating the relation of the impersonal and
objectified forms of action to the concrete local and particular worlds in which all of us necessarily exist" (Smith, 1987, p.108). As administrative assistants, nurses or homemakers, women (and men who work on and outside the margins) deal with the concrete and relational details of everyday life, facilitating the more abstract activities of dominant others. This is the basis for Smith's insistence that women's standpoint directs us to begin with the point of view of an embodied, active subject in a specific historical setting.

Neither her emphasis on women’s standpoint nor her analysis of the bifurcation of consciousness need be taken as indications that Smith’s intent is to delve extensively into the depths of "endless idiosyncratic consciousness of unique individuals" (Smith, 1993, p. 394). She cautions us that ideological versions of everyday life infuse insiders’ accounts as they attempt to explicate their circumstances and activities. She recognizes that in the process of recounting - or accounting for - experience, insiders weave a complex tapestry of discourse, tacit knowledge, social relations and intersubjectivity:

"Experience is a method of talk, a language game, in which what is not yet spoken struggles dialogically to appropriate language sedimented with meaning before the moment in which she speaks. It is through and through saturated with the social relations, including the social relations of discourse, in which what is being spoken of is embedded as well as those of which the moment of speaking is part." (Smith, 1997, p. 394)

Smith (1990b) acknowledges the problematic revealed by ethnography: we cannot know the world as "outsiders" but as "insiders" to its social organization. Her inquiry extends from a "member's knowledge" (Garfinkel, 1969) of local settings and how they work to an examination of extra-local forms of social organization (Smith, 1987, 1990b). Unlike
others who delve into the realm of subjectivity. Smith argues that restricting analysis solely to consciousness obscures all but the most immediate of material conditions. She turns instead to a more reflexive base that incorporates "member's knowledge" as the starting point for an inquiry that moves from local activities to extra-local relations of ruling.

In defining women's standpoint, Smith rejects an ontology of meaning or idealism, and directs attention to a materialism anchored in sensuous, embodied experience. She draws on ideas presented in Marx's *Theses on Feuerbach*, wherein he criticizes a materialism that disregards the sensuous nature of human activity and observes that idealism ignores the sensuous, active basis of embodied existence. Marx's materialism is a synthesis of both stances, for he recognizes an understanding or knowing that is put together in people's practices and activities, and which is embedded in their physical being. Smith's strongest influence in adopting this position continues to be the women's movement of the 1960s and 1970s, when women learned to speak from their own experience and embodied knowledge. During that period, Smith and others critiqued the exclusion of women's understandings from the codified foundations of knowledge developed by the academic disciplines. Her institutional ethnography extends from this critique and intends a materialism that "conceives of the social as actually happening in time and place in the ongoing concerting of the activities of individuals" (1993, p.42). Embodied directional activity is expression of the self and of the social world. Tacit knowledge emerges from this socially coordinated field (Smith, 1997).

Although Marx's use of the term "social relations" referred to an actual temporal
sequence of activities involved in forming a social course of action. Smith's application of the term expands this definition. Social relations in the Marxian sense involve a process whereby generality and intersubjectivity are achieved in the conduct of social courses of action. However, Smith regards social relations as a focal point of an ethnographic inquiry that explores the activities of particular local settings and how they operate in conjunction with extra-local influences. Social relations in this sense comprise an analytic device which

"Enables us to go from the moment of observation...to an analysis of how it is organized by and articulated to foregoing and subsequent moments..." (Smith, 1990a, p. 151)

Smith's institutional ethnography is concentrated on particular manifestations of social relations. These are the relations of ruling, the complex social arrangements through which power and dominance are enacted in contemporary capitalist society. Patriarchal relations are profoundly embedded within these arrangements. While she occasionally makes use of the terms "state" and "class", Smith calls for a terminology that goes beyond these concepts and

"...brings into view the intersection of the institutions organizing and regulating society with their gender subtext and their basis in a gender division of labour. "Relations of ruling" is a concept that grasps power, organization, direction, and regulation as more pervasively structured than can be expressed in traditional concepts provided by the discourses of power." (1987, p.3).

For Smith, the health care system and the state are part of a complex of textually mediated relations that includes professionals, bureaucracies, and specific social institutions which are all situated within an historical context of capitalist patriarchy. These relations of
ruling are extralocal in nature, and involve a continual transcription of the local and particular into abstracted and generalized forms that are disconnected from temporal or spacial coordinates.

The process of transcription externalizes social consciousness in practices that objectify reasoning and knowledge as properties of formal organization rather than of individuals. These complex social forms could not have been foreseen by Marx in his time, but are more akin to Weber's ideas about bureaucracy and the rationalization of capital, or Foucault's notion of bureaucratic organizations as arrangements for the panoptic surveillance of large populations by comparatively small groups of professionals (Foucault, 1975). Smith calls bureaucracy a mode of ruling that separates the performance of ruling from particular individuals; the relations of ruling become objectified and textual in form, and are mediated by professionals and bureaucrats at the margins of social institutions.

Institutions are complexes of relations which form facets of the ruling apparatus organized around distinctive functions. Institutions represent the intersection and coordination of more than one relational mode. These extensive and complex divisions of labour are knitted together by the common currency of discourse. Smith's notion of discourse is similar to that of Foucault, but in her formulation, the text is displaced as the focal point of analysis. Instead, discourse is

"...an assemblage of statements arising in an ongoing conversation mediated by texts among speakers and hearers separated from one another in time and space." (Smith 1990a, p. 161)
Textually mediated discourse accomplishes a radical detachment from lived embodiment.

In selectively removing concepts from everyday usage, textual inscription decontextualizes and strips away all but the most salient of observations. It suspends concepts, detaching them from time and space to depersonalize their accessibility and eliminate the need for direct communication. Readers themselves become interchangeable. Finally, textually mediated discourse develops a world in common and forms a standardized template for activity. For Smith, the materiality of text as it coordinates activity marks the interface of extra-local and local relations.

Professionals use the schema or language suggested by discursive practices to render their actions and experiences understandable to other professionals operating within the same cluster of relations. This procedure is particularly relevant to the regulation of interdisciplinary practice, where common terminologies unite various categories of workers who possess widely disparate skills and technologies. Translation is accomplished through a textually mediated structure which has expanded beyond mere "paperwork" to sequences of talk, the media, and computers. "Cases", for example, are organizational elements that objectify and make continuous the relations between individuals and their records (Smith, 1990b); such documents are abstract forms of discourse that organize and coordinate particular concrete social relations.

Direct contact with the people whose embodied existence is abstracted by these documentary records is not always required. Decisions can be made on the basis of the factual accounts contained within the records themselves (Smith, 1990a). Case records
facilitate “professional regression” (Abbott, 1988) by obviating the embodied presence of the client.

The social relations involved in the inscription of knowledge to a textual format accomplish its externalization by dislodging knowledge from the active knower. Smith (1990a) points out that knowing is a subjective activity, whereas knowledge requires the disappearance of the subject in order to achieve objective facticity. Specialized social conventions have developed to eradicate subjectivity and context from the textual construction of scientific knowledge. The writer is disembodied and dislocated in time and space to achieve a Cartesian posture of "objective" or pure consciousness. The disadvantage of adhering to these ideological practises is that they confine inquiry to the conceptual level and suppress further exploration of the relations subsumed by the concepts themselves (Smith, 1990a). Concepts such as sex roles, for example, tend to imply a rational and equitable distribution of domestic responsibility and inhibit attention to the problematic of negotiating responsibility. Sex roles become the explanatory variable instead of particular social relations in which inequity and dominance are enacted.

Lived actuality is represented in virtual form on textual surfaces, and these in turn coordinate activity and inform collective consciousness. Smith (1990a) explains that observables or concepts possess two sides. One aspect of an observable is the concept or category which becomes a construct of scientific discourse. These form finely honed taxonomies into which all manner of human phenomena may be inserted. The second aspect is the underpinning of a given observable in the particularities of human activity.
Indeed, this aspect forms the phenomenal substructure without which a concept or category could not exist. The material experience of the world is transposed into consciousness and given discursive expression as concepts or categories. What can be thought is already organized in embodied activity. Smith (1990a) argues that these are not relations of determination, but relations of meaning which are indexical in the ethnomethodological sense. That is, the meaning of categories and concepts is located in their grounding within actual social relations.

Consciousness itself is a social product: thoughts are produced and shared with others in sequences and exchanges of talk. Language is the consciousness of others who preceded us, thus our consciousness is expressed, even thought, on others’ terms. Women express their consciousness using linguistic structures developed predominantly to express the consciousness of patriarchal antecedents. These structures preclude precise description of women’s experiences and create a bifurcated experience of the world (Smith, 1987, 1990a). However, Smith also points out that discursive practices have become increasingly differentiated and specialized in textually mediated forms of social organization such as medicine, law, management and government. Radical shifts in the relationship between consciousness and social relations within these fields increase the separation of a concept from its ground. In these fields, ways of knowing are situated in extra-local relations. Ideas or concepts are transformed into anthropomorphic entities to which agency is attributed.

Smith (1990a) proposes a methodology that restores concepts to their contextual
origins. This ethnography is intended to preserve the presence of active subjects in the coordination of social relations in order to reduce the risk of identifying mystical connections between concepts. She further argues that inquiry must begin at the site of embodied activity rather than from within the extra-local discourses of the ruling apparatus so that the relations of ruling are explored from the standpoint of the ruled (1987, p.98). The conceptual practices of power are conducted under the guise of neutrality and impartiality; class, gender and ethnoracial inequities are effectively obscured unless investigation is launched from the standpoint of those who are discounted. Smith disagrees with Foucault’s conceptualization of a mystical power/knowledge coupling, asserting instead that power is realized or enacted in concerted activities. For example, the power of facticity is embedded in the social relations that separate knowledge from experiencing and knowing subjects. The creation of “objectified knowledge subdues, discounts, and disqualifies our various interests” (Smith, 1990a, p. 80).

Smith’s materialist ethnography does not involve description of individual meanings or shared cultural understandings attached to particular experiences. Indeed, her methodology “understands thought, concepts, textual work, and what is ordinarily thought of as meaning as what people do, as existing in time, and as integral constituents of social relations and organization” (Smith, 1990a, p. 202). To portray these activities as meaning or culture would misrepresent them as mere thought and displace them from a spatiotemporal context. Language and unique typifications of settings serve as resources in this project, but the objective is not to develop descriptive definitions of these terms.
Instead, unique terminologies form the methodological ground of institutional ethnography. Learning how to mean in a specific setting is a process of acquiring an intrinsic language of social organization. It is a part of understanding how the social is brought into being within a particular location.

In summary, Smith's institutional ethnography offers an analytic framework that is concerned with the core social relations underpinning issues identified in the above critiques of health and social sciences theories. Her ideas and methodology have inspired considerable debate and many studies (see for example, Campbell & Manicom, 1995). Her analytic framework preserves the active embodied participation of women in social life, yet it incorporates the practices through which extra-local influences condition this participation. In the final section of this chapter, I consider criticisms of Smith's work and discuss implications for the present study.

**Critique and Discussion of Dorothy Smith's Analysis**

Smith's insistence on the standpoint of women as a point of analytic departure is the crux of several criticisms. Luxton and Findlay (1989) find Smith's use of the category "women" evades issues of class and ethnoracial differences among women and presents women as a singular group with a monolithic consciousness. Smith herself acknowledges the problem of understanding how relations of ruling differentially affect women of various backgrounds:

"The relations and apparatuses of ruling constitute other Others - of class, of gender, and of race. This statement is to be taken quite literally. The divisions between gender, class and race don't exist at the level of the everyday/everynight world of peoples' actual lives; to be black, a woman and working class are not
three different and distinctive experiences.” (Smith, 1989, p. 54)

She notes that the objectifying practices of textual inscription that underpin the discursive basis of contemporary social consciousness position the reader within an Archimedean standpoint detached from social life. This impersonal position obscures the subject - other relations at the core of the consciousness from which it gazes. Although Smith does not explain how these issues of difference are to be treated in the conduct of institutional ethnography, others who have taken this problematic up using Smith’s methodology elaborate on this theme in their own work (see for example Ng, 1995). As noted earlier, inquiry can begin from anyone’s local situation as it is experience or told.

Hekman (1997), too, takes issue with the notion of women’s standpoint. In her reading of Smith, she notes a dichotomization between the abstract conceptualizations created by sociology and the actual lived realities experienced by women. Hekman claims that Smith privileges the tacit knowledge and experiences of women and advances this perspective as the source of truth about dominance and oppression. Further, she argues that Smith proposes a method that directs attention from concepts to reality, but fails to acknowledge that lived experience itself is discursively constructed. Hekman is apparently concerned that Smith’s emphasis on women’s standpoint threatens to parallel the exclusory practices of hegemonic groups in marginalizing other standpoints and other experiences. Calhoun (1990) reiterates this point, observing that some men may experience bifurcated consciousness.

Hekman’s reservations may be unfounded. Smith does not advocate an inquiry
that focuses on or privileges women’s standpoint; rather, she proposes that inquiry begin at women’s standpoint. She remarks on this issue:

“What had seemed at first merely a problem of absence, to be remedied by including women as topics in appropriate sites, has come to be seen as a deeper and virtually total gender warping of culture and intellectual life.” (Smith, 1989, p. 38)

Her project is to study how this warping of knowledge and culture has transpired and how its repercussions manifest in women’s lives. In her rejoinder to Hekman’s critique, Smith (1997) points out that she does not suggest that concepts and reality are two different regions, nor does she recommend a shift in emphasis from concepts to reality. Instead, the shift she proposes

“...is to recognize that concepts are also in actuality and that the objectifications of what I early on described as the relations of ruling are themselves people’s socially organized practices in the actual locations of their lives.” (p. 391)

Thus she reminds Hekman that inquiry moves from women’s standpoint to social relations and the manner in which they are coordinated around concepts or discourse. Beginning from the standpoint of women is not meant to privilege a particular perspective; it is a position from which to explore how conceptual practices are manifested in everyday life.

Hekman’s arguments raise the issue of essentialism. Smith’s emphasis on the category “women” introduces the possibility of claims to a universalizing discourse written from the perspective of that category’s occupants (Calhoun, 1990). Reference to the sensuous, active embodiment of women could serve to intensify this problem, for it threatens to anchor difference within the putatively natural realm of the biological (Butler, 1998). But Bordo (1998) reports that her own insistence on bringing the materiality of
women’s bodies back into postmodern feminist analysis initially met with considerable scepticism and concerns about essentialism. In Bordo’s case, conceptualizing the body as a concrete, even biological, entity placed her in conflict with the increasing trend within postmodern feminism to identify with pure Cartesian consciousness (a trend Smith, too, has critiqued; see Smith, 1993). However, Bordo argues that the inclusion of biology in feminist analyses need not be taken as an explanation for inequity: introduction of the physiological body provides another ground for exploring how scientific taxonomies shape and constrain social relations.

As noted above, Smith rejects claims that the standpoint of women is the perspective of all women and insists on studying women as active, embodied participants in social relations from their own standpoints. Calhoun (1990) observes that there is considerable importance attached to highlighting the standpoints of concrete actors, rather than simply a category of the excluded. This device avoids an objectifying universalism, while it also embraces a tension between idealist and materialist positions. Luxton and Findlay (1989) acknowledge this tension, but note that Smith’s silence on the issue of subjectivity leaves room for refinement and extension, particularly in regards to the generous redefinition of “work” proposed by Smith (1987) herself. Although Smith has repeatedly cautioned against preoccupation with subjectivity, her exploration of the origins of a bifurcated consciousness in women suggests a point of entrée to an investigation of emotional labour as well as the interpersonal and intersubjective components of power relations.
Smith's inclusion of the body is a fundamental element in maintaining a useful tension between idealism and materialism. Perceiving women as conscious, active, embodied participants in social relations denotes agency and sustains the possibility of resistance. Emphasis on material embodiment and active engagement in social life checks inclination toward immersion in the psychodramatics of oppression. It leads us to explore the sensuous experiences of the heart and heart disease, while encouraging our inquiry to extend to analysis of how some aspects of those experiences become worked up as professional knowledge while others are obscured. But while DeBeauvoir (1989) argued that a woman's body is a "situation" (p. 34) which limits possibilities for transcendent engagement in social life, Smith would challenge this assertion. For Smith, the body is the locus of active experience and expression. She proposes, for example, that women are not passive products of socialization, but the creators of their own demeanor (Smith, 1990b). Bodily comportment is cultivated as an identification with or even a challenge to prevailing discourses of femininity.

Although at first glance, Smith seems to duplicate a Cartesian fragmentation between consciousness and embodiment by depicting women as existing in bodies, she describes the production of consciousness as an embodied, and often intersubjective, accomplishment:

"But like everyone else, she also exists in the body, in the place in which it is. This then is also the place of her sensory organization of immediate experience: the place where her coordinates of here and now, before and after, are organized around herself as centre; the place where she confronts people face to face in the physical mode in which she expresses herself to them and they to her as more and other than they can speak. Here there are textures and smells..." (Smith, 1987, p.
The sensory organization of experience portrayed in this and other similar passages encompasses awareness of and concern about one's own body as a biological as well as social phenomenon. The body is a source of information and a locus of tacit knowledge pertaining to everyday pursuits, hence it is inseparable from consciousness (Smith, 1997).

The importance of Smith's analysis to the present study lies within its potential to facilitate connections among several layers of experience and activity. Women who are recovering from surgery deal with alterations in bodily experience, identity and everyday activity. They remain participants in gender inequities in homemaking activities and in local social relations. The health professionals who provide their treatment are simultaneously informed by textually inscribed knowledge, social discourses about gender and the contextual features of their own workplaces. Smith is concerned with knowledge: its various locations, its contours, its construction and its use value in social relations.

Of particular importance is Smith's description of discourse as "skeins of social relations" (1999, p. 158), rather than as a system of meaning. Particular terms or concepts mediate these relations, forming the basis for worlds in common between such diverse actors as women with heart disease and the multifarious health professionals who assist them. These discursive elements are taken up by women with heart disease as they learn to mean within a destabilized world where displacements in social standing and location follow the identification of their health problem as "heart disease". That one concept, or diagnostic category, is the discursive hinge which articulates the social relations of illness.
by providing a world in common which coordinates the activities of women and health professionals. This perspective is taken up in the analysis of data in the present study, and in the next chapter, I discuss the study methods.
CHAPTER FOUR:
RESEARCH METHODS AND PROCEDURES

The Study Purpose and Research Questions

The purpose of the study was to examine the social relations reflected in the instance of women’s experiences with heart disease and aortocoronary bypass surgery. Although diagnosis and surgery occurred on the professional ground of doctors’ offices, diagnostic laboratories and hospitals, most other events, including noting ominous signs and symptoms, and recovery from surgery, transpired in the home - a location where women customarily accomplish the activities which constitute home, gender and self care. As Smith (1987) points out, during periods of marked disruption and reorganization in the lives of individuals and families, the interactions between the local and extralocal spheres of the social world stand in sharp relief. Aspects of daily life that once were part of an assumptive order become suddenly discordant and formerly tacit understandings become explicit. The events surrounding diagnosis of coronary artery disease, ACBS and recovery form one such period of disturbance. In the following sections I outline the methods and design of the research.

The Study Questions

One overarching question guided the design and conduct of the present study:

What social relations are reflected in women’s accounts of their experiences with heart disease and aortocoronary artery bypass surgery (ACBS)?

Four subquestions were derived from this major focus:

1. What are the daily activities of women as they recover from ACBS?
2. What kinds and sources of knowledge do women require in this process?

3. What are the material and social conditions under which experiences with heart disease and ACBS occur?

4. What activities do health professionals pursue in facilitating recovery for women at various stages of their encounters with the health care system?

The questions were formulated through a review of the substantive and theoretical literature. They were further developed with reference to the analytic framework of the research: Institutional Ethnography. A discussion of the methodological implications of this framework follows.

**Institutional Ethnography**

The conceptual groundwork of institutional ethnography directs attention to the social organization of knowledge (Smith, 1987, 1990a, 1990b, 1998; Campbell, 1998). A fundamental assumption of this approach is that everyday life is discursively organized, and that discourse itself is textually mediated. Smith (1998) argues that textual discourse represents "skeins of social relations" (p. 158); it organizes and is organized by social processes. However, Smith also reminds us that people are discursively active from different locations 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). Textually mediated discourse provides an overarching ideological framework which permits these various experiences to be constructed as similar.
For example, as noted in an earlier chapter, the literature dealing with cardiovascular disease in women obscures the emotional labour inherent in homemaking by constructing the issue as a matter of physical activity. Wilke, Sheldahl, Dougherty, Hanna, Nickele, and Tristani (1995) measured cardiac workload during brief periods of sweeping, vacuuming and putting away groceries. They found that most activities tested imposed a mild to moderate cardiac workload and they suggested that these activities could safely be performed in addition to regular cardiac rehabilitation exercises. Frankenhaeuser (1991) and her colleagues, however, found that physiologic signs of stress (elevated catecholamines and blood pressure) were higher in female managers on their return home than during the hours of paid employment. Male managers showed a reverse pattern. Sympathetic arousal is not necessarily simply a direct outcome of the mildly to moderately demanding physical activity described by Wilke and her colleagues. An affective response to the conditions of that work also has to be taken into account. Lack of control over the pace and demands of domestic labour may induce a stress response (Karasek, 1990).

Smith would urge us to consider that there is a disjuncture between the experiences of home for men and women - and for laypersons and exercise scientists - based on their different social locations in relation to textual and discursive representations of the home and their everyday/everynight work related to that setting. Wilke and her colleagues, based on their location as purportedly dispassionate and objective observers of tasks in a simulated or “controlled” home environment, assume that cardiovascular stress related to these tasks arises from physical exertion only. Male managers occupy the social
location of those who "unwind" at the end of regular hours of employment, hence their pattern of reduced sympathetic arousal. Yet, hidden in the male response are the social relations of homemaking: the concrete and invisible tasks of homemaking are done for their benefit. In contrast, at the end of paid employment hours, female managers exchange one stressful job for another. Homemaking is not simply a matter of physical labour. It is a matter of preserving the physical and emotional wellbeing of others by coordinating the multiple activities that constitute family and home (Bowlby, Gregory & McKie, 1997; Gurney, 1997). In so doing, women are accountable to demonstrate competencies and behaviours that meet socially accepted norms of femininity (West, 1993; Zimmerman and West, 1987). The entanglement of gendered identity, emotional ties and obligation condition the experience of home for women in a manner that is not necessarily apparent or relevant to men and exercise scientists.

As the above example illustrates, the purpose of an institutional ethnography is to examine various aspects of a phenomenon from the standpoints of the individuals involved in that phenomenon. Analysis is extended to explore the links among these individual stories of experiences and the social relations reflected in the language of their telling (Smith 1999). Participants' voices permit access to description of the discursive organization of social life, but participants do not directly articulate these arrangements. An assumptive understanding of discursively mediated social relations deeply structures consciousness, language and narrative accounts. Campbell (1998) explains that the discursive organization of social relations is ubiquitous, yet not readily apparent to its participants. It is the task of the researcher to explicate or expose assumptively concealed
social relations.

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). Observations or interviews provide entree to the organization of everyday activities, enabling analysis of social relations in which these experiences are embedded. The analysis does not endeavour to faithfully describe the subjective experiences of those who participate in discursively organized social relations. Instead, the intent is to “write back into the account of experiences the social organization that is immanent, but invisible, in them” (Campbell, 1998, p. 60). Inductive creation of theory is not the aim of this analysis. Exploration of experiential accounts with reference to the conceptual frame informs an attempt to discover the concerting of social relations within a particular instance.

The Social Relations of Ethnography

The present research sought to reveal the social relations of women’s recovery from aortocoronary bypass surgery (ACBS). It began from the central problematic suggested by Anderson (1991), Dyck (1992), Kasper (1994) and Thorne (1990): women with chronic or catastrophic illnesses experience conflict at the intersection between the social discourse of femininity and the professionalized discourse of self care. It is informed by the substantive work of many authors who studied women’s working lives and the cardiovascular health of women from feminist, sociological or techno-medical perspectives. Its assumptions and approach were structured by Smith’s conceptual frame as set out above and in the previous chapter. An obvious source of concern was my
growing awareness that these different informative sources operated from dissimilar perspectives. Furthermore, my own professional background and research training were not necessarily congruent with Smith’s philosophical approach.

Smith (1990b, 1999) cautions against naive attempts to faithfully and objectively describe social phenomena. There is a “double relation” between a researcher’s textual representation of the meanings of particular terms and the social relations embedded within the actual usage of this language in everyday life. In effect, efforts to describe the meanings of various terms and categories of experience suppress “the social relations of which they are part and which control how they mean in the setting itself (where control is a social, not individual process)” (1990b, p. 105). The activities of research and the production of textual accounts of research findings are often ideological, generalizing practices which inform professional or bureaucratic approaches to particular problems or issues found in the everyday and local. No researcher or professional occupies a neutral position:

“As professionals, academics, or social activists, we participate in the relations of ruling when we undertake certain jobs and state or community responsibilities. Understanding that helps us decide what kind of stance we can or will take on a particular occasion. Not understanding it means that we may be ‘doing ruling’ despite our intentions to work ‘on the side of the oppressed.’” (Campbell & Manicom, 1995, p. 11)

In this view, the conduct of reflexive research and professional practice requires a critical awareness of one’s own place in the relations of ruling.

Thus, researchers who espouse a ‘naturalistic’ stance or who aspire to objective description may disregard the effect of the social nature of research or the production of
knowledge. Yet the processes of qualitative research are entirely social. Participants tell their experiences within the limitations of language, conscious awareness and rapport. Accounts are subjected to the conventions of grammar and punctuation in the process of transcription. Dramatic emphasis, emotional shadings and the quality of rapport may be diluted in the transition to the printed word, and the embodied presence of interviewer and participant in a spatiotemporal context is obscured. During coding, the researcher determines which segments of the interview are entered into analysis and under which categories these segments belong. The diverse voices of the participants, along with the researcher's own knowledge (however vicarious) as a member of the social relations composing the phenomenon of interest, are distilled into a generalizing descriptive model. Published accounts of research findings cannot present all of the nuances of the setting. They are structured by conventions dictating the content of such reports and are permeated with the tacit and explicit insider's knowledge possessed by the writer. Finally, the reader actively engages with the textual description by filtering its details through another set of tacit and explicit understandings, adding and omitting information to produce yet another version of the account (Smith 1999; Stake 1994).

Within the web of activities that comprise the conduct of research and its reportage, there are, therefore, numerous points where social organization enters into description as a constraint or condition on what can be spoken, what makes sense to be described, what can be asked and what can be understood. The social organization of a setting or phenomenon determines its own description. The describer is a member of that which she describes:
“Her relation to the setting, how it becomes observable to her, the sense it makes, the ways in which terms mean and may be used are organized prior to her descriptive work. They enter into any description that she can make, for any description she can make presupposes her tacit knowledge as practitioner of the relations in which the sense of the setting arises for her.” (Smith, 1990b, p. 108)

Revealing deeply embedded, tacitly understood social relations is an alternative to naive description, yet Smith (1990b; 1999) admits that difficulties inhere within such a project. For example, she describes her research with Alison Griffith on the activities accomplished by mothers in relation to their children’s education (Smith, 1999). Despite her experience as a single mother, and her political awareness of the issues faced by single mothers in their negotiations with their children’s schools, she was initially unable to recognize the influence of normative conceptions about the family on the social relations of education and policy. The tacit understanding of this set of relations was deeply embedded in her own assumptive consciousness. Smith (1999) cautions that as expert participants in textually mediated discourse, social scientists may inadvertently contribute to or reproduce social relations to which they are opposed.

Smith (1990b) explains that the influence of the extralocal on everyday life does not easily reach the comprehension of those who experience its effects. Indeed, they may perceive the events around them as random or chaotic instead of conditioned by discursive politics. I did not find explicit references to particular extralocal influences within the narratives of women who had undergone CABS. Many of the women were instead concerned with disruptive bodily experiences and the minutiae of close interpersonal relationships. It was, as Smith predicted, easy to become absorbed in the poignant subjective interpretations of the participants, but these revealed little about the relations of
ruling. Their embodied locations facilitated a particular understanding of their experiences but rendered other aspects unclear.

Chase and Bell (1994) conclude that women will often not reveal their experiences of oppression to interviewers, or even themselves. As they point out,

"...experiencing oneself simultaneously as subject and subjected is oftentimes confusing and sometimes painful. It is not always easy for a woman to determine the boundary between her active subjectivity and her subjection. Is subjection constituted by the situation itself or by one's orientation to the situation? Can one decide not to conceive of oneself as subjected? That women experience the boundary as shifting and as something they must make decisions about is evidenced by their accounts. (p. 78)"

They suggest that women be considered the narrators, rather than the subjects of their experiences. They remind us that understanding narratives requires "interpretation of the telling itself" (1994, p. 79). A further extension of this argument directs attention to the interview interaction itself, with particular emphasis on how the researcher's interests configure the narrative. Based on the questions and implicit concerns conveyed by the researcher, respondents do the interpretive work of selecting what they presume to be appropriate anecdotes and attaching relevant meanings to these accounts.

The social relations of recovery were difficult to discern at the surfaces of the accounts, but were often embedded within the rhetorical devices of their construction. Atkinson (1992) explains that standard qualitative analysis relies on the disaggregation and fragmentation of text so that it can be regrouped under thematic headings. However another, less commonly used strategy is to examine the narrative event as a performance which may take specific forms. In particular, Atkinson describes the "medical atrocity tale" as
...a widespread type of occupational narrative in which is enshrined tales of gross incompetence, appalling consequences, and dire penalties...the atrocity story is a powerful means for the transmission and inculcation of occupational values and rhetoric. (1992, p.463)

Although the rhetorical device Atkinson refers to was observed in the context of medical rounds, and consisted of tales told by physicians about medical practice, I encountered a variation of this genre in my discussions with respondents about the treatment they received from health professionals. Many of these lay versions concentrated on the impersonal treatment of their bodies during particular events. These anecdotes highlighted their lack of control and bewilderment over professional activities. They revealed the schisms encountered at the intersection between the women’s everyday/ everynight local worlds and professional practice. Ultimately, they pointed out the relations of displacements in their descriptions of feeling “out of place”.

I was led to attend carefully to the terms the women used, noting that they hesitated over unfamiliar medical expressions but confidently invoked such words as ‘diet’ and ‘exercise’. In the former case, the women were still “learning how to mean” (Smith, 1990b, p. 109) within the context of their interactions with health professionals in hospital and clinic settings. In the latter case, the women were initially confident that they shared with health professionals an understanding of the meaning of ‘diet’ and ‘exercise’, yet they still experienced difficulties enacting the expectations associated with both (and other) categories of self care. In these instances:

The words used are essentially part of the activity which forms a phase of the social relations. The social relations are not a context for the use of the term but the use of the term, how it means there, is part of the activity forming the relation. Thus, learning how to ‘mean’ with words correctly in that setting is learning how it
is socially organized. (Smith 1990b, p. 109)

As a health professional and a homemaker, I was sure I understood the meaning of shared terms like ‘diet’ and ‘exercise’. I thought I knew how to mean with these terms in the home and in the clinical setting. Assumptive understandings about these terms, and about the more general concept of health teaching were so deeply embedded in my consciousness, that their radically problematic attributes evaded me for a time.

Smith (1990b, 1999) emphasizes the importance of attending to ideological terms, as they represent social relations within particular settings. DeVault (1990) further suggests that areas where words fail, or where speech becomes awkward and halting, may signal a disjuncture between personal experience and socially constructed explanations of events. Words may not be available to articulate women’s embodied realities, while some extraordinary experiences may indeed be unspeakable (McKeever, 1999). The simplicity and familiarity of certain terms conceals tremendous social complexity; the absence of suitable descriptors facilitates or obstructs the purposes of various participants in the relations of ruling. It is apparent that language, particularly ideological terms, serves as an analytic or linking device which connects the phenomenal world of individual consciousness and meaning to the material world of social relations. Furthermore, the materiality of embodied activity conditions individual experiences of ideological terms such as “health” or “gender”. It also reveals the imprecisions and contradictions embedded in various usages of terms such as “exercise” and “diet”.

As the foregoing discussion indicates, it was apparent from the beginning that conceptualizing the present study as an institutional ethnography bore implications for
sampling, procedures and analysis, as well as establishing the validity of the study. In the following sections I examine the question of validity and describe the research design.

Validity of the Research

Several authors have proposed standards or guidelines by which the validity or credibility of qualitative research can be judged (Bogdan & Bilken, 1992; Burns, 1989; Guba & Lincoln, 1989; Hammersley, 1992; Kirk & Miller, 1986). An issue central to these discussions is that of reflexivity, a deliberative approach to one’s own position relative to the situated understandings and social locations of participants. The reflexive character of ethnography renders it vulnerable to neo-positivist criticisms that its claims are not only subjective, but:

partisan, partial, incomplete and inextricably bound to the contexts and rationales of the researcher, contexts he or she may represent (albeit unknowingly) and the rhetorical genres through which the flawed ethnographic reports are manifested and held forth” (Altheide & Johnson, 1994, p. 487)

An important development in social science was the uncoupling of research from the production of knowledge. As Altheide and Johnson (1994) indicate, research has recently aligned with multiple other projects, including political purposes such as emancipation or liberation. Hammersley (1992) explains that the function of ethnographic social research is to represent reality, rather than to faithfully reproduce every detail. One foundational tenet of ethnography is that:

representation must always be from some point of view which makes some features of the phenomenon relevant and others irrelevant. Thus, there can be multiple, non-contradictory and valid descriptions and explanations of the same phenomenon. (Hammersley, 1992, p.51)

These situated understandings are incommensurable. One perspective cannot be ranked as
more valid than another.

This trend towards relativism within ethnography is self-refuting. If all claims to knowledge are situated, if all descriptions are relative, how does ethnography differ from any other descriptive work, including fiction? And how is the validity of ethnographic research to be judged? Hammersley (1992) goes on to identify within the philosophical underpinnings of ethnography a doctrine of realism that stands in contrast to the tradition of social constructivism. He argues that ethnographers proceed with the understanding that:

there is a reality independent of the researcher whose nature can be known and that the aim of research is to produce accounts that correspond to that reality (p. 43)

Most proposed indices of the validity or credibility of qualitative work are grounded in this ontological stance. However, as Hammersley points out, realism and relativism cannot logically coincide as a philosophical base for ethnography.

Rather than debate the merits of either extreme, Hammersley (1992) rejects dichotomy and proposes a third position: subtle realism. Altheide and Johnson (1994) argue a similar stance, which they call analytic realism. The assertions of this ontology retain some aspects of relativism and naive realism, but reject others. In this perspective, the aim of research is to investigate phenomena which are knowable and exist independently from the researcher. However, we cannot have direct access to social phenomena, nor can our interpretations entirely bracket cultural assumptions. Thus, the knowledge which is constructed about independent, knowable phenomena is a social construction, infused with assumptions and shaped by particular purposes. It follows that
the standards by which this knowledge may be judged ought to differ according to the purposes for which it has been developed (Hammersley, 1992). Building on this argument, Altheide and Johnson (1994) note that when knowledge is defined as understanding rather than "codified, theoretically integrated information, standards of validity shift" (p. 488). They further suggest that the nature of concern with ethnographic validity may shift according to the audience and purpose of the work.

For example, ethnographic accounts which provide us with descriptions of events that we cannot ourselves witness or experience are intended to furnish information about certain aspects of social life. The tenets of subtle realism indicate that we can never directly access a phenomenon, and thus can never be certain that a description is true. However, it is possible to be reasonably confident about the truthfulness of a description. Indeed, if information about a phenomenon is desired in order to shape professional or social practice, the truthfulness of claims to knowledge should be assessed (Hammersley, 1992).

Alternatively, ethnographic research may also regard accounts as phenomena in their own right which are to be understood and explained. In such instances, the truth or falsity of an account bears no relation to its interpretation. Here, the investigator deliberately disregards or suspends judgement about the validity of an account in order to comprehend its significance. As described in an earlier section, Atkinson's (1992) analysis of field data from medical rounds did not dwell on the accuracy of individual narratives, but identified the common structure and intent of a particular type of narrative: the medical atrocity tale. Similarly, the narratives related by the women who participated in
the present study served as an entry point for analysis of the social relations of health care. These anecdotes permitted exploration and understanding of the disjunctures inherent within the social relations of health care delivery.

Both purposes may be combined in the same study, although Hammersley (1992) cautions us to demonstrate that information has been validated and explanations are not distorted by cultural assumptions. The validity of ethnographic accounts is determined by the plausibility and credibility of claims made by the ethnographer (Hammersley, 1992). The reader compares claims made by the researcher to what is already known about the phenomenon to gauge plausibility. Claims must seem reasonable in view of existing literature, practice or common knowledge. Credibility is determined by the amount and quality of the evidence offered. Altheide and Johnson (1994) add that validity is established through thorough disclosure. Ethnographers ought to account fully for their investigative approaches and strategies, for the substance and limitations of their findings, and for their own reflexive presence in the work. It is important to provide evidence not only of the quality of the claimed knowledge, but of the investigation itself, because the former is inextricably grounded in the latter.

With these arguments in mind, I will describe the conduct of the research, with attention to the sampling methods, data collection procedures and analysis. The aim of this description is to provide a full account of the investigative approach so that readers are able to assess the credibility of the work.

**Research Design**

The methodological basis of the study required a design incorporating an
experiential approach to data collection which began with, but extended beyond, the standpoints of women who had undergone ACBS. It demanded an analysis which attended to the intersection between the local and extralocal, embodiment and ideology. The sampling methods, data collection procedures and analysis are described in the next portion of the chapter.

**Sampling Methods**

As opposed to random sampling procedures, theoretical or purposive sampling (Strauss & Corbin, 1990) is congruent with the aim of selecting individuals and situations where aspects of the phenomenon one wishes to consider are most likely to be present. In this instance, the intersection between women’s health needs and their responsibilities as homemakers was of interest. Hence, eighteen women who were recovering from CABS were purposively selected from the client group of the department of cardiovascular surgery at a teaching hospital in Metropolitan Toronto. A variety of women with different ages, sociocultural circumstances, and biographical backgrounds were specifically selected. Each woman was approached during the last two days of her hospital admission by a Clinical Nurse Specialist associated with the cardiovascular service. This contact read a brief summary of the proposed study and asked if the woman would be interested in hearing more or actually participating. She requested permission to release the names and phone numbers of those women who expressed interest.

A telephone call was made to each woman prior to her discharge from the hospital. Questions about the study were answered at that time, or during a hospital visit to the potential participant. Most women asked about the time commitment involved in
participation, explaining that they felt very tired and unwell following their surgery. The women were reassured that they could stop interviews at any point, or could arrange to complete each interview at more than one sitting. One woman was concerned about having her words tape recorded. Her biographical history as a holocaust survivor led to initial uncertainty about this aspect of the study. She was offered the option of having notes taken during the interview instead of audio taping and she agreed to participate on this basis. She later decided that the second interview could be tape recorded.

Twenty-five women were approached to participate in the study and five refused to have their names released to me. Three refused on the basis of feeling too unwell following the surgery to imagine themselves able to engage in the interviews. Two refused because they were not interested. Of the twenty women who agreed to participate in the study, two were rehospitalized with complications and were unavailable for the first interview. Later contact revealed that one, an elderly widow, was hospitalized for treatment of a cardiac arrhythmia. The other woman’s illness was not specified during a telephone conversation with her spouse. It is possible, given these events, that the women who ultimately participated in the study differed from those who chose not to participate or who were lost from the sample because of hospitalization. Those who chose to participate and who were not lost from the sample may have been more disposed to sharing their stories with another woman or may have felt less ill at the time of recruitment. It is possible that those who declined to participate or who were lost to the sample had poorer outcomes following surgery or felt sicker than the participants.

In addition, eleven health professionals were invited to participate in the study.
These informants were all involved in the care of women who undergo ACBS. The purpose of these audiotaped, focussed interviews was to obtain information about the activities and experiences of health professionals related to women who had ACBS. Within this group were two cardiovascular surgeons, two nurses, one dietician, one social worker, two physiotherapists, one occupational therapist, a cardiologist and a physician specializing in women’s health issues. All who were invited agreed to participate.

Data Collection

Data collection took place over a period of approximately one year between December, 1995 and November, 1996. The interviews with women was halted over a period of almost two months in January and February of 1996 because sampling was also underway for another study and it was decided that simultaneous recruitment of potential participants for two studies might create systematic sampling bias in the other study.

Interviews with women after ACBS

The study proceeded from the standpoints of 18 women who were in the process of recovery from ACBS. Interviews took place in the homes of the women at a date and time of their choosing. Each woman was interviewed twice: at four weeks and four months following discharge home from the hospital. The interviews were unstructured discussions that began with a single question from the interviewer: “I am interested in learning about your experiences following your surgery. Please begin anywhere you want and tell me anything you want.” A schedule of prompts was developed with the assistance of a nurse educator and colleague who had recently recovered from ACBS herself. This colleague agreed to a pilot interview in which she shared her experiences and insights.
From this discussion, the list of prompts was elaborated. The colleague reviewed this list and offered further suggestions (See Appendix for schedule of prompts for first and second interviews). The participants discussed their experiences as they saw fit. As each topic was raised I asked questions to encourage elaboration, adhering to the structure of the woman’s unfolding narrative. At the end of the interview, or if the participant requested it, I referred to the prompts to ensure major topics had been covered.

The timing of the initial interview coincided with features of early recovery described in the literature. Gillis (1991, 1984, 1992) describes the first six weeks following the homecoming of a person who has undergone ACBS as a time of stress and upheaval that holds different meanings for the person and his or her significant others. Although there may have been time to prepare for the home care of the recovering person, unforeseen problems and concerns may arise. Conflicts may surface over the amount of care available or the recovering person’s need for independence. Within this period also, the recovering woman is most prone to the physical discomforts and manifestations of healing (pain, fatigue, limitations in capacity for self-care), as well as emotional and social sequelae such as depression, anxiety and isolation.

The second set of interviews were concerned with issues surrounding resumption of activity. These interviews took place in the fourth month following surgery, by which time the extent of physical improvement following surgery was apparent. One of the primary influences on activity at this time is the outcome of the surgery (Allen, 1990; Penckofer, 1990). Following surgery, the relationships among the body and social life, health and illness are salient, as improvement in physical status (or lack of improvement in
some cases) alters the range of possible activities (Radley, 1988). Of concern throughout the second set of interviews was the incorporation of information from various sources into a revision of self-care activities.

One common ethnographic technique of verification used in this study was the "member check", that is, asking participants to comment on observations and themes derived from previous interviews. In addition, I engaged in "peer debriefings", or discussions with my nurse educator colleague about my continuing analysis of the data and my impressions of interviews and field observations.

After signing a consent form at the beginning of each of the two interviews, the women were asked to give their own, unstructured accounts of the events leading up to their surgery and their experiences while recovering from CABS. Each woman was asked to select a pseudonym under which her interviews would be transcribed. The narrative portion of the interviews lasted between 45 minutes and two hours. When the narrative portion of the interview was completed, the women responded to questions from the 1990 General Social Survey on Family and Friends (Statistics Canada, 1991) and the 1991 General Social Survey on Health (Statistics Canada, 1991). The questionnaire used during the first interview contained items selected to obtain demographic information and data on prior health status and social relationships. The questionnaire used during the second interview focussed on pain and activity (see Appendix for questionnaires used during first and second portions of the interviews).

The two sets of interviews with the 18 participants took nine months to complete. The first set was personally transcribed. The second set were professionally typed by a
transcriptionist who had considerable experience with qualitative interviews. These transcripts were checked carefully against the audiotape versions to detect errors.

**Key informant interviews with health professionals**

The activities and experiences of health professionals involved in the care of women after CABS were solicited during interviews with 11 health care professionals. Most of these professionals worked at the hospital where the participating women had their surgery. These interviews were informed in part by knowledge of issues uncovered during the interviews with recovering women. The primary focus was on the work and observations of the health professionals themselves (see Appendix for schedule of questions and probes). The interviews took place at times and locations that were convenient for the respondents. Two declined audio taping and direct quotation. These interviews ranged in duration from 30 to 60 minutes. They were personally transcribed.

**Analysis of Data**

Transcription of interviews proceeded in the manner described by DeVault (1990, 1991), with attention to notation of such details as long or short pauses, laughter or other emotional responses, and marking of words or phrases that were said with particular emphasis. DeVault (1990, 1991) and Kasper (1994) are particularly interested in points where respondents experience some confusion or hesitancy, not because of the emotional content of such areas, but because such moments are frequently indicative of a disjuncture between women's experience and the capacity of conventional modes of expression to convey the essence of that experience. The participants' words were not "cleaned up" or paraphrased, although less relevant passages were summarized for later reference to the
audiotape if necessary. Transcriptions were entered into NUD*IST for coding.

Collecting, coding, and initial analysis of the data were contemporaneous. While this technique bears some similarity to the grounded theory approach (Strauss & Corbin, 1990), the desired end was not a theory of a particular social phenomenon, but a detailed description of how women recover from CABS and how social relations involving women, health professionals and others are coordinated.

The term "social relations" served as an analytic device around which crystallized an account of the actual practices of individuals and the ways in which these activities were coordinated. This device directed analysis of the activities of different participants as they participated in the recovery process of women who have had CABS - the women themselves, health care professionals, family, and friends, for example - and enabled exploration of how these activities were linked and concerted at different sites and times. A concept central to the analysis of social relations in this study was that of health information or advice offered to these women. This informative practice typified the translation of scientific and professional knowledge into the everyday experiences of women, and included the manner in which the women in turn conveyed their experiences and concerns to professionals.

Kasper (1994) describes her analysis of a series of interviews with women who were dealing with the disfiguring effects of mastectomy and chemotherapy in treatment of breast cancer. Her technique was developed with reference to the tenets of institutional ethnography and served as a model for most of the analytic procedures used in the present study. Her three-part data analysis simultaneously retains intact the stories of individual
participants as well as including a systematic comparative analysis of themes among the various narratives. In the present study, as in Kasper's (1994) work, the first part of the analysis was accomplished by the respondents. During interviews the women selected and interpreted anecdotes or examples from among a large background repertoire of experience. Some thoughts or experiences were omitted from the discussion while others were expounded. Thus, as Kasper points out, the respondent is "a rightful partner in producing an analysis of the data" (1994, p.275). Each account is an individual, unique statement of experience that cannot be regarded as part of a standardized pool of responses to scheduled questions.

Kasper (1994) explains that the second part of her analytic procedure contains three steps which move from detailed examination of each participant's narrative to comparison of the accounts provided by all respondents. Accordingly, the second part of the analytic procedures for the present study began with an initial focus on the facts and meanings contained within each transcript to uncover a coherent system of meaning. This step was operationalized in a careful condensation of each participant's story. These summaries were biographical accounts which in some instances demonstrated patterns of life-long activities from which the women derived a coherent sense of selfhood. Each narrative was treated as an in-depth case study, which Sokalovsky (1996) asserts is ideal for uncovering biographical themes. A second step within the second part of the analysis was an attempt to draw linkages between anecdotes or events described by each woman and the biographical themes identified in her case. This interpretive appraisal attended to embodied activities and sensory perceptions as well as the cognitive and interpersonal
domains of experience.

The final step within the second part of the analytic process involves a search across interviews for organizing relationships, contradictions, and similarities (Hammersley & Atkinson, 1983; Kasper, 1994). Although Kasper does not make reference to coding procedures or use of computer software during this step, the NUD*IST software programme (Richards & Richards, 1991, 1993, 1994) was used during the present study to facilitate coding and retrieval of related segments of transcripted data. Initial coding decisions were informed by the research questions and general themes suggested by the analysis of individual cases. For example, review of the narratives revealed that most women presented their experiences in a chronological format that revealed a trajectory of significant events. This trajectory began with the events and activities surrounding the diagnosis of CAD. This group of experiences marked entry into the social category, “women with heart disease”. The next set of significant events occurred during hospitalization for surgery. The women provided details of a profound shift in geographical and social location that occurred at this temporal juncture. The other two points in the trajectory were the early weeks after return home following surgery and the later period after surgery, which occurred almost exclusively in the women’s homes, or in the homes of close family or friends. Accordingly, data were grouped using the four part temporal scheme suggested by this observation.

This process of coding or disaggregation of data was facilitated by the participation of my nursing colleague, who read the first five transcripts and coded them according to my preliminary scheme. We reviewed our coding of these transcripts
together. Although this might be construed as an attempt to establish "interrater reliability" in the quantitative sense, it was actually an exercise in cross referencing my own understanding of the women’s narratives with that of another woman who had experienced a similar life event. My colleague generously shared the similarities and differences between the transcribed narratives and her own recovery from ACBS, and suggested coding refinements. In particular, she alerted me to the complexities of homemaking, particularly the emotional work that the participants described doing on behalf of loved ones and themselves.

Kasper (1994) explains that the third stage of analysis in her research relates the themes developed in the first two stages to the conceptual framework guiding institutional ethnography. The three stages of analysis combined to enable movement:

from the particular and personal, through increasingly more generalized levels of meaning, and finally to an analysis of private meanings in a larger social context. (Kasper, 1994, p.277)

Kasper does not describe in detail her analytic work during the third stage. However, third stage analysis in the present study was the point where identification of ideological terms and rhetorical devices was of greatest value. In addition, interviews with health professionals informed analytic linkage of the local with institutional ways of knowing and creating knowledge.

For example, in an interview with a dietician, I sought details about the dietary information conveyed to people following ACBS. I came away from this exchange with a sense of dissatisfaction which seemed disproportionate to the wealth of description imparted by this generous informant. It occurred to me much later that this had been a
discussion between a nurse and a dietician - two colleagues who shared an ideological vocabulary that linked our different, but compatible foci of practice (Smith, 1999). We shared the impression that the term “diet” meant the same thing for us both, therefore we generalized this impression to include the population of people who had heart disease. We understood diet in terms of grams of fat, high and low density lipoproteins, amounts of fibre, and/or numbers of servings of various food groups. I later discovered that the source of my discontent was deeply buried in my own assumptive understandings, but in plain sight on my interview transcripts and in the vivid memories of many of the women’s struggles to “do” diet. I came to realize that a diet may be a textually inscribed prescription that identifies ideal types and amounts of food, or it may be a set of embodied practices and decisions that are far more complex than many health professionals acknowledge. The simplicity of the textual or virtual diet excludes the embodied experiences of taste, texture, craving, deprivation, gratification, and habituation. It ignores the biographical, social, cultural, sensual and emotional significance of particular foods, their preparation and their enjoyment.

Thus, in the final stage of data analysis, it was my task as the researcher to make connections between accumulated observations and understandings. Intersubjective understandings figured heavily in this process, as did the juxtaposes of various situated knowledge, including my own. Although as interviewer/observer I could claim to be the instrument of data collection, I could not seriously claim to be “any person, without gender, personality, or historical location, who would objectively produce the same findings as any other person” (Warren, quoted in England, 1994, p. 85). My reflexive
understanding of the social relations of women’s recoveries from ACBS shifted as the analysis progressed. Hammersley (1992) encourages researchers to suspend their own cultural, discursive or ideological filters when they want to understand why or how things work. With reference to institutional ethnography, George Smith refers to this as “materialist epoché” (Smith, 1990, p. 410). The investigator endeavours to bracket "sociological theory, political ideology, and other abstract and abstracting practices of traditional sociology so as to leave social phenomena...concretely embedded in the social organization of the everyday world" (Smith, 1990, p. 410). With reference to her own analysis of the “Standard North American Family”, Dorothy Smith (1999) readily acknowledges the obstacles to accomplishment of this epoché. Hence, my aim in subsequent chapters is to provide an open account of the data analysis that illustrates for the reader the progression from a description of private meanings to an understanding of the social relations of recovery from ACBS.

In the next section of this chapter, I provide a demographic description of the group of women who participated in this study. Selected biographical, social and economic indicators are reviewed.

The Study Participants

Table 1 summarizes the demographic information about the women who participated in the study. These 18 women ranged in age from 38 to 78 years, with a mean of 60. Five (28%) were between the ages of 36 to 50, 5 (28%) were between the ages of 51 to 65 and 8 (44%) were between the ages of 66 to 80. This distribution of ages reflects the greater prevalence of heart disease in older women. Thirteen of the women
were married or living common-law. Three were divorced and two were widows.

Table 2 lists the women’s demographic information in ascending order of income. The modal household income was between $20,000 and $39,999 per year, with 7 women reporting this level. Two of these were divorced and employed in positions which allowed sick benefits. One was a widow who had pension income in addition to a government pension. The remaining four were married and retired, but also had additional pension income. Another four women reported yearly household incomes below $20,000. This low income group reported very different demographic profiles. Emma was divorced, had no sick benefits from her job as a temporary office worker and relied on government assistance during her long convalescence. Gert was married, but her spouse’s income from vegetable farming was low. Two other women with low incomes were older, with retired spouses, and relied entirely on government pensions.

Four women had household incomes between $60,000 and $79,999. All were married; two had husbands with well paying jobs, while the other two were employed full time. Finally, two women reported incomes between $40,000 and $59,999. Ann’s husband earned most of the family income, while Cookie and her partner both worked full time at lower paying jobs. One woman refused to give financial information. Brownie was widowed and owned a two-storey, detached house in a popular middle class area.

Seven women had immigrated to Canada. Four were born in European countries, including Germany (2), the Ukraine and Holland. Two women came from the British Isles (Wales and Ireland). Another immigrated from Turkey. All but one were white; the exception was a woman of colour who came to Canada in the post World War II years as
Table 1. Demographic Summary for Participants in Study

<table>
<thead>
<tr>
<th>CASE</th>
<th>NAME</th>
<th>AGE</th>
<th>MARITAL STATUS</th>
<th>EDUCATION</th>
<th>INCOME</th>
<th>ORIGIN</th>
<th>OCCUPATIONAL HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ruth</td>
<td>56</td>
<td>Divorced</td>
<td>Grade 10</td>
<td>$20,000-39,999</td>
<td>Ireland</td>
<td>Homemaker/ full time benefits manager</td>
</tr>
<tr>
<td>2</td>
<td>Brownie</td>
<td>71</td>
<td>Widowed</td>
<td>Grade 10</td>
<td>refused</td>
<td>Canada</td>
<td>Homemaker/ part time clerical in later years</td>
</tr>
<tr>
<td>3</td>
<td>Sonia</td>
<td>70</td>
<td>Widowed</td>
<td>Grade 12</td>
<td>$20,000-39,999</td>
<td>Germany</td>
<td>Homemaker</td>
</tr>
<tr>
<td>4</td>
<td>Ann</td>
<td>58</td>
<td>Married</td>
<td>Business School</td>
<td>$40,000-59,999</td>
<td>Canada</td>
<td>Homemaker</td>
</tr>
<tr>
<td>5</td>
<td>Emma</td>
<td>60</td>
<td>Divorced</td>
<td>Com. College</td>
<td>&lt; $20,000</td>
<td>Canada</td>
<td>Homemaker / full time clerical after divorce</td>
</tr>
<tr>
<td>6</td>
<td>Cookie</td>
<td>48</td>
<td>Married</td>
<td>Grade 8</td>
<td>$40,000-59,999</td>
<td>Canada</td>
<td>Homemaker/ full time factory worker</td>
</tr>
<tr>
<td>7</td>
<td>Bany</td>
<td>78</td>
<td>Married</td>
<td>Grade 8</td>
<td>$20,000-39,999</td>
<td>Canada</td>
<td>Homemaker/ part time clerical in later years</td>
</tr>
<tr>
<td>8</td>
<td>Eva</td>
<td>75</td>
<td>Married</td>
<td>Grade 7</td>
<td>&lt; $20,000</td>
<td>Canada</td>
<td>Homemaker/ full time clerical</td>
</tr>
<tr>
<td>9</td>
<td>Samara</td>
<td>38</td>
<td>Married</td>
<td>Com. College</td>
<td>$60,000-79,999</td>
<td>Turkey</td>
<td>Homemaker/ part time translator</td>
</tr>
<tr>
<td>10</td>
<td>Luigi</td>
<td>49</td>
<td>Divorced</td>
<td>Business School</td>
<td>$20,000-39,999</td>
<td>Canada</td>
<td>Homemaker/ full time clerical after divorce</td>
</tr>
<tr>
<td>11</td>
<td>Tipp</td>
<td>67</td>
<td>Married</td>
<td>Business School</td>
<td>&lt; $20,000</td>
<td>Canada</td>
<td>Homemaker/ part time clerical in later years</td>
</tr>
<tr>
<td>12</td>
<td>Vi</td>
<td>73</td>
<td>Married</td>
<td>Grade 9</td>
<td>$20,000-39,999</td>
<td>Canada</td>
<td>Homemaker</td>
</tr>
<tr>
<td>13</td>
<td>Gert</td>
<td>58</td>
<td>Married</td>
<td>Grade 9</td>
<td>&lt; $20,000</td>
<td>Holland</td>
<td>Homemaker/ part time house cleaning</td>
</tr>
<tr>
<td>14</td>
<td>Laverne</td>
<td>44</td>
<td>Married</td>
<td>Business School</td>
<td>$60,000-79,999</td>
<td>Canada</td>
<td>Homemaker / full time service manager</td>
</tr>
<tr>
<td>15</td>
<td>Agata</td>
<td>68</td>
<td>Married</td>
<td>Grade 8</td>
<td>$20,000-39,999</td>
<td>Ukraine</td>
<td>Homemaker/ part time clerical in later years</td>
</tr>
<tr>
<td>16</td>
<td>Margaret</td>
<td>53</td>
<td>Married</td>
<td>Business School</td>
<td>$60,000-79,999</td>
<td>Canada</td>
<td>Homemaker/ co-owner family business</td>
</tr>
<tr>
<td>17</td>
<td>Olga</td>
<td>50</td>
<td>Married</td>
<td>Grade 10</td>
<td>$60,000-79,999</td>
<td>Germany</td>
<td>Homemaker</td>
</tr>
<tr>
<td>18</td>
<td>Olivia</td>
<td>71</td>
<td>Married</td>
<td>Grade 8</td>
<td>$20,000-39,999</td>
<td>Wales</td>
<td>Homemaker/ full time factory worker</td>
</tr>
</tbody>
</table>
the bride of an immigrant from the West Indies.

None of the study participants had university degrees, in comparison with the 10% of the general population of Canadian women with university education (Statistics Canada, 1995). Six (33%) had business school or some post secondary education other than community college, while 2 (11%) had community college education. The total in these two categories is 44%, compared to the 32% of the general population of Canadian women with post secondary education other than university (Statistics Canada, 1995). One woman (6%) had a high school diploma, while 5 (28%) had some secondary school education. Four (22%) of the women had no secondary school education. Only 14% of the general population of Canadian women have less than a Grade 9 education. In the general population of Canadian women, older women are more likely to have lower levels of education (Statistics Canada, 1995). In this sample, the higher proportion of older women would be expected to reflect this trend in education. For example, three of the 8 women in the age 66 to 80 age group had less than a Grade 9 education, while one of the 5 women in the age 36 to 50 age group was educated at this level. The younger woman in the less educated group might be considered a special case. She was raised in a remote area of the east coast, where disadvantages included poverty and lack of educational facilities within convenient distance from home.

All of the women had raised children and had been occupied as homemakers for most, if not all, of their adult lives. Four had not held paid employment since marriage. Six entered the paid labour force on a full time or part time basis after divorce or after their children had left home. Eight combined full or part time paid employment with
Table 2. Participants in Study Arranged in Ascending Order of Income

<table>
<thead>
<tr>
<th>CASE</th>
<th>NAME</th>
<th>AGE</th>
<th>MAR. STATUS</th>
<th>EDUCATION</th>
<th>INCOME</th>
<th>PARTNER</th>
<th>OCCUPATIONAL HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Emma</td>
<td>60</td>
<td>Divorced</td>
<td>Com. College</td>
<td>&lt; $20,000</td>
<td>N/A</td>
<td>Full time clerical after divorce</td>
</tr>
<tr>
<td>8</td>
<td>Eva</td>
<td>75</td>
<td>Married</td>
<td>Grade 7</td>
<td>&lt; $20,000</td>
<td>Retired</td>
<td>Full time clerical</td>
</tr>
<tr>
<td>11</td>
<td>Tipp</td>
<td>67</td>
<td>Married</td>
<td>Bus. School</td>
<td>&lt; $20,000</td>
<td>Retired</td>
<td>Part time clerical in later years</td>
</tr>
<tr>
<td>13</td>
<td>Gert</td>
<td>58</td>
<td>Married</td>
<td>Grade 9</td>
<td>&lt; $20,000</td>
<td>Vegetable Farmer</td>
<td>Part time house cleaning</td>
</tr>
<tr>
<td>1</td>
<td>Ruth</td>
<td>56</td>
<td>Divorced</td>
<td>Grade 10</td>
<td>$20,000-39,999</td>
<td>N/A</td>
<td>Full time benefits manager</td>
</tr>
<tr>
<td>3</td>
<td>Sonia</td>
<td>70</td>
<td>Widowed</td>
<td>Grade 12</td>
<td>$20,000-39,999</td>
<td>N/A</td>
<td>Homemaker</td>
</tr>
<tr>
<td>7</td>
<td>Bany</td>
<td>78</td>
<td>Married</td>
<td>Grade 8</td>
<td>$20,000-39,999</td>
<td>Retired</td>
<td>Part time clerical in later years</td>
</tr>
<tr>
<td>10</td>
<td>Luigi</td>
<td>49</td>
<td>Divorced</td>
<td>Bus. School</td>
<td>$20,000-39,999</td>
<td>N/A</td>
<td>Full time clerical after divorce</td>
</tr>
<tr>
<td>12</td>
<td>Vi</td>
<td>73</td>
<td>Married</td>
<td>Grade 9</td>
<td>$20,000-39,999</td>
<td>Retired</td>
<td>Homemaker</td>
</tr>
<tr>
<td>15</td>
<td>Agata</td>
<td>68</td>
<td>Married</td>
<td>Grade 8</td>
<td>$20,000-39,999</td>
<td>Retired</td>
<td>Part time clerical in later years</td>
</tr>
<tr>
<td>18</td>
<td>Olivia</td>
<td>71</td>
<td>Married</td>
<td>Grade 8</td>
<td>$20,000-39,999</td>
<td>Retired</td>
<td>Full time factory worker</td>
</tr>
<tr>
<td>4</td>
<td>Ann</td>
<td>58</td>
<td>Married</td>
<td>Bus. School</td>
<td>$40,000-59,999</td>
<td>College Professor</td>
<td>Homemaker</td>
</tr>
<tr>
<td>6</td>
<td>Cookie</td>
<td>48</td>
<td>Married</td>
<td>Grade 8</td>
<td>$40,000-59,999</td>
<td>Labourer</td>
<td>Full time factory worker</td>
</tr>
<tr>
<td>9</td>
<td>Samara</td>
<td>38</td>
<td>Married</td>
<td>Com. College</td>
<td>$60,000-79,999</td>
<td>Business Manager</td>
<td>Part time translator</td>
</tr>
<tr>
<td>14</td>
<td>Laverne</td>
<td>44</td>
<td>Married</td>
<td>Bus. School</td>
<td>$60,000-79,999</td>
<td>Car Mechanic</td>
<td>Full time service manager</td>
</tr>
<tr>
<td>16</td>
<td>Margaret</td>
<td>53</td>
<td>Married</td>
<td>Bus. School</td>
<td>$60,000-79,999</td>
<td>Co-owner Business</td>
<td>Co-owner family business</td>
</tr>
<tr>
<td>17</td>
<td>Olga</td>
<td>50</td>
<td>Married</td>
<td>Grade 10</td>
<td>$60,000-79,999</td>
<td>Machine Mechanic</td>
<td>Homemaker</td>
</tr>
<tr>
<td>2</td>
<td>Brownie</td>
<td>71</td>
<td>Widowed</td>
<td>Grade 10</td>
<td>refused</td>
<td>N/A</td>
<td>Part time clerical in later years</td>
</tr>
</tbody>
</table>
homemaking work throughout motherhood. Eight of the women were or had been engaged in clerical work of various descriptions, including store sales representatives and office or secretarial work. Two occupied full time management positions and one worked at a family business which she owned with her husband. Three were employed in jobs requiring physical labour, including factory work or house cleaning.

Several of the women had other health problems besides heart disease. Three (17%) had diabetes. This is a higher incidence than the 4% seen in the total population of Canadian women, but is reflective of the increased risk of heart disease seen in diabetics (Statistics Canada, 1995). For example, Samara, the youngest woman in the group of participants, was diagnosed with Type I diabetes as a child. Seven (39%) of the women had arthritis, which is also a higher incidence than the 25% seen in the total population of Canadian women (Statistics Canada, 1995). This may be reflective of the preponderance of older women in the group, but it is also noteworthy that those with certain forms of arthritis demonstrate a higher incidence of heart disorders than the general population.

Seven (39%) of the women reported having been told that they had elevated blood cholesterol levels. This is much higher than the 8% seen in the general population of Canadian women (Statistics Canada, 1995), but is to be expected in a group of women with coronary artery disease. Indeed, even more of the participants could have had elevated serum cholesterol levels, as three did not know if they had this health problem or not, and had never been told by their physicians what their serum cholesterol levels were.

**The Institutional Setting**

Although study settings customarily consist of a particular geographic location,
this investigation concentrates on the multiple sites of the health care system where the women received care and treatment. Institutions are complexes of relations which are organized around distinctive functions. Institutions represent the intersection and coordination of more than one relational mode. These extensive and complex divisions of labour are interlaced by the common currency of discourse which facilitates the coordination of the activities of workers of diverse backgrounds and in different sites (Smith, 1990a, 1999). For example, the diagnosis, "heart disease" serves as a orientating category which activates sequences of diagnostic and therapeutic tasks with remarkable similarity throughout physicians' offices, diagnostic laboratories and hospitals across the province. These sequences are inscribed in the text. They appear in medical, nursing, physical therapy and nutrition science textbooks, journal articles and hospital documents known as critical pathways, which set out expected courses of events for particular diagnostic categories.

Thus, an institution may be comprised of nodes of interconnected professional activities at multiple sites. All of the women who participated in this investigation were admitted to the same hospital for their surgery. This was the only institutional site which all held in common, for each was referred to one of the hospital's cardiovascular surgeons after consultation with different general practitioners, cardiologists or other specialists. The hospital was affiliated with a university and was an educational facility for various levels of students in the health professions. It maintained strong research programmes in a variety of specialty areas. It was also about to undergo a "re-engineering" process which would result in major changes to its cardiovascular programme. This process was
intended to align and coordinate professional care with greater efficiency and cost effectiveness.

The women had been admitted to one of two nursing units which specialized in cardiovascular surgery. They were usually admitted the night prior to the surgery, unless they were admitted on an emergency basis. Most of the necessary laboratory tests were done during a visit shortly before the surgery was to take place. During this visit, or on the evening prior to the surgery, patients were given an opportunity to view a teaching video, which gave information about the surgery and what might be expected afterwards. After surgery, patients spent a period of about one day in a special intensive care area where they were carefully monitored. They were then transferred back to the nursing unit, where they remained until they were discharged home about five days after their surgery. This trajectory represented the usual course of events, although in some cases there were complications or problems which necessitated a longer admission. Prior to going home, there were opportunities to attend a number of educational seminars which dealt with general self care at home, exercise and activity recommendations, desirable dietary patterns and family issues.

The length of admission for ACBS had been reduced considerably for fiscal reasons in the years prior to this investigation. Thus, one site of care for the women who participated in this study was the home. Indeed, in recent years, the Canadian home has become the locale of services for acute and chronic health care (McKeever, 1996: 1994). However, not all persons who go home soon after surgery receive or require home care services. After surgery, many people return home to be cared for by family or friends if
they do not need to receive professional monitoring or care. Before discharge to their homes, these patients or their close others receive instruction in the essentials of their care. As I will explain in succeeding chapters, this instruction is the discourse which unites and coordinates the activities which occur among professionals in the hospital with those which are carried out in the home. It is the basis for congruence between professional health care and self care.

However, the home is not only a site of health care or self care. It is the hub of a variety of activities which are in part organized by a gendered division of labour. The work that is carried out in the home is constitutive of health, for it ensures that inhabitants will be sheltered, fed, rested, clean, clothed and provided with care. It assures that the activities of inhabitants will be coordinated with those of workers in other settings: schools, workplaces, financial institutions and the health care system, for example. As I have explained earlier, much of this labour in the home is done by women. Thus, it is not always certain that women will find the home a place of rest and recuperation following surgery. Although this investigation concerns itself with women’s experiences in other sites of health care, it is especially attentive to the disjunctures inherent within the notions of health care and self care for women in the home.

Summary

The 18 participants described in this chapter represented various age, class, socioeconomic and ethnic backgrounds. Nevertheless, all shared the common experience of having aortocoronary artery bypass surgery. All had extensive contact with professionals at various locations in the health care system. Each of the women returned
home after hospitalization for surgery and had different experiences of family care and self care. In the next four chapters, I discuss these embodied social experiences. Each chapter begins with a comparison of two case studies which illustrate some differences and similarities seen during the analysis of the women’s narratives. I then proceed to describe the participants’ experiences in relation to the research questions, pointing out differences and similarities. This portion of the discussion corresponds to the second stage findings of data analysis, although elements of the third stage are woven into this section. Finally, I discuss linkages between the women’s personal experiences with extralocal social structures to enlarge on the third stage of analysis.
CHAPTER FIVE

NAMING THE PROBLEM

Participants began their narratives with descriptions of their discovery of a problem. This predicament was initially apparent, not as a confrontation with social or individuated meaning, but as a crisis arising from their sensuous experience of their bodies. Awareness of the problem was sometimes gradual and occurred over months or even years as physical symptoms such as shortness of breath and pain slowly began to limit participation in formerly taken-for-granted routines of activity. In other cases, the onset of heart disease was more sudden, so that the women could actually recall the precise day and time when they first experienced severe symptoms. Some women suffered myocardial infarctions that were unheralded by perceptible “warning signs”, hence were catapulted into a search for a new understanding of themselves and their biographies. For all women, changes occurred in many facets of their lives, from the type and intensity of physical activity, to relationships with others, including conceptualization of themselves and their bodies. But it was a problem which began and persisted in the concrete, sensuous world of their active female bodies.

Diagnosis and development of treatment plans were dialogic sequences of action that were initiated by medical consultation. In seeking to decipher problematic physical changes, the women entered into extraordinary interactions with physicians which led to construction of a world in common, mediated by a unique lexicon (Smith, 1999). During diagnostic studies, the women were made aware of damage to their hearts and heard
statements about their prognoses and treatment options. Although the medical language of cardiovascular care was derived from a scientific world view that reduced and universalized particular aspects of embodiment, individual women confronted the particularized spatiotemporal implications of illness in their sensory and active experiences of their bodies. The women made choices and preparations based on the future possibilities they derived from medical prognostications and their biographical understandings of themselves.

Diagnosis named for the women and their physicians the nature of the problem and raised the possibility of remedial action. Emerging from diagnostic categories were vast implications for activity and responsibility. The women had a chronic, potentially life threatening illness - one which transformed the views of others about them and their own perceptions of themselves. Diagnosis was a process of abstracting or separating certain relevant signs and symptoms of disease from the women as embodied actors. The women’s personal biographical identities were exchanged for “case” identities or diagnostic categories. Their particular bodily experiences were worked up according to techno-medical discursive practices which allowed these experiences to be known in common among the women and their physicians as “heart disease”. Coordinating this common knowledge was a discourse which highlighted particular treatment procedures and recommended risk modification behaviours.

The women encountered conflicts associated with competing priorities. They were deeply engaged in an embodied world of heart disease that served as the everyday
counterpart to the codified diagnostic category elaborated in medical discourse. Among the major physical cues associated with heart disease were apparent limitations to activity imposed by angina pain and shortness of breath. Others did not always notice or perceive these physical changes, but those with direct involvement in the women's usual patterns of activity were affected. These others were engaged with the women in interdependent webs of social relations; changes in the women's activities produced tugging and straining at the weave of each network. Not all women were immediately at liberty to relinquish taxing chores or responsibilities, nor were all women interested in doing so. The problem named "heart disease" held many complexities.

Case Studies

Before I review themes related to this period in the participants' trajectories of illness, treatment and recovery, I briefly illustrate the changes involved by recounting the stories of two women whose experiences of joining the social category, "woman with heart disease" differed markedly. One woman, Olga, repeatedly had consulted her family doctor for a period of almost two years to learn why she was fatigued and suffering chest pains, only to suffer an MI while on vacation. The other, Laverne, was diagnosed more quickly. Marked differences existed between these two women despite similarities of age and economic status.

Olga was an immigrant from Germany, with limited education and little employment experience in Canada. She confessed embarrassment to me about her heavily accented English, and explained that it made her shy when dealing with professionals.
This revelation surprised me, because despite her accent, Olga had an excellent vocabulary and a sophisticated understanding of the English language. Laverne was Canadian born, possessed a community college diploma in business administration and had worked for many years as a national service manager of a large health care equipment supply company. She described a very positive professional and personal history of relationships with health professionals.

**Olga**

My interviews with Olga were among the longest: three hours and two and a half hours respectively. She was a natural story-teller, with an expressive face and a flair for dramatic, detailed description of events. She lived in a casually furnished two story home with her husband and a son of 22. The tape of the interview was punctuated by sounds from a large tropical bird that was kept in the living room; a dog dozed at Olga’s feet during the first interview.

Olga was 50. She had diabetes, which was managed by adherence to a diabetic diet and use of oral hypoglycemic medications. She complained that it took some time for her family doctor to take her symptoms seriously enough to investigate and diagnose her diabetes. Olga admitted that she was overweight, but she found it difficult to reduce. She had smoked cigarettes since she was 15, but quit on learning that she had heart disease when she was 49. Her father died of heart disease at 52, and had suffered from angina for many years before that.

She had come to Canada from her native Germany in her early twenties. She was married at eighteen and had her first child when she was 19. She had an equivalent of a grade ten education. In both interviews, Olga confided that she longed for employment outside her home, but she could not write in English and had found this was a powerful barrier to obtaining the type of work she wanted. She had managed to get a part time job at a department store several years prior to the interview, but did not enjoy stocking shelves and tidying merchandise, so she quit. The work resembled housework, which she hoped to escape. When she was a teenager, she had wanted to work as a photographic laboratory technician, but had been persuaded by her mother to become an office worker. After marriage she worked as a housewife, although she found housework boring and unfulfilling. She enjoyed photography as a hobby, and some of her beautiful photographs of flowers and nature hung throughout the house.

The family income was between $60,000 and $80,000 annually, but her husband worked very long hours to generate this amount, and he had little energy to help with homemaking during the evening hours. Olga’s son did not help out either...indeed, she
complained that he tended to increase her workload with his untidy habits. Only her youngest daughter assisted with housework, but she was a university student in residence in another city.

Olga learned that she had heart disease while on holiday in Cuba. One morning she awoke with chest pains and shortness of breath which did not subside when she went outside for fresh air. She attributed the problem to smoking too much, and worried that she had some kind of lung problem. She had experienced progressive tiredness, chest pain and shortness of breath before the holiday, but after an electrocardiogram and Holter monitoring her family doctor could find no problem. He also suggested that she was bored and needed to get a job to divert her attention. The symptoms she experienced in Cuba were worse than before, so she had her husband contact the hotel nurse. A taxi was called to take her to a local hospital. Olga's story includes an animated description of her wild ride to the hospital, the primitive conditions she encountered in the local hospital, and her bewilderment on attempting to decipher the communications of her Spanish-speaking doctor. Luckily her husband was born and raised in South America, so he could translate, although his dialect and that of the Cuban hospital workers differed. The doctor immediately gave her nitroglycerine and Olga was surprised at how quickly her chest pain was relieved by medication.

Immediately on her return to Canada, Olga consulted her family doctor:
“"The first thing when I handed him the letter they gave me there and the electrocardiogram thing, the first thing he said, "Oh, those doctors are so stupid."" She was upset by this judgement, pointing out that the Cubans were poor, but not stupid. Emboldened by indignation, as well as the gravity with which the Cuban doctors had regarded her condition, she insisted that she be referred to a cardiologist. According to Olga, this was a pivotal event, because the cardiologist she saw investigated her complaints and booked her for a stress test, which brought on angina pain within two minutes. A later angiogram showed that she had coronary artery disease severe enough to require either angioplasty or surgery. An attempt at angioplasty was unsuccessful, so Olga finally underwent ACB twelve days later.

While she waited for her surgery, Olga remained responsible for her customary homemaking duties.

“"Well I still... eh, yes I was told to take it easy but I'm a sort of a tough cookie, it's very hard to put me really down, you know...But I kept on doing that all, ah, I didn't quit with my walking and before it, before the surgery...I had to do--I used my [nitroglycerine] spray a lot. Walking and yes, the worst I found was vacuum cleaning.”

Her biographical understanding of herself as a “tough cookie” guided her efforts to resist the debilitating effects of heart disease.

The news that she had heart disease was upsetting and she still marvels at the barriers she encountered in obtaining a diagnosis.

“"It's--like I said, it all was so sudden and so overwhelming and... until now I sometimes sit here and I say I can't believe all this, you know. Especially because
at least two years before Cuba, I had these... symptoms. And there was one particular time, that was a year and a half ago in November in the fall, I was halfway in the forest when I had an attack and I started to cry there, I said to my husband I can't walk any more. And I said, I don't know what's going on, and it was the first really fresh cold day, and I thought it was my lungs that were giving me trouble and I said to him, I said, "I guess the cold air is hurting my lungs". And I walked so slowly out of there, I don't know how long it took me, I couldn't walk fast. I had to walk really slowly. And he wanted to bring me to the hospital, the Emergency, and I said to him, you must be kidding, you know. (Laughing) I said, no way, you go home. And by the time I walked out of the forest and he brought--I stopped right walking where it was a point that he could bring the car down. They have gates so you cannot go in with the car. And I was better after a while again, you know. But that was--and that is what I told my doctor. I told him that. He did an electrocardiogram, looked at it, I don't know... Because he looked at it and he says, "Ah, nothing wrong, nothing wrong". Of course every time I'm on that machine there's nothing wrong, even the ones in Cuba, there was nothing showing really. Then he would also say stop smoking. Yeah, I must say that every time I saw him he told me that.

Her own disbelief and fear of a serious problem, indicated by her rejection of her husband's offer to take her to the hospital in the incident above, interacted with her family doctor's skepticism to further delay identification of the problem underlying her symptoms.

Laverne

Laverne, too, enjoyed telling a story and often laughed about the absurdities of her encounters with heart disease. She lived in a large, attractively decorated two-storey home in a small city about a 40 minute commute from her workplace. Her 20 year old daughter and 23 year old son lived with her and her husband. Throughout both interviews, her son roamed from the garage to the basement as he worked on an older model car with a friend. Two dogs cavorted in the backyard and kitchen.

Throughout her 44 years, Laverne had enjoyed good health. She noted that her tendency to overweight and her smoking had likely contributed to her heart disease, and she was struggling to revise her dietary habits. She joked about her fondness for fast food in both interviews. Laverne described a particularly strong family history of heart disease: her father had died of an MI at age 42, and her brother had a fatal MI in his early fifties. Her job was stressful, because her management position made her responsible for ensuring speedy repairs for her company's equipment; she explained that clients resented loss of income if repairs took too long. Laverne was also accustomed to frequent travel to branch offices all over Canada, because she did some training of new employees. She liked to relax at the family cottage on weekends and summer holidays, but described a hectic pace on weekdays.
The family income was between $60,000 and $80,000 annually. Her husband was a mechanic, and worked occasional evening shifts. He usually “helped out” with some aspects of housework, but Laverne and her daughter did the bulk of the homemaking chores. Laverne was strictly instructed to drastically reduce her activities before surgery because two of her coronary arteries were severely obstructed. She had taken sick leave from her job. Her husband was informed that Laverne could have a serious MI at any time and he took complete responsibility for the housework with the help of their daughter. She noted that her son had never participated in housework and this did not change.

Six months prior to our first interview, Laverne noticed that she was sweating and short of breath while raking leaves with her husband. She immediately consulted her family doctor, who tested her for thyroid disease. When the results were negative, Laverne thought no more of the incident and it was not repeated until three months later. At that time she was visiting her company’s Ottawa branch office and, after a day of meetings and dining out, she had her first and only episode of angina.

“And, ah, when I got back, it took about 45 minutes for me to settle down. Like my chest was just pulling in here and I was like shaking all over and I was sweating and I thought I had indigestion, to be quite honest with you; and I know this is the most common of what people think. It never dawned on me what it was about. I just thought maybe I’d eaten--because I’d eaten Chinese food in the--at lunch time with everybody else and then J. and E. had given me, ahm, actually she was very good because she knew I was trying to diet at the same time as being there, right (chuckles), and she had made like Weight Watchers' dinner chicken with vegetables and no skin and the whole bit, so it...... Now I know it couldn't be supper because it was too nice a dinner. But that's exactly what I thought it was. But it took about 45 minutes. I finally got in the tub and had a nice, ah, soak in the tub, everything seemed to go away.”

She consulted a relative who was prone to indigestion to compare experiences, and was puzzled when the relative insisted Laverne did not have bodily symptoms that were consistent with indigestion that evening.

Another troubling problem was that she had noticed changes in her mood and patterns of dealing with co-workers. Not only were her bodily responses unrecognizable - she was no longer acting like “herself”. After several instances of unusual shortness of breath, Laverne consulted her family physician again. Her doctor immediately arranged for stress testing and an appointment with a cardiologist. Eight weeks after her first episode of chest pain in Ottawa, Laverne had her ACB surgery.

“And, ah, so I really have the doctors to thank, ahm, especially L. who is the cardiologist and Dr. R. for pushing it through. Because if they hadn't have done it so quickly, who knows? We might not be here. (laughs) And we like to be here (laughs).”

Laverne’s biographical experience with health professionals led her to choose a
family physician who was affiliated with a major teaching hospital in Toronto. She thought highly of his teaching position and felt this was evidence of his skill as a diagnostician. Most importantly, she appreciated his concern with her as a person, and believed that he seriously considered her reports of sweating, shortness of breath and mood changes. She mused that he could easily have interpreted these signs as indicative of menopause or overwork. In contrast, Olga was repeatedly told she was bored and needed the diversion of a job. She felt her communications with her doctor were interpreted in light of her lack of education and her accented English. She doubted his diagnostic skills, asking me during the interview if a family doctor could accurately read an electrocardiogram or if a cardiologist was better prepared for this task. She worried that he missed important information in her previous tests, thus delaying her diagnosis, and believed that the biggest breakthrough in her efforts to be correctly diagnosed was her eventual referral to a cardiologist with a new practice and current training. She changed to a new family physician after her surgery, because management of her diabetes had become a problem and she wanted a doctor who responded to her concerns.

Both women had family histories of fatal heart disease, and both puzzled over bodily changes for some time before diagnosis taught them to read these sensations as heart disease. The language they used to describe these altered sensations from their hearts and bodies was phrased in active terms: chests were “pulled” and hearts were “attacked”. They were no longer in harmonious or habitual co-existence with their bodies. Their hearts were besieged by illness and the women described themselves as vulnerable
or endangered. Olga struggled to remain a “tough cookie” while Laverne confronted her mortality as she insisted she liked “to be here”. In addition, Olga endured an intermediate phase where she was taught to believe that her bodily messages were either “nothing” or signs of emotional imbalance.

Entering the category “woman with heart disease” led both women to a new understanding of themselves, their bodies and their health, yet their families’ responses to this transition differed considerably. Olga’s family did not relieve her of homemaking responsibility at any point. Although her husband exhibited concern about her symptoms and at times helped her gain access to medical attention, the socioeconomic pressures of his position as sole breadwinner were used to justify his lack of participation in household chores. Olga described him as concerned, but unable to help because of physical exhaustion.

Laverne, on the other hand, was able to take sick leave from her paid employment and her unpaid work as a homemaker. Her (highly respected) family physician warned her spouse that Laverne could suffer a fatal MI at any time. It is possible that the dramatic impact of her medically sanctioned removal from the labour force further underscored the gravity of the situation. Her earnings comprised at least half of the family income but she did not mention this loss of income as she explained her spouse’s unprecedented acceptance of all homemaking responsibilities. Instead, she described him as deeply afraid that she would suffer harm. Interestingly, no such indications of spousal anxiety were apparent in Olga’s story.
These themes appeared in the other women’s descriptions of their entry into the category “woman with heart disease”. I begin the general discussion with accounts of how the women conceptualized themselves before, during and after diagnosis. Then I discuss their major activities during this phase of illness and how these activities informed their understandings of their identities. I then describe their interactions with others beginning with a section on their interactions with health professionals and concluding with a section dealing with their interactions with close others.

**Speaking Spaciotemporal Interruptions of the Self**

A unique feature of every interview was the manner in which each woman described a biographical pattern of selfhood which contrasted with the more recent self with heart disease. Each woman used a summary of her valued life experiences as a point of reference when assessing the impact of heart disease on her understandings of herself. Although the details of each biography differed according to social and material conditions, major thematic similarities were apparent. Closely affiliated with biographical descriptions were observations about embodied selfhood under conditions of illness. The women described ways that discursively organized activities of homemaking and caring informed their understanding of themselves and how heart disease interrupted and altered these patterns. The realization that there was indeed a problem flowed from these temporospatial comparisons.

**The Self in Biographical Terms**

In their narrative examples, the women described their life histories in terms of
their care of others or work on behalf of others. Their thoughts about their identities flowed from these accounts. Their lives were orchestrated around the needs of others and, in some cases, the additional demands and benefits presented by paid employment. During periods of personal upheaval, some women described a pattern of “enduring” or carrying on through difficult times of intensified labour. This pattern often reflected a disregard for personal development or health needs because of the overwhelming demands contained within the immediate situation.

Most described themselves as self-reliant, active, and involved in the care of their families and social network members; they were emphatically caregivers, not receivers of care. These identities were part of the lifelong pattern of work and responsibility for the physical and social wellbeing of others. They were prominent actors in the lives of others, and were entrusted with the concrete, mundane details of care that promoted the optimal functioning of the family and social network. In these ways, they contributed to the micro economy of everyday life. Brownie, for example, ensured that her husband’s health and very survival were protected. Olivia took care of her husband following surgery to correct a joint deformity related to arthritis:

“...And he was subject to reactions, there was an uncontrolled - I think they called him a brittle diabetic. And he had bad reactions. It was really common for me to feel him jerking in bed at night. You know, I’d wake up and he was unconscious. And I’d have to get up and get sugar cubes and force them in his mouth and speak really loudly to him to make him chew them so that I could get through to him. Because there was no way that I could force any liquid in his mouth, because he’d choke.” (BROWNIE 1248-1265)

***

“And when he was sick, I, well I had to look after him. Because he couldn’t get out of bed.” (OLIVIA 516-519)
Several women raised siblings or children of other family members when death or ill health tragically interrupted family integrity.

“So I was ten one day, and the next morning I was twenty. I had to grow up very, very fast. And, um, I guess it stems back to that point where I had to be, I had to raise my younger sister.” (EMMA 1092-1098)

“So I ended up looking after my two sisters because my Dad was working and there was nobody else to do it. We had no other relatives or anything handy. I just stayed off school and I looked after the two of them because you see. my youngest sister was nine years younger than me and it made a big difference between the ages.” (VI 298-304)

***

“And I raised my niece and she was like a twin to my younger son because there was only eight months between them, and people used to say if I got anything for him I always got something for her, you know, and I used--I had a big pram, I used to put one on each end and wheel them. (chuckles) and that... yeah.” (VI 554-559)

Other narrative examples illustrated the ways that some women provided a structure of continuity and stability so others could attend freely to the demands of their lives.

“I had so much to do because I raised my own family, then one of my daughters had a dreadful experience with a husband. And she came back with one baby and she was pregnant with a second. So we had them there, and my husband had a stroke a few years down the road from the heart attack. And I’m telling you, I had to go out and get myself a job, and go out and work as well as trying to look after all this.” (EVA 967-974)

***

“I was always healthy, always very active and everything. People were sick, I used to go and clean their houses and look after them and now I (laughs)...” (GERT 1285-1289)

The above descriptions were often made with a matter-of-fact tone that obscured the nature of the work and the resultant personal implications. Brownie, the woman with the diabetic husband, did not mention the knowledge and vigilance required to take care of her spouse, nor did she remark on the debilitating interruptions of her sleep. The women
who raised younger siblings said little about the impact of these arrangements on their own childhood needs for play and study time, although one said that her schooling had been interrupted; they said even less about the accelerated process of acquiring knowledge related to nurturing and homemaking. The personal costs were treated in the narratives as if they were assumed and unremarkable.

The anecdotes themselves illustrated the women’s understandings of themselves as active and reliable participants in an informal web or network of helping relations. They illustrated the issues and concerns that compose a world in common for women as they explain their lives to another woman. There was a pride of accomplishment associated with these recollections that underscores the centrality of women’s unique local knowledge and skills to construction of a gendered identity. The anecdotes suggested that the ability to physically enact certain concrete knowledge and skills to further the wellbeing of others conditions a woman’s situated identity or subject position.

Crisis and everyday concerns were met with an emotional response that was characteristic of each woman. Responsibility for the emotional wellbeing of others was a major theme. Comportment during difficult times was also a facet of each woman’s gendered identity. Patterns of concealing their own feelings from others and reassuring others were described. Strength lay in orchestrating smooth interactions and minimizing conflict or negative feelings. Like Olga, women like Brownie and Emma prized the facade of the “tough cookie”:

“I guess, I don’t know, I’ve never been a person to be really down about anything really. And I think my daughter-in-law was more upset about, ah, when we went
to, when we had the interview with [the cardiovascular surgeon], she was quite upset about it. More so than I. And I said: Well, if it's something I have to have done, I have to have it done. You know?” (BROWNE 564-578)

***

“And you know I’m the type of person who will, if something’s bothering me, I’ll be smiling rather than crying about it. And they didn’t know how much things were bothering me. And, because you have to be, like, dealing with the public you have to be, ahm, you know...happy go lucky, and you could be madder than hell at somebody and um, well, you just didn’t show it.” (EMMA 957-970)

Laverne explained that her sudden inability to maintain a cheery outlook for her co-workers was a powerful indicator of ill health:

“And plus, since Christmas I got bitchy and depressed and I don’t usually get depressed; and I’m not bitchy in my department. I have seven people who work for me and I’m sure that they would all attest to the fact that I’m usually the one who’s up in the department. If anybody is bitchy it’s usually them...Like I knew I was bitchy but I didn’t know I was bitchy with my department, and I would cry at the drop of a hat...But I don’t usually cry for no reason. And I said: something has to be wrong because I don’t feel right.” (LAVERNE 114-153)

For another participant, the manifestation of strength in adversity was not only important for the wellbeing of others; the ability to remain calm was reassuring to herself:

“Of course, you are so, you stay so strong, you know. I was so. you know. strong. I was doing things [babysitting for daughter] and so maybe I forgot about myself sometimes.” (AGATA 163-167)

The women’s life stories were often punctuated with references to recent major changes and with allusions to “heartbreaks” and revisions of self. These stories were couched in an idiom of emotionality that marked another dimension of the heart. Of the eighteen participants, two were recently widowed, three were divorced, and three others had forged new common law or marital partnerships. These women described biographical unfoldings that featured financial struggle, reconfigured positionings in their
social networks, and tales of imposed self-reliance. Heart disease was only one facet of their understandings of themselves and their hearts. Hearts could be attacked by forces other than ill health. Emma explained the upheaval of divorce:

"It was very difficult for me when the separation first came because I had not worked for many years, and I did not know what this big world was. We had our own circle of friends, um, belonged to a lot of different clubs that were the same people of course. And it took me five years to adjust to going out there. The type of work I did before I was married, or even two years after I married, no longer existed. Computers were the big thing." (EMMA 1293-1309)

Many of these biographies involved enactment of selfhood. The women were what they did. They were caregivers, nurturers, and hard workers in paid or unpaid activities. Their bodies were inseparable from these identities, and indeed, were integral to the physical activities that constructed identity. The early signs of heart disease were noted as cause for concern when they interrupted activity. New understandings of their bodies, and hence, themselves, evolved from these interruptions.

**The Embodied Self in Problematic Terms**

The women’s descriptions of embodied experiences of illness provided a stark contrast to their life histories as active, able participants in local social relations. The recognition of a physical health problem was prompted by the gradual loss of capacity to participate in various activities. Interestingly, it was the loss of the ability to walk without physical discomfort that brought the most consternation. The women described feelings of shortness of breath and chest pain that accompanied physical activity, but it was the resultant cessation of activity which indicated an intrusion on their everyday routines. The loss of mobility meant the loss of the vigorous self, and it meant the decline of a social
pattern of mobility with and for others. In virtually all of the interviews, intensification of this problem appeared as a prominent marker signalling serious illness.

“Well, it was just getting harder and harder and harder. I was finding myself, I was stopping on the street, and I was out, short of breath. And then coming home, I’d be getting on a bus instead of walking home. this sort of thing. And then I was out west, visiting my cousin and I had some other friends out there. And she’s a great walker and she wanted to go for a walk. And I kept saying: I have to stop. I can’t walk.” (BROWNIE 644-659)

***

“So I told him, it doesn’t get any better, that [pain] there for so many days and I can’t walk.” SONIA 161-162)

***

“So I went to the school, I could BARELY walk to the office from the parking lot. I was just leaning up against the...I knew there was something DRASTICALLY wrong.” (LUIGI 383-386)

***

“And I’d have to sit down, and I’d sit down for a few minutes. it would go away and then I would walk again. But I didn’t walk very far and it would start again. So I knew something was wrong...” (TIP 445-450)

The significance of interruption in routines of activity is seen in the women’s descriptions of themselves and their lives as heart disease progressed. They lost their identities as active contributors and instead became slow moving inhabitants of a shadow world where the simple enjoyment of children or grandchildren, attention to the home, and participation in paid employment were curtailed. For some, these losses were presented as the rationale for seeking medical attention and for consenting to diagnostic studies or surgical intervention. There was a temporal discontinuity which intruded upon the assumptive routines of the everyday. Ann longed to do “ordinary things” again, while Emma mourned the loss of her “Speedy Gonzalez” persona. Gert hoped for the return of her formerly vigorous enjoyment of time with her grandchildren.
"So I was looking to become well. You know? INT: Yeah. By "well" what do you mean - how would you define that? ANN: Well to become active again in the home things, the things that I do in the home. And the things that I do outside, like help out in the church, things like that. Also playing with my grandchildren. Things like that, ordinary things that I love doing. I was always restricted because I'd get pain.” (ANN 291-311)

***

"I had to totally change my whole... I went from Speedy Gonzalez to walk slow.” (EMMA 35-37)

***

"Oh! I was so... A year ago I spoke to my daughter. It was the 24th of May and we -- the park in [town] had fireworks, and I thought: How can I ever walk up to the park? And I (whispering) I could never make it, that’s how bad I was then. I was so afraid; I never told them, see, that I had the problem. But she gives me the dickens, she says: You should have told us! She’d say: Take the kids to the park, and I used to make an excuse: Not really today. But it will all come back. Because you need -- I was really active before with them all the time. As soon as they were babies they were here, you know. Because they like being here (chuckles).” (GERT 1248-1261)

Medical consultation brought a second transformation. While the first change was located in the women’s capacity to endure the rigours of everyday tasks and responsibilities, the second change lay in the new perspective on their bodies. As “women with heart disease”, the women learned a dispassionate, fragmented medical discourse, as evidenced in the way they discussed their own body systems as separate objects, and explained the flaws in their hearts and coronary arteries. The bodies which had nurtured, worked and played became the possessors of problematic, even dying parts. The self fragmentation which began with the identification of symptoms such as shortness of breath, tiredness, or angina, was extended and refined with the availability of a causal explanation. Women like Ann referred to “the” heart or “the” arteries, or distanced them
further using the term “it” to refer to what were clearly perceived as defective objects
within them:

“Of course, it was still healing from the heart attack. The heart had healed a
bit...not the part that had died with the heart attack, that of course doesn’t come
back...but the blood vessels had started to form in the heart.” (ANN 105-115)

***

“Three of the veins were totally plugged. And the different tests I had to have,
sometimes they don’t...they’re sitting kind of still and they’re not functioning. But
they could still possibly be alive.” (EMMA 416-422)

***

“The doctor said I couldn’t have lasted very much longer. I had every artery filled
up in the top of my heart.” (BAMY 96-98)

***

“The arteries weren’t working at all, and there was a diagram on the sheet they
gave me. Two of them weren’t working. They didn’t say they were plugged.
One of them was half plugged. So they said there was two of the original four that
had been done were absolutely working perfectly. But there were two, the lower
right ventricle wasn’t getting any blood, so it was trying to make a bypass on it’s
own.” (EVA 647-653)

***

“What happened it wasn’t my heart that acted up, it was the arteries going into --
taking the blood into the heart that got plugged up. And that’s what had
happened.” (TIP 163-166)

The discourse of distancing and fragmentation informed a stance of outright
rejection when the women described their initial reaction to the news that they had
sustained a myocardial infarction or had heart disease. Several participants received their
diagnoses with disbelief, surprise and dismay, with some even citing their former
convictions that heart disease did not affect women. Others believed they were too young, or that their health habits were too meticulous for heart disease to be possible. In some cases, even physicians responded with amazement.

"You know, I know it's a man's disease. More men have this heart problem than women." (BROWNIE 689-692)

***

"I was aware this was ninety nine percent a man's problem. You hear, on TV or the paper, you'd maybe scan through the paper and say: 'Oh, gee, yeah, heart disease is becoming number one'. But to actually say I was totally aware of it, well, I may have heard it, but it went in one ear and out the other. And when I had my heart attack, my only reaction was: 'I've had a heart attack? Oh, COME ON!' That was my reaction." EMMA 2412-2425

***

"I couldn't believe it...I said: It couldn't be me, my husband should be having it! Because he was the one who was eating a lot. I was saying to him: 'Oh, you're gonna have a heart attack, you eat too much'. You know? And he was using the butter. I don't. And he was always eating, he never stops eating. And I was always saying: 'You're gonna have a heart attack, you're gonna have a heart attack!' And I was the one who had it!" (SAMARA 132-136)

***

"I don't know of anybody else in the family, either aunts or uncles or anything else that had any problems. I couldn't believe it, that's what I kept saying. I didn't eat fat, I didn't eat a lotta bakery or pastry or anything like that and I'd eat just strictly my meals and I wasn't one for junk food, so I said I don't know what could happen. But the arteries got plugged, what could have plugged them I don't really know." (VI 330-338)

***

"I've not had any troubles before. I had no high blood pressure, no high cholesterol, nothing. I mean I smoked, that's about the only thing I had going against me, plus I'm only 44 years old! And ah, so the doctor says, he says: 'I can't believe this!' But it's very genetic. (LAVERNE 204-214)

In these responses, the women obliquely suggested a moral element embedded within the
discourse associated with heart health. Many took refuge in their convictions that the
disease had hereditary origins and vigorously rejected inferences that they had indulged in
personal habits that placed them at risk.

The women described a process of retrospectively integrating their new
understanding of their bodies into previously unexplained or misattributed symptoms or
experiences. They described themselves as having previously gone about their daily
routines unaware of the serious threat to their health. Some said that they participated in
exertions that they might not have tried had they known of their heart disease. Others
realized that they had not been attending or “listening” to their physical sensations: they
either ignored telltale signs or attributed them to other causes. Diagnosis established a
new world of possibilities. The women described reassessments of the significance of
physical symptoms.

“And I think that’s what a lot of the problem was, because before my angina was
diagnosed, I may have had pains, but because I’m so used to having pains with my
arthritis, I may not have recognized ah, warning signs, you know.” (ANN 695-707)

***

“I had to be very active [in job as property manager], but my whole life, I’d be a
goer. And so therefore, when I had my heart attack, which they think I had
possibly several before I had the biggie, which I didn’t even know. Because I
didn’t even know that I had the heart attack.” (EMMA 42-53)

***

“I get angry, and something came over on my chest. Not so painful, so I ignore
it.” (SAMARA 103-104)

***

“I remember walking over from here in December, going over for Christmas
shopping. And I felt this AWFUL PAIN! I couldn't breathe but it was WAY up here, like right across here [pointing]. And I thought it was anxiety, stress, uh...panic, because my son was having a great deal of trouble with his relationship, and you know Christmas was always so important and it was very difficult for me...So you know I got over there and I sat down at the first bench. I breathed and got quieted down and then off I went. I proceeded on. And it HAPPENED several times, MANY MANY times, and I did not equate it with my heart. Because first of all I had never had angina, it wasn't around my heart, and it wasn't my arm, it was up here. It was in my breathing, it was in my...actually I thought I had asthma or something. I thought there was something, you know. I did NOT equate with my heart.” (LUIGI 325-348)

The sensual realm was attended to with a new, sometimes frightening, intensity. They learned to tell angina pains from benign pains, and to respond appropriately with medication or rest. Self care was marked by a medicalized consciousness.

“And I was saying to the doctor, I remember that very clearly, that I have sharp—that I had pain still, but he asked me are they sharp, dull or what, you know. And I said they were sharp. And he said then I didn’t have to worry about it. It wasn’t the heart then, sharp pains.” (OLGA 620-624)

Olga’s doctor taught her the difference between heart related pain and pain that did not signal angina. The need to make this distinction suggests the presence of danger or risk and this presence was noticeable in the statements made by the women. Ann’s concern that the constant pain associated with her arthritis may have led her to miss “warning signs” exemplifies these references. Cookie described her nights of worry over every twinge of pain - waiting for a heart “attack”. The presence of her nitroglycerine provided some security in this time of fearful waiting for treatment.

“And every bit of pain when you lay down, when you first go to bed, you think: What if it’s a heart attack? I had the nitro right beside the bed. Wherever I walked, I had the nitro.” (COOKIE 130-133)

***
"But then, I didn't know how dangerously I was." (BAMY 96)

The recognition of a distinct physical problem initiated the quest for a solution. Some women were treated conservatively at the outset with medications, dietary changes and instructions to exercise by walking. Yet the side effects of medications led two women to describe themselves as “zombies”: beings who were neither truly alive nor actually dead. Their time was spent in somnolence, fear and discomfort, in stark contrast with their past lives. A point was described in each narrative where physical incapacity became extreme, the sense of endangerment too intense to bear. Desperate measures were called for.

“I was just like a zombie. I couldn’t pass that chesterfield. I was laying down all the time.” (BROWNIE 746-749)

***

“I was on a lot of medication which was, you know I was. I felt, going around like a zombie. I was not in control of my own life, really. And I thought: I don’t want this. This isn’t what I want the rest of my life.” (ANN 82-89)

***

“And pills, the doctor gave me some pills and I couldn’t take them before the surgery because they gave me such a headache. Oh, this was the worst headache, I never...I cried, I couldn’t do nothing. Oh it was terrible. I’d be sitting on the couch with the blankets over me in case I fell asleep, I could go to sleep. I’d sleep for a half hour and then wake up with this headache.” (COOKIE 136-147)

***

“I know those pills make me weak, I always thought that.” (BAMY 299-300)

***

“I said: Listen, do I have a heart problem or don’t I? I said: I can’t be going on
like this, this is the fourth time since December I’ve been in the hospital. I said: Now something, surely you can do something!” (OLIVE 102-106)

***

“I was getting to the point where I could barely cross the road without having to bring out the nitro, so I knew it [the surgery] had to be done.” (EVA 660-662)

The idea of surgical intervention introduced the concept of bodily repair or reconstruction to the situation. This notion, in combination with fragmentation and distancing from the physical self led to some descriptions that featured confrontations with mortality and profoundly mechanistic imagery.

“[The surgeon said] you’ve got four blocked arteries. I can fix two of them for sure, the third one I will try, but I don’t think I can do anything for the fourth one.” (BROWNIE 1042-1047)

***

“I’d gone for an angiogram and the doctor for the angiogram said it was about 70 and 30, you know. Wait a couple of years and then maybe go back and have another angiogram. So then I went back to the cardiologist and he did another test. Then he wanted to send me to have a surgical opinion and I went and had a surgical opinion. [The surgeon] said to me: ‘This is just my opinion - that you are 90 and 80 percent blocked and you could drop at any time, you know.’” (MARGARET 16-25)

The blunt pronouncement made by Margaret’s surgeon offers a glimpse of an intersection where warnings are conveyed and solutions are offered by expert others as “opinions” and choices. Given the implications of this shared reality, it is small wonder that women like Eva would find comfort in imagining themselves as easily repaired machines:

“The human body is like an old truck. This part wears out and that part wears out, and you get it replaced today, or you get it fixed up as best you can. So last time when I came out, the kids said: ‘Well here you are again mom!’ And I said: ‘Yup, all I need now is a face lift and a new paint job [chuckles]’” (EVA 982-987)
It was evident that, as they entered the diagnostic category, "women with heart
disease", participants were oriented by the discourse surrounding this category as they
reconstructed embodied understandings of themselves. Ill health insinuated itself into each
woman’s consciousness when the usual round of activity was interrupted. Leder (1990)
reminds us that the body is at its most invisible when it is functioning well, but in illness
we “experience the body as the very absence of a desired or ordinary state, and as a force
that stands opposed to the self” (p.4). The visceral body is concealed from view. It
functions beyond conscious control and emits ambiguous sensory messages, because the
viscera possess fewer sensory receptors than the surface body and minimal motor
responses. Paradoxically, while the surface body projects outward in intentional activity
and sensory experience, the visceral body recedes from consciousness. In healthy activity
we are free of the body but in pain and physical limitation, corporeality becomes an
oppositional moment.

Negative sensory experiences originating from the viscera form unwelcome and
distressing intrusions. Anginal pain and dyspnea, for example, were described by the
women as ominous “warning signs”. Through interaction with their physicians, the
women began to appropriate a discursive understanding of themselves as in danger or at
risk. The lay term, “heart attack” suggests an injury to the heart and the self by
frighteningly hostile forces. Refuge from this fearful situation was offered by the
discursive underpinnings of medical care. The problem was named and described with
such precision that the women were able to describe arterial obstructions in comfortably
distanced terms. Something could be done - in fact, many possible solutions were associated with the diagnosis "heart disease".

The everyday face of the diagnostic category, "heart disease" was one of sensory distress and devitalization. Diprose (1994) notes that sexed identity is produced through the incorporation of social discourses and practices. Smith (1990b), argues that these discourses and practices position women as different from or other than men. Women's bodies form the corporeal ground where physical distinctions and patterns of activity are recognized as distinctly feminine. Recognition is the inseparable counterpart of identity: West and Zimmerman (1987) note that gendered identity is bound with a compelling accountability to others and to self for the enactment of gender-appropriate behaviour. Hence, Diprose's (1994) insistence that we are our bodies. Distance from a dysfunctioning body could hardly protect the self if selfhood is forged in activity. When participants complained that they had become zombies who were captives of devitalized bodies, they identified themselves as occupants of a marginalized state. Emma lamented a loss of mobility when she demoted herself from "Speedy Gonzalez" to "walk slow". There was evidence of distancing from aspects of the physical self, especially the diseased heart, but there was also evidence of identity altered in undesirable ways. These new embodied versions of selfhood were unrecognizable in comparison with biographical precedents.

Finally, identification as a "woman with heart disease" was legitimized through medical consultation. It was not a matter of establishing an individuated consciousness,
but was accomplished through interaction with health professionals, and following sequences of activity that elicited the information required for diagnosis. As the different experiences related by Olga and Laverne indicate, widely disparate interactions were noted with health professionals. Yet these differences merely represented variation in the ways that women were entered into a realm of activity that was coordinated by a techno-medical discourse.

**Engagement with the Health Care System: Seeking Diagnosis**

Concern about the disturbing symptoms they experienced prompted most of the women consult their family physicians. In more urgent cases, emergency services were required. These contacts marked engagement with the system of health care that formed the institutional context of this ethnography. The discursively coordinated activities initiated on contact began with identification of the pathophysiological basis of symptoms. Diagnosis is the identification of particular individuals using a universal conceptual label that allows health professionals from a variety of disciplines to plan and coordinate their interventions on behalf of the affected person and in relation to one another (Smith, 1991).

In the activities of diagnostic testing, presenting physical symptoms serve as initial cues to investigation of various possibilities. But women's presenting symptoms may differ from the standard profile developed using the male standard, thus their experiences have been discursively regarded as "atypical" or obscure (Jadin & Margolis, 1998; Wenger, 1998). Because women do not expect to be diagnosed as having heart disease, they may present their symptoms to their physicians in a manner that fits an anticipated diagnosis of breast
cancer, for example. Cookie did not associate her years of cigarette smoking with a risk of heart disease and feared that lung cancer was the cause of her profound shortness of breath.

"It felt like my chest was filling up. I couldn't walk. Especially walking up a grade or something. And I thought: 'Oh, it's my lungs.' Because I smoked and maybe something's happened already. So I came back and went to see the doctor." (COOKIE 15-18)

Similarly, Ann associated her shoulder pain with the chronic aching she had endured for years with arthritis.

Additional considerations that entered into consideration during diagnosis included age, gender, and biographical information. Some women were indignant to find that peripheral considerations contributed to premature (and erroneous) closure of the diagnostic or treatment process. Some experienced simultaneous social identification which contrasted with their biographical understandings of themselves. One older woman found that after a cursory examination, a cardiologist was convinced her symptoms were benign; he suggested that she was malingering.

"And he asked the usual questions, you know, and um, then he checks my heart, you know those things he sticks in his ears, he tested my heart that way, there was no cardiograph. And he says: 'Brownie, do you baby yourself?' Well, I just said: 'No, I don't. I looked after a sick husband for a good many years'. And I said: 'I did a lot of things around the house that were his jobs, really'. He would have done them if he'd been well. But I said: 'I don't think I can be accused of babying myself at all'. And, um, so I don't know, I've never gone back to him again. Never." (BROWNIE 777-798)

In later contacts with other physicians, she worried about further negative labelling.

"And then I went to a dietician at [hospital] after I had this so-called heart attack, or whatever. [chuckles] He even had me doubting that I had one, you know, and
maybe that's why I didn't push my doctor harder because I thought: Well, I don't want to be a complainer. You know, you, it sort of took away my...I don't know what it did to me. It made me think, well maybe I'm complaining and I haven't got anything wrong with me.” (BROWNIE 1293-1307)

Brownie had made an observation based on her sensuous experience and had consulted a physician to learn the cause. The cardiologist’s response led her to doubt the validity of her own reading of her body.

Others encountered similar prejudgments based on social labels such as age, weight and nationality. These labels were based on noticeable physical characteristics such as ageing, body size or accented speech.

“So that time, or the next time, he shook hands with me, and I came home to Frank and I said: You know, I think that doctor thinks I’m going to die. Because a doctor never shook hands with me and said goodbye to me, never, any doctor never did. And I said: You could tell it was because he's sure he isn't going to see me again. And I know what was in his head. Sure enough, he never bothered trying to get me down, he said I was too old to get operated on...and that was that, and he never bothered.” (BAMY 177-183)

***

“The arm, it was always painful. And I would start to have the back pain. When I was lying down it hurt a lot. But the doctor said: You are getting heavier. heavier, that’s the problem. [chuckles] So my thought was my weight, that’s why. But almost a year it was like that.” (SAMARA 88-90)

***

“Instead of finding out why I was complaining, he told me to find a job. And so 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 about thinking of my father. That always worried me. That might be something there with the heart. So--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 185-200)
For these women there were repeated contacts with physicians who did not correctly interpret symptoms until myocardial infarction occurred. Tip, an older woman, was told her shortness of breath was caused by asthma, and she was medicated with bronchodilators for over a year without noticeable improvement. Olga suffered an MI while on holiday in Cuba, but was told by her general practitioner that the diagnosis was probably incorrect because medical practice in Cuba was not as advanced as in North America. In recounting these histories, the women expressed disappointment and anger: they did not feel that their trusted physicians had listened to and interpreted their situations clearly. They were not safe from the terrible dangers associated with ill health if they could not rely on their doctors to remain vigilant on their behalf.

In marked contrast, other women described contacts with physicians who kept them and their embodied selves at the centre of the dialogue. The meanings of the most subtle of symptoms and situations were understood and acknowledged with accuracy. These women were, like Laverne and Luigi, often younger, articulate and assertive. Their physicians received the information they offered and considered it with reference to the conceptual categories of medical discourse, but remained aware of the significance these complaints held for the women as embodied persons.

“Anyway, when I went to the doctor’s and I broke into tears he says: “Well there’s got to be something wrong because you don’t cry.” And I don’t. I mean like I cry at home, you know, I mean sad times, happy times, whatever. But I don’t usually cry for no reason. And I said: ‘Something has to be wrong because I don’t feel right’.” (LAVERNE 145-153)
"...and I went and made an appointment with him and I told him that I was having palpitations, you know, and he immediately made an appointment at the hospital and I went and had that, uh, thing that you had to wear, um...INT: A Holter monitor? LUIGI: Yeah, a Holter monitor for...I mean he didn't pooh-pooh it or he didn't say: 'Oh well, it's that time of the month.'" (LUIGI 513-521)

Luigi subsequently suffered an acute myocardial infarction, and soon afterwards her marriage dissolved. She feared that her emotional distress would have detrimental effects on her heart so she contacted her cardiologist.

"He immediately took me in - well you can't get an appointment for him, you make an appointment 6 months in advance. He immediately took me in, he must have seen me 3 times. Just to check my HEART [chuckle] you know, he was very good. He was extremely solicitous and uh, you know he gave me a stress test, anything that would relieve the stress, that part...I was having trouble dealing emotionally without WORRYING [about further heart problems]" (LUIGI 535-545)

My discussions with three male physician informants (one cardiologist and two cardiovascular surgeons) touched on the issue of gender bias in the diagnosis and treatment of cardiovascular disease. Two informants denied that gender bias existed locally, basing their statements on the results of Canadian studies such as Ugnat & Naylor (1993) and Mickelborough (1994).

"The American literature suggests there's a major bias. That's totally incorrect in Canada. There is none. As a matter of fact, we go out of our way, at least I know I do, and here we do more with women than men. So if anything we're discriminating against men. We'll investigate women much farther than we will men because it's harder to diagnose it. So we actually go farther. So in Canada, I think it's backwards. It's probably a negative discrimination." (Cardiologist)

The above comment indicates an increasing aggressiveness towards diagnosing heart disease in women and implicitly positions women as "other than" men with this disease.

Recent articles such as Jadin and Margolis (1998) and Thomas and Braus (1998) point out
the differences between male and female patterns of risk factors, presenting symptoms, diagnostic test results and trajectories of heart disease. It is harder to diagnose heart disease in women because they exhibit different patterns from the already established category, "men with heart disease", which has already been well ensconced in putatively gender neutral textual descriptions in medical books.

Interestingly, arguing from a physiological focus, one surgeon explained that there were no major physical differences between men and women when cardiovascular surgery was in progress. However, the second surgeon explained that he was aware of systemic gender biases that permeated all social relations at all levels. Informed by gender issues within the medical profession, personal experience and by popular authors like Tannen (1990), who analyse gendered communication patterns, he pointed out that it would be difficult to deny that relationships among physicians and patients were influenced by gender. Thus, while his two colleagues argued that current informed practice was to investigate women's symptoms more aggressively and that surgical outcomes for women were steadily improving, he suggested that women and their physicians regularly enacted relations of dominance, no matter what the patterns and outcomes of treatment. He illustrated his comments by noting that in Ontario, male family physicians were more likely than females to report difficulties attracting and retaining patients:

"Women are more nurturing than men are. What's happening in this community where there is a supersaturation of family physicians is that the women coming into practice have no problem getting patients. Obviously ... one of the messages I take to the profession, and I gave a presentation this morning, it was the first time I saw in the audience, it was almost fifty-fifty. And I said: There are a lot of young women here...is there anybody who doesn't have a full practice? Couple of the..."
men put up their hands, and they were older. And I said: Well, gentlemen, I think you’d better sit down with your female colleagues and ask what it is they’re doing that you’re not doing. Because there’s the message everywhere in society out there that people are looking for women as physicians because they care more, apparently. Now they may not, but they are more nurturing. They are prepared to take more time. So when you talk about the numbers of physicians and the ratios in society, these don’t take into account that nowadays, forty percent of the graduating classes are female. And that they will take more time and that they are going to practice differently and they’re not going to bill as much and they’re not going to work as many hours during their childbearing years. And if you’re only looking at the numbers, you can make some terrible mistakes in planning what you’re going to need ten years from now.” (Cardiovascular Surgeon #2)

Embedded within this statement, aside from a clear recognition of the value of women’s caring attributes, are elements of a discourse of femininity. Women are expected to be more nurturing and to take more time with their patients; female physicians enact their gendered identity in a form of medical practice that contains elements of social homemaking.

Each physician took up the term “gender” in our discussions as it was relevant to particular activities. For two, the question of gender bias was a diagnostic and treatment issue. A textually mediated debate was in progress about the existence of diagnostic practices that placed women with heart disease at a disadvantage. One explained that surgical technique could improve outcomes for women and Canadian studies had demonstrated this point. Another noted that the textual existence of a debate about gender bias had led to some changes in diagnostic approaches to women with signs of heart disease. The third was active in professional organizations and applied the term to his interest in the implications of the increasing numbers of women in medicine. The concept of gender could be activated with reference to many facets: treatment of the sexed
physiological body, social inequality, demographics of medical human resources or approaches to caring for patients.

Thus, three issues arose from discussion with the study participants and professional informants. First, there were instances of mistaken diagnosis and incorrect management that appeared to stem from the textually entrenched differences between men’s and women’s presenting symptoms of heart disease. As Luigi suggested, some symptoms might be attributed to menstrual irregularities or menopause as easily as heart disease. To further compound the problem, many women do not expect to have heart disease and may omit mention of some symptoms to their physicians because they do not seem relevant to the diagnoses that they do expect. Lay persons have access to media reports and self help literature that present common signs of heart disease, but signs of breast cancer are equally accessible. As Cookie points out, women may consult their physicians with a diagnosis already in mind and they may omit mention of symptoms which do not conform to this expected diagnosis.

A second issue emerges in the gendered and hierarchical social relations accompanying medical consultation. Some participants, like Brownie and Olga, changed doctors because they felt they had been socially mistreated as well as misdiagnosed. Although Brownie had established a biographical identity based on hard work and extensive family caregiving, her cardiologist implied that she was a malingerer, who “babied” herself. Olga was advised to get a job so she would not focus on her physical symptoms; she was identified as a “bored housewife”. Both women were unrecognized.
That is, their established identities were erased and replaced by alternative versions in the medical consultation. These alternate identities were (mis)informed by interpretations of obvious characteristics or distinctions: gender, age, and markers of cultural, education and class difference. Waitzkin (1989) describes the brief nature of the medical consultation, which necessitates rapid assembly of available physical cues and personal information. Social biases may skew the interpretation of these indicators in a time-pressured context.

In addition, women's physical maladies are sometimes dismissed and psychologised. Goudsmit (1994) cites reports from newspapers and medical literature where women have been misrecognized as hysterics or malingerers despite the presence of classic signs of physical disease.

Thirdly, the idiom of medical practice is the function and pathophysiology of the human body. Hence, one cardiovascular surgeon was able to assert that there were no differences between men and women in the operative theatre, because the structure and function of the heart is the same for men and women. The idiom of medical science precludes recognition of social determinants of illness or contextual barriers to self-care; these are defined as beyond the scope of practice. In a curious sense, the sensuous, active body is erased within this discourse although its parts and functions are cast in sharp relief.

Furthermore, the social negotiation of gender proceeds during the medical encounter within the boundaries of the medical lexicon (West, 1993). Under the guise of scientific neutrality, diagnosis proceeds as an orderly analytic process. "Bias" is a dreaded contaminant of scientific reasoning, but its existence can be measured and refuted through
a textual process of (presumably unbiased) epidemiologic study (Mickelborough, 1994; Ugnat & Naylor, 1993).

All of these issues interact forcefully to elaborate the analysis of Laverne and Olga's different experiences. Laverne displayed markers of a particular class location (education, experience with health professionals, and Anglo-Canadian background) that provided her with advantages in the medical encounter. But most remarkably, her personal profile mimicked that of the male "classic case" for CAD: middle age, stressful management career, high cholesterol diet because of business travel, and an assertive, time pressured manner that suggested Type A behaviour pattern. By contrast, Olga was, in her own words, a "housewife", a member of a marginalized, unpaid occupational group whose labours are invisible. Her male physician assumed she was bored, never acknowledging her biographical identity as an unacknowledged and poorly supported worker. As the antithesis of the male "classic case", she waited far longer than Laverne did for definitive diagnosis and treatment.

Engagement with the health care system was described at times as frightening and dehumanizing. Relationships with other health professionals at this early stage were seen as supportive and affirming if the women's social identities were preserved. Humour was often the vehicle that dispelled tensions and fears during moments of pain and uncertainty; it also conveyed deeper messages of acceptance and recognition of the social person. Humour softened the effect of an intense focus on the woman's diagnostic status and acknowledged the woman herself. In situations of extraordinary intrusion, it preserved a
semblance of the everyday.

"And um, the nurses said: We want you to take your clothes off. Well of course I was kind of...slow. And they literally RIPPED my clothes off and I thought: what the HECK'S goin' on here? So anyway, they were just running. Had all these machines on me. And this on doctor comes in and he's you know, looks me over and, I guess he was just a GP or an intern or something. And next thing we know, this other man comes in. So I could see him...and I'm lying there laughing and joking with these nurses, and...and I had basically just thrown on a track suit. And I had this flowered brassiere, and the nurse picks it up and goes: WOW nice underwear! [chuckles]. And we were kidding back and forth." (EMMA 201-225)

***

"So he called the paramedics back again and they came. And of course it happened to be that they were the same ones that had come the weekend before. So he said jokingly, he said: 'You know, Vi, we gotta stop meeting like this; we can't meet like this every weekend'. You know, just making conversation. So I said: 'Well I'll see, I'll try not to let it happen again.'" (VI 38-44)

Interestingly, this humour preserved gendered identity. Emma was unceremoniously stripped of her clothing in a context of emergency care, yet her feminine choice of a flowered brassiere was duly noted and praised. Vi's male paramedic implicitly recognized her femininity by invoking a time-honoured flirtatious cliche. These social pleasantries illustrate how deeply the negotiation of gendered identity permeates everyday exchanges: gendered identity is imperceptibly recognized and reinforced in the social idiom of small talk and humour as it is within the scientific idiom and context of the medical encounter. It may be regarded as intensely reassuring to be acknowledged as a recognizably feminine person in situations where all other forms of recognition are in jeopardy.

Once the women left the familiar locations of home, job and family to enter into negotiations with health professionals, they entered a new geographical and social location
that was organized to facilitate professional practice. Privacy was lost in favour of
effecting rapid turnover rates in diagnostic testing and treatment. The women became part
of a growing queue or group of individuals who required attention.

"And I think there was about - let’s see, one, two, three - six of us in the same
room all having the same procedure. And then that night - you have to rest for
quite some time [after angiogram], you know with that weight where they went in
through your groin, they have to keep it on there for the pressure. And the doctor
came in. And he went to this one woman and he says: Well, we’ll try - and you
could hear it was right in an open room, you could hear what he was saying - I
heard him tell her that she could have balloon angioplasty. And then he went to
this man next to her, and I couldn’t hear what he said to him. But then he came to
me and he said: I’m afraid you’re going to have to have surgery. And then he told
that to the man that was in the next bed to me too. He said: ‘You’re slated for
surgery, too.’” (BROWNIE 829-865)

Furthermore, during diagnostic procedures, hitherto invisible aspects of the blood and
internal organs were made visible to the medical gaze through technological intervention.
Some women found themselves excluded from open discussions about their physical
selves, while others described being “worked on” or “hooked up”. On occasion, the
women knew from the expressions or behaviours of those around them that significant
observations and decisions were being made, however the women themselves were
excluded from these events. Erasure of their sensuous bodily experience was
accomplished within this discursive context.

“And I thought it was really neat when they were both working on me ‘cause there
was a cardiologist and a training doctor, and ah, it was like they were using a joy
stick.” (LAVERNE 290-294)

***

“So he looks at me and he looks up at the monitor and I can’t see it because it’s
behind me. And he’d gotten me hooked up to everything.” (EMMA 230-235)
"And that [scanning] machine comes around your face really (chuckles) close and I said: PLEASE try and ... and so they were being very careful. But it only went around once or twice and all of a sudden he shut everything down, he just SHUT it all down. And it was done, and I was out. So I knew there was a problem. He called in another doctor to see and I knew there was a problem because I wasn’t in there 5 minutes.” (LUIGI 429-437)

These anecdotes also highlight aspects of the social positionings of the women and health professionals in relation to one another. As the participants gradually became aware of the precarious nature of their own physical health they placed their trust in health care professionals to assist them in prolonging survival and improving their ability to function. The degree of expertise possessed by the professionals they encountered was acknowledged and highly respected by the women. Physicians possessed not only the ability to name problems but the knowledge and skill required to plan and effect solutions. The significance of these activities becomes clear in the desperation reflected in Olivia’s entreaty to her doctor:

“I said: ‘Listen, do I have a heart problem or don’t I?’ I said: ‘I can’t be going on like this, this is the fourth time since December I’ve been in the hospital.’ I said: ‘Now something, surely you can do something!’” (OLIVIA 102-106)

The indignation reflected in Olga’s or Tip’s anecdotes about misdiagnosis was perhaps an indication of their intense disappointment on being unable to learn from their doctors the name of the problem which produced their inconveniencing and frightening symptoms. As Olivia suggests, solutions are forthcoming only after a problem is positively identified.

The faith placed in these professionals gave them liberty to propose prescriptions for behaviour and activity modification in terms that might prove unacceptable from other
sources. Women wryly described being upbraided by physicians; often the humour that accompanied these anecdotes indicated acceptance of the admonishments and the privileged social position held by doctors.

"He says: 'You're not going ANY where!' So I looked at him and I said: 'But I HAVE to!' (chuckles) And I was giving him almost like, shit: 'I've got to get out of here! My boss is waiting.' And I says to him: 'I've got four floors to do, I've got thirty-three apartments.' He says: 'You hold it right now.' He says: 'You've had a heart attack.'" (EMMA 235-247)

***

"So he came in to me and I said: Were you phoning 911? He said: Yes. And I could see he was very angry. So I said: What for? He said: What the hell is wrong with you, Olive? I said: Why? He said: You know you had a heart attack?" (OLIVE 41-47)

The evident frustration of the women's physicians in these reported exchanges arose from the women's apparent lack of recognition of their own peril. Olivia endured 24 hours of chest pain thinking she had nothing more than severe indigestion before finally seeing her family doctor, while Emma was doggedly bound to the stressful work activities which she later came to believe contributed to her heart disease.

On engagement with the health care system the women entered into a discursively coordinated sequence of activities which were bewilderingly fraught with inconsistency. The women and their physicians approached these sequences with varying levels of understanding of what actually constituted the symptoms, what could be the underlying problem, what courses of action would assist in determining the name of the problem and how the problem could be remedied once it was identified. Given these possible discrepancies, it is remarkable that diagnosis was readily achieved with reasonable
certainty in any of the cases. Engagement with the health care system marked a transition into a world in which previously concealed aspects of the women's bodies were made visible, were abstracted and recorded using diagnostic tests and were compared to universalised diagnostic signs which sometimes were more reflective of men's experiences with heart disease. Their everyday, sensuous field of knowledge about their bodies was excluded from this world as a more objectified language and vision of their bodies prevailed. Yet diagnosis also brought comfort and reassurance; once named, the problem could be challenged and possibly resolved. The extraordinary limitations and discomforts could at last be attributed to something.

**Living the Problem in the Everyday**

With the onset of physical symptoms, many of the mundane tasks of everyday life became more difficult for participants to pursue. Few women took the step of entirely relinquishing responsibility for their homes and for others. The availability of a diagnosis often did little to alter daily rounds. Although diagnosis provided a pathophysiological explanation for the problems encountered in pursuing particular patterns of activity, there remained on the other hand the concrete need to ensure these activities were attended to. As noted earlier, the tasks of homemaking and sustaining others were also self-reproducing. Ironically, the women were struggling with the need to maintain their identities through familiar patterns even as they encountered these activities as potentially threatening to physical comfort and wellbeing.
Household Chores

Despite chest pain and shortness of breath, household tasks were completed as usual by most of the women. Three of the older women were accustomed to paying “cleaning ladies” to do heavier tasks like vacuuming, washing floors and cleaning windows. Two of these were widows who lived in two storey houses, and one lived in a small apartment but had mobility limitations due to arthritis. Remarkably, in the other cases, family members did little to help out unless specifically asked to do certain tasks or unless performing chores they usually took responsibility for. Some women described their housework activities immediately prior to surgery in a manner that reflects considerable time and effort:

“I’d have to...if I get up and I...sort of dusted upstairs, got dressed and dusted upstairs, I’d have to stop and sit down several times before I could go on. If I vacuumed upstairs, I did a room and then I had to stop and sit down because my chest would start to hurt me. And same with down here. If I dusted I’d have to stop every...so often and sit down.” (TIP 613-625)

***

“I...I managed somehow, and until the day--day before I went for the surgery I was washing tons of clothes and I help myself with the [nitroglycerine] spray a lot, you know.” (OLGA 735-738)

Gert prepared the house for her own absence and homecoming after surgery so that there would be less work to be done by her men, who as men, were not expected to cook:

“I cooked and left it in the freezer for the men because they’re not, you know, they’re not cooks, and I already did some of the spring cleaning if I could. My son did the walls anyhow. I helped him out with that a little bit, but I didn’t do much, you know, just some. I couldn’t do that much because I was heavily on the spray, on the nitro spray.” (GERT 187-201)
Ruth reduced the effort of shopping by making multiple small trips over the course of the week rather than enduring one larger expedition. This increased the amount of time she spent shopping, however:

"I did go out every day, because I’m on the main road. And I didn’t shop a big shopping. I just went every day." (RUTH 1107-1115)

Household chores were increasingly difficult for the women to accomplish as they waited for treatment. Some persisted by using nitroglycerine spray. They continued on after medicating themselves, rather than withdrawing from the activities that produced angina pains.

**Emotional Labour**

All of the women acknowledged the emotional impact the prospect of surgery had on their wellbeing and that of their family members. Fear and anticipation of the surgical intervention ahead preoccupied the participants at this point. Many worried about the possible outcomes, and worked to avoid upsetting others. Sometimes the topic was acknowledged by family and close others but carefully understated.

"INT: What about your family members? How did you approach their concern?
BROWNIE: Well, they didn’t say too much to me about it, you know, but I knew they were concerned because they were calling me all the time, you know. And ah, more than usual. Yeah. INT: What sorts of things did you say to them?
BROWNIE: Not very much because they avoided talking too, really, about it. It’s just that , you know, if I needed anything to be sure to let them know."
(BROWNIE 607-621)

***

"There were a lot of tears...and sitting there thinking: What am I going to do? And you end up crying . And you don’t feel like telling anybody you’re crying, what you’re thinking and...because he’s very hyper himself, so." (COOKIE 179-182)
"I think I truly believe because of my childhood I’m a SURVIVOR... and my big, my BIG concern was my family. I didn’t want to put any onus on them, umm I wanted to relieve them of any pressures. like I really tried HARD to: I’m okay, everything is okay, and let’s get on with our lives." (LUIGI 266-271)

The youngest respondent had school age children, and her worst fears for their emotional security were realized in the following anecdote:

“But the only thing, the big one worried when I had the heart attack. He says: Something’s gonna happen, the family’s gonna broke [break up]. (chuckles) That’s what he told his friends: ‘My mom’s gonna die or something’s gonna happen. I think I’m gonna find myself on the street’. he was telling his friends.” (SAMARA 343-346)

Thus, while they were concerned for their own safety, the participants were aware of the needs of their close others and worked to reassure them. Emotional or invisible labour, like responsibility for housework, did not cease prior to surgery.

Yet the everyday world contains emotional events which are not necessarily “work” or “labour”. The heart is the symbolic seat of the experiences of love, fear, sorrow and joy. Indeed, in orchestrating an orderly household environment, the women anticipated the needs of their loved ones and worried about the continuation of loving bonds. For example, in advance preparation of meals for her family to eat while she was in hospital, Gert ensured that the concrete needs of her family would be satisfied in her absence, but also was comforted that tangible reminders of her concern would be present for them. Samara’s truly heartbreaking anecdote acknowledges the barely speakable; she was aware that she could die, leaving her beloved two young boys grief stricken. Her chuckle in relating the story is the retrospective flourish of a survivor. For each woman,
the pain of contemplating mortality was compounded by witnessing the fears of others. They were comforted by their efforts to soothe their loved ones.

Self Care

From the diagnosis, "heart disease", flowed a moral discourse that bore implications for self care. Participants learned from health professionals, lay oriented health literature and the advice of close others that certain behaviours would minimize discomfort, and limit (or even reverse) the progress of heart disease. They struggled with schedules for medications, at times stumbling over purposes, dosages and names of complicated regimens:

"INT: So they prescribed medication for the angina? BAMY: Yeah...they gave me ten bottles, ten different pills. Then they operated and I was just cut down on a little heart pill they gave me so I wouldn't have...infection in my heart...and, uh, another little blue pill, a half of one a day...or twice a day, rather." (BAMY 289-295)

Many confronted the realization that lifetime habits, such as cigarette smoking, had contributed to their heart disease. Samara admitted that she was "killing" herself by smoking, again acknowledging the unspeakable possibility of her own death with a nervous survivor's chuckle:

"It [smoking] wasn't helping me, it was killing me. [chuckles] I even have half a carton, I'm keeping it as a souvenir. But I won't smoke again. Because I had the hardest pain in my life. High blood pressure, high sugar levels, and I was killing myself. No more." (SAMARA 267-269)

Confrontation with discursive allusions to personal responsibility inspired some remedial action. Margaret hoped to "reverse" damage by altering her diet and vitamin intake:

"And then I read a lot about, ahm, about reversing this -- this disease, you know,
because there are different things to do. And, ahm, I was taking the Lecithin and doing that breakfast which I had done ever since I had my heart attack and it seems to make me really feel good. Anyway, eat a lot of fruit and vegetables and take a lot of vitamins. I take my vitamins, I take a lot of vitamin B6 and a multivitamin, not overdoing it, but ahm, and a vitamin E every day.” (MARGARET 83-93)

Walking was taken up by most as a prescribed form of exercise when they initially recovered from myocardial infarction or when angina first appeared. One woman described herself as “addicted” to walking and said that when her angina again worsened to the point where she was unable to walk as far and as briskly as before, she became concerned (SONIA 81). Others made similar remarks; walking was a popular form of cardiovascular exercise, and inability to continue without nitroglycerine spray was interpreted as an ominous sign. Luigi’s emphasis on feeling fine on a routine of exercise and diet after her MI suggests the preeminent need to reverse or overcome damage.

“I kept on doing that all, I didn’t quit with my walking before the surgery. I used my spray a lot. Walking and yes, the worst I found was vacuum cleaning.” (OLGA 674-680)

***

“. . .because what happened was that a piece of cholesterol had broken off and blocked the artery, and that’s what happened. It’s all my blood cholesterol. I was put on cholesterol pills, medication. I became very conscious of everything I ate. I went out, we went out and bought a Nordic ski track. I became very conscious of that. And I did really well, you know, went back to work. As I said I, uh, was fine and everything was FINE.” (LUIGI 241-249)

New information about personal health was often obtained prior to the surgery either during hospital admissions with acute myocardial infarction or during outpatient contacts. Often there was reference to textual transmission of knowledge about diet or
other topics when these teaching sessions were discussed, however, as Agata explained, these interventions were not always satisfying.

"But they say is not exactly -- they told me the diet but, you know, watch the fat in the diet and salt. INT: The foods that you eat. AGATA: Yeah, that's what they told me. Not much about explain of the, you know, dieting. INT: Not too much detail? AGATA: No, not too much detail. I think it's nice if somebody would explain, you know. Yeah, that's right somebody explain, you know, how the -- well like me I don't sometimes understand much, but still somebody should talk to me, that's different." (AGATA 96-114)

Thus there was a difference for Agata between knowing what foods to eat and understanding the process of following a diet. Her statement suggests that dietary practices are part of a local set of embodied routines which in turn must be altered when certain atherogenic foods become restricted. She was unable to activate the knowledge she had been given by health professionals about these foods.

It is apparent that some of the women had began to draw on widely different, and occasionally divergent, sources of information in their early attempts to develop new patterns of self care. They tried various combinations of books published for lay readers, printed and verbal information obtained from professionals, and local knowledge gathered through discussion with peers. However, it appears that the available knowledge was limited, relating mainly to exercise, diet and medical treatment options. Although some of the women indicated an awareness of the harmful effects of stress on their health, and two even obtained counselling to help them work out ways of coping with the stressful aspects of their lives, there was no recognition that their biographies were structured by a gendered division of responsibility that constituted unhealthy conditions. That some
women persisted with household chores up to the day before admission to hospital attests to the assumptive character of these activities.

Emotional care of others, providing food and orchestrating an orderly and clean home environment comprise the idiom of the home and family. As noted previously, the discourse of gender is activated in this context as much through concrete activity as through sequences of talk. Diprose (1994) remarks that women's bodies are contested ground in ethical debates on abortions and surrogacy. Women's bodies and identities are dedicated to the wellbeing of others in physical reproduction and the reproductive work of homemaking. Delphy and Leonard (1992) assert that women are oppressed, not because they are women, but because of the range of reproductive labour that their bodies can perform in the service of others. However, these sources do not acknowledge the compelling ways in which women's social identities and emotions are invested in this realm of activity - in short, how the discursive framework of homemaking organizes women's consciousness in the local world.

Prior to surgery, the study participants dealt with the contradictions of attempting to moderate activity in the presence of progressively debilitating symptoms while simultaneously remaining emotionally and personally bound to the work of homemaking. Participants used nitroglycerine spray and self pacing techniques to overcome the barriers imposed by illness in attempting to adhere to habitual routines. At this early stage, some sought to rectify or reverse damage so that they could continue with or return to customary patterns, but many reported very little access to the practical knowledge
required to practice self care.

**Relationships With Others**

Prior to surgery, there was some reorganization of relationships with significant others, although these changes did not always directly correspond with the needs identified by the women. The most commonly cited form of supportive assistance was accompaniment to physicians’ appointments and diagnostic tests. Husbands sometimes performed this role, but not always:

"And he was there of course when I had the surgery. But with the stress tests and the ordinary doctor’s appointments, he didn’t. I don’t expect him to come. I think it would be fine if he did but I don’t really feel it’s necessary for him to be there. I mean, he wasn’t there when my children were born. [chuckles] We’re of that generation where this is women’s work." (ANN 1595-1609)

Widows and divorced women relied mostly on daughters and daughters-in-law for this form of support, even though these female relatives usually had full time paid employment. In such cases it was obvious that female kin interrupted and reorganized daily routines to accommodate extraordinary demands:

"I started to walk and it really started to hurt my arm, so I hardly went around the corner and I realized that my walking is not--could not walk any more, so I just came back from it and I was so scared, I didn’t--yeah, I mention to my daughter so she says: ‘You know mom, Monday night the doctor works late, let’s ask him. Call him up’. And then I say: ‘Oh, no I don’t want to bother him, maybe it will go away’. But that night she says: ‘Mom, before I go home’. She comes to pick up the children and now after my husband passed away I’m alone, you know. So she was worried about me. So she says: ‘Before I start putting them to sleep or giving them bath, before I start anything, let’s go over to the docto’r. So I say: No, no, no’. Finally I let her leave, she left, she picked up the kids, you know, to go home, and then I wanted to go upstairs and lie down and change and I felt my arm starting to hurt really bad, so I got scared being by myself. I’d rather go now than to have to wait till the middle of the night. So I called her and I told her, she came running immediately." (SONIA2 117-137)
One woman, Samara, became so ill prior to her surgery that she was unable to physically deal with the demands of her household. Although Samara was married and her husband was supportive, the demands imposed by his job meant that he could not sustain the constant level of care required. In this case Samara's mother travelled from England to care for her during the weeks before surgery. From this description it is evident that the mother provided round-the-clock attention:

"But at home, I would go to the washroom twice a night, so somebody has to help me. So I don't have to wake my husband. He needs his rest too. So she was there to help me. With having baths and going to the washroom. And cooking and looking after the kids." (SAMARA 305-308)

Olga alluded to the persistence of gendered divisions of responsibility when she discussed the absence of help from family members prior to her surgery:

"My daughter was away, she goes away to university so she wasn't much help. My son, forget it. [laughs] Won't help, you know. I mean, I help HIM! [laughs] I just like, brought in a couple of things again from the patio there. He takes out glasses and stuff and he leaves it, doesn't care. So forget about him. I help him more than he. My husband, at the time, worked 12 hours a day. He's a mechanic, a lathe operator. And until two months ago, from about late summer last year, they had so much work to do, they had that--he had to work seven days a week." (OLGA 697-710)

Women's routines and work, as well as their bodies, are therefore subject to interruptions when significant others require assistance, but different conditions apply to men. The idiom of the home and family includes, for Ann's generation, the stipulation that women accompany ill family members to medical and other health related consultations. Sonia's daughter anticipated her mother's need for emergency care, indicating a preoccupation with Sonia's health. This invisible work of worrying and attempting to
coordinate the needs of her own household occurred at the end of a day in the paid labour force. Nevertheless, Sonia’s daughter was compelled to interrupt her evening chores to rush her mother to the emergency department. It is noteworthy that this caring work was fully reciprocated; Sonia provided after-school care for her grandchildren.

Samara was a 38 year old mother of two elementary school age children, and was economically dependent on her husband. Interruption of his working life was unthinkable, so Samara’s elderly mother travelled from England to provide her with 24-hour care. Likewise, Olga’s family was dependent on her husband’s income, and his long, exhausting hours of employment precluded his participation in housework. Her youngest son was available, but it was clear that within the idiom of this family, women sustained men but reciprocation was not expected. In Olga, Samara and Ann’s cases, men’s participation in paid employment placed them within the realm of the formal economy, while the women worked within a shadow or parallel economy of reproduction (Illich, 1989). The gender typing of informal caring work meant that Olga, in the absence of female kin, had no recourse but to continue homemaking without assistance.

The need for physical care or help was not a prominent feature of the references to this phase of illness, however. Various forms of emotional and informational support were discussed more frequently as forms of assistance that comforted the participants in their most vulnerable moments. Other social network members provided local knowledge, advice and, occasionally, misinformation. Persons with heart disease were often accessible through the women’s social networks to offer advice after the women were diagnosed.
These contacts had been indoctrinated by bodily experience and through contact with the health care system, and could prepare participants for their surgery and recovery. Occasionally, peers who offered advice and information did not have heart disease, but had some other health problem or had past experience with unrelated surgeries. Finally, some women could recall past life experiences with others who had heart disease and compared themselves to these others.

"I had the breathing, but I'd never get chest pain. I would get this full feeling up in my throat...Quite a few years ago, my husband had a heart attack and I know he was...took him over to the hospital in the middle of the night and he was just going crazy. He woke up, you know, he had chest pains, and they were really bad." (BROWNIE 1208-1226)

***

"Someone said to me after - this fella, he'd had a heart attack - and he said to me: That feeling does not go away for about a year, it's sort of like having an accident, and you keep looking in the mirror every time you stop so no one hits you. You know? And I could understand, and I'm glad he told me that because often you don't have much input from people with heart conditions. So I think that's important." (ANN 316-331)

Ann’s anecdote reveals the world of risk and danger held in common by those with heart disease. She did not expect others to understand this and appreciated the opportunity to speak with someone who shared this world.

"Well, my sister-in-law, she watches these things on TV. The operations. She says: you know, they stop your heart. Then you think: What if they can’t make it go again?" (COOKIE 108-110)

Cookie’s experience reveals that misinformation could be transferred as easily as reliable knowledge. Her exchange with her sister-in-law indicates the role played by the media in reporting health news to the public. The formerly private world of the operating
room has opened the intricacies of surgical practice to the public as remarkably as technology has exposed the interior workings of the human body to surgeons. Literature about healthy lifestyles for the prevention and treatment of heart disease facilitates access to information about low cholesterol diets, exercise and stress management, reducing dependency on health care professionals for advice.

While most of this literature is written by professional experts from a variety of disciplines, there is also a parallel network of lay experts who provide first hand information about the embodied experience of heart disease. Local knowledge, as opposed to the abstract, generalized, textual knowledge of the health sciences, addresses the idiosyncratic experiences of the everyday (Harvath, Archbold, Stewart, Gadow, Kirschling, et al, 1994). However, it is important to note that this knowledge is informed by techno-medical discursive practices. Ann and Brownie’s anecdotes indicate that they had engaged in understanding the diagnostic category, “myocardial infarction”, from an emotional, sensually embodied perspective that complements, but is not equivalent to, the understandings possessed by health professionals. Their experiences were similar to Smith’s (1999) description of locating in the topography of real streets the points depicted on a map. Ann and Brownie’s comments suggest that the embodied experience of “heart attack” comprises their version of the real streets of the diagnostic category “myocardial infarction”- versions which may differ from the streets as they are known by health professionals. These topographies are shared and elaborated in a transfer of knowledge that is framed in bodily terms.
Discussion

Loss of mobility, shortness of breath and pain were among the physical cues that alerted the study participants to the prospect of serious illness. These distressing sensory events were interpreted by the women as a specific kind of problem. Before they knew what the reason for these experiences could be, and before they knew what the implications of this reason could be, they knew they had a health problem and they knew what to do to begin to deal with it. Each woman knew at a particular point that she had recourse to a social process in conjunction with a specialized kind of professional whose job it was to assess people with health problems, assign a name or diagnostic category to these problems and proceed with some course of activity that would address the problem. The women did not have to construct a plan or a meaning that would guide them to consult their physicians. A discourse preceded the particular situation and the women already knew how to be active within the structures of this medicalized discourse of self care.

I have built on the work of Leder (1990) and Diprose (1994) to interpret the embodied crises experienced by the women, but these theoretical perspectives do not entirely link the individuated embodied experience of illness with the embodied experience of being discursively active within an institutionalized set of relations that deal with illness. In seeking medical counsel, the women entered into social relations which abstracted, altered and, occasionally, misrepresented their embodied identities. Smith (1990a, 1999) analyses the manner in which scientific representations of human phenomena abstract
salient elements of experience into focussed, textually mediated accounts. The definition of “salience” rests entirely with the professionals and scientists who describe and work with these phenomena. Thus, the base of literature on phenomena associated with heart disease is constructed according to the requirements and assumptions of those who diagnose and treat heart disease, not those who live with it. Similarly, the process of diagnosis is one of recognizing and interpreting salient facets of embodied experience presented and articulated by those who consult their physicians with a particular complaint. This process, too, is governed by the requirements and assumptions of the professionals who are charged with the responsibility of assigning a diagnosis, but it is also influenced by the manner in which patients have worked up the problem in anticipation of the consultation. The consultation may be brief and the limitations presented by its location away from the local and familiar further impair representation of the problem. Naming or diagnosing health problems is fraught with complexities and barriers.

The two-sidedness of the diagnostic process meant that some participants encountered incorrect interpretations of their problems and these instances carried profound implications. Distinctive aspects of their physical presentation and comportment were abstracted and separated from their actual embodied selves. For example, Olga’s occupation (housewife) was interpreted as an indication that she must surely be bored and depressed. This was distilled into a misrepresentation of her health problem: tensions arising from personal dissatisfaction somatised as chest pain. Brownie, after a lifetime of caring for a husband with brittle diabetes, raising two sons and homemaking for all three,
was asked if she tended to "baby" herself and subsequently struggled to convince herself that she was not malingering. In these instances, there was a disjuncture between what the women knew about themselves from experience and the impressions created through the discursively driven diagnostic practices of physicians.

Even when the diagnosis of "heart disease" was successfully assigned, the two sidedness of the problem remained. The category "heart disease" preceded each woman and was constructed as an indicator around which specific professional activities would be coordinated. It provided a common understanding for professionals with specialized but complementary functions. Each could anticipate certain approaches and expect specific outcomes based on previous experience and textually conveyed research outcomes. For each woman, on the other hand, "heart disease" was an explanation, but it was not necessarily the actual problem as they experienced it in the local and concrete world of the everyday. Their understandings of the problem were conditioned by their situated consciousness of themselves as gendered participants in particular activities, including homemaking and family care.

For the women, the problem presented as a physical incapacity to act in the myriad, biographically developed and discursively driven ways that signified gendered selfhood. They were "women with heart disease". They were not always free to delegate their homemaking activities when they were ill. For women like Samara, who was so severely physically incapacitated that she required the presence of female kin to assume responsibility for her own physical care needs as well as for coordinating the household.
extreme illness accounted for her abandonment of homemaking responsibilities. Laverne received an injunction against housework from her family physician. However, Tip and Olga endured long months with persistent symptoms which were not understood by close others, physicians or themselves as signs of life threatening illness. They had no socially recognized explanation to account for their diminishing capacity to manage their homes. In the interim between surgery (and even diagnosis) they struggled to act in accordance with their idiosyncratic interpretations of the discourse of feminine homemaking responsibility.

On the everyday side of the diagnostic category “heart disease” there was a profound risk of death. In contemplating the end to self, the women imagined the rupturing of personal histories that were active and purposeful. The heart is a physiologically functioning organ but it is also the metaphorical seat of emotion and emotional bonds. The metaphorical significance of the heart is deeply social, for emotion arises in activity with and for others. Distress associated with illness and the threat to life included concern about the others who depended on the women in multiple ways. As they confronted the possibility of disintegration the women found continuity in comforting these others and anticipating their needs. However, they also found unspeakable sadness and fear in empathizing with loved ones and pondering their own emotional responses. Angina may be relieved by nitroglycerine spray, but heartache cannot be treated within the realm of medical therapeutics. Their hearts and bodies became vulnerable objects which impeded conduct of the self-reproducing activities of homemaking. More than their
bodies and hearts were under attack. At risk was an entire world of emotional connection and continuity of self through activity on behalf of and with others.

A final disjuncture was experienced with diagnosis of heart disease. When they entered the social category “women with heart disease”, participants struggled to retain aspects of their biographical identities while learning the comportment expected of persons belonging to this diagnostic group. Conflict arose between these two aspects of selfhood. Luigi was scolded by her cardiologist because she fulfilled her (discursively driven) expectations of herself as a reliable employee by completing a temporary job placement against medical advice. Olga knew she was to avoid strenuous physical activity, but her family continued to expect her services as a homemaker and she felt accountable to sustain her exhausted husband. In entering the social relations of illness, the women were confronted with conflicting responsibilities. Ironically, they were implicated as the authors of their own illnesses as they reviewed the habits of a lifetime in search of explanations for their present predicaments.

The above disjunctures culminated in two contrasting idioms of responsibility: the discourses of homemaking and femininity, and the discourse of self care. Participants were accountable to perform the physical and intangible activities of nurturing, caregiving and housecleaning. However, as members of the social category “women with heart disease”, they were expected to rest and learn healthier patterns of behaviour. These discourse created profound bifurcations as described above. Naming the problem from a medical standpoint was a critical step, however. Options for treatment were available and
one of these was aortocoronary bypass surgery. In the next chapter I discuss this aspect of the women's narratives.
CHAPTER SIX
DISPLACED PERSONS: ENCOUNTERS WITH THE WORLD
OF THE HOSPITAL

Once identified with the diagnostic category, “heart disease”, the women were
introduced to a discursively based world in common with their physicians and other health
professionals. This two sided world was permeated with a lexicon of risk and
responsibility. The discursive practices associated with the participants’ treatment
culminated in a period of hospitalization for aortocoronary bypass surgery. The hospital
sojourn displaced the participants in many ways. They were dislocated from their familiar
home settings and were inserted into an institution that was governed by processes and
contingencies beyond their control. In surgery, the participants were radically
dispossessed of their physical selves, and personal agency was regained gradually and
painfully. At some points they were not physically or cognitively capable of caring for
themselves and were obliged to rely on the judgement of others to see them safely through
the first days following surgery. Hence they were socially displaced in an arrangement
that contrasted sharply with their biographically constructed understandings of themselves
as active in orchestrating comfort and order in the lives of others.

Zussman (1993) observes that, prior to the 1960’s, studies of social life among
hospitalized patients flourished. Interest in the experience of hospitalized persons has
waned in recent years, however, and has been replaced by a reintroduction of the patient
“as a central participant in medical decisions” (Zussman, 1993, p. 182). He argues that
the development of social ties among hospitalized persons is precluded by an increasing
trend towards shorter admissions and community care, so ethnographic study of inpatient cultures is becoming less prevalent. Accordingly, emphasis has shifted to the interactions among health policy, professional practice and individual agency within the health care context. Smith (1990a) also directs attention to the ways policy and professional discourse condition local activity, but the phenomenal ground of her analysis begins with individual experience but extends to the organizational forms peculiar to specific institutions. Hospitals are situated within a health care system which is composed of diverse sites and multiple activities. As such, they are characterized by discursive practices which “organize the interchangeability of actual events, the treatment of individuals [whether persons or events] as equivalent “for all practical purposes.” and the coordination of processes and events occurring at different places and at different times” (Smith, 1990a, p.172). Within this organizational form, the identities, thoughts, feelings and sensory experiences of those who act and those who are acted upon are of little consequence.

It was soon apparent from the participants’ detailed and impassioned descriptions of their hospital experiences that this phase warranted careful attention. The women chronicled patterns of interaction among patients and health professionals which elaborated on themes established prior to hospitalization. These narratives, combined with input from health professionals, suggested that social life in the hospital was a continuous structure which endured despite the brevity of individual patient tenure. This organizational form featured a medicalized discourse, divisions of labour and a set of fiscal contingencies which formed the context of hospitalization. Although elements of the
organizational form composed a world in common, it was a world experienced differently by women and health professionals.

Case Studies

I begin this chapter with two examples of the social relations of care in the hospital. As in the previous chapter, these examples illustrate some common themes found in the participants' narratives. Differences are also evident in the stories told by the two women. Although both were admitted to the same hospital and the same nursing unit, their experiences and responses contrast in some ways. Biographical patterns, preparedness for surgery, and previous experience with health care configured their interpretations of events during hospital admission.

Emma

At 60, Emma was a meticulously groomed woman whose narrative shifted easily from distant past events to present experiences and, occasionally, to future plans. I first met with her in her condominium townhouse, which she shared with two boarders. She explained that this arrangement provided additional income as well as welcome companionship; it was her tenants who summoned an ambulance one night when she experienced an episode of congestive heart failure. One of her two grown daughters lived in a suburb across the city and another lived in a small town a two hour drive to the north. She had four grandchildren.

Emma's biographical themes featured a strong orientation towards personal competency and strength expressed in the care of others. Her older sister suffered an accident at age fourteen and became paraplegic. Emma was partially responsible for raising a much younger sister when their mother was preoccupied with the caregiving responsibilities evolving from the family tragedy. To compensate for this premature burden, Emma was given opportunities to take any music, skating or dancing lessons she desired. She learned to take pride in her acceptance of responsibility and in her accomplishments. When her eldest daughter, as a preschooler, suffered a terrible accident that resulted in repeated hospitalizations and surgeries, Emma took pride in her availability to both daughters. She felt that a long standing closeness with her younger daughter was testimony to her efforts to balance her mothering activities during a period of intense competition for her attention. After her daughters were grown and Emma was divorced. Emma's father fell ill and required care. Emma left a well paying and satisfying job as a
store manager to stay with him and provide help until his death over a year later.

When she was in her mid forties, Emma's husband divorced her and subsequently married a much younger woman. The experience was shattering; she had not held employment since her first child was born and re-entry into the labour force was difficult. She remained single following the divorce, learning to value her independence and ability to support herself through a variety of jobs. She derived great satisfaction from social contacts at work and enjoyed her popularity with other workers. One of her particular skills was the ability to orchestrate a positive social environment with her jovial, energetic approach to her work. However, ill health motivated her to seek less stressful temporary office work. Her stated annual income was $15,000 at the time of our first interview, and she had no sick leave benefits from her previous employment. Between our first and second interviews, she sold her condominium to provide the financial resources she needed to support herself.

Emma was healthy prior to a hysterectomy at age fifty. She had smoked since her early twenties and was finding it difficult to quit the habit despite encouragement to do so. She was very aware of her precarious health, remarking that one surgeon had refused her as a candidate for ACBS. Another was willing to do the surgery, but warned her that a second operation would not be possible despite the fact that many people have a second bypass five to ten years after the original operation. In her words: "Well, you see, three of the veins were totally plugged. And the different tests I had to have, sometimes they don't, they're sitting kind of still and they're not functioning but they could still possibly be alive. And this is what they had to find out from these tests. And, um, of course it showed they were still functioning, and that's why they figured that the bypass would work. And the thing is that I would never be able to have it again. And ahm, this is from the surgeon's viewpoint. And if there was ever another heart attack I wouldn't probably survive it."

Prior to the surgery, Emma avoided thinking about these issues, although she put her financial affairs and will in order. She did not attend preoperative information sessions held at the hospital, where a preparatory video was shown: "but no, I didn't see anything. I didn't see anything until after [the surgery]. And I think it was just as well. Whoa. God it was gross!"

Both daughters made arrangements for child care so they could be with her on the day of surgery. Emma described the traumatic effect on her daughters of waiting for her surgery to be finished: "And the volunteer said: Well there's a hold up a little bit but your mother's doctor wants to speak to you. Well, my kids were like [makes groaning sound] naturally: Has everything gone okay? Unbeknownst to me. They waited and they waited. I didn't even know what was going on. The other woman that was in the room with me - there was two, like a nurse to both patients - she had a cardiac arrest. And of course it was whatever number they call. And my kids were just around the corner and they thought it was me. And all of a sudden, it was umpteen nurses and doctors and machines and they're all going into the room that they know I'm in. Well, my poor kids, and of course, the doctor wants to see them. My kids were a total WRECK."

Emma's subsequent recollections of the early post operative phase were vague. "I don't remember a whole lot to tell you the truth. They had me so doped up. I have these
flash backs, and I wonder if I remember this or did I dream it. But it was scary.” Emma did remember many details of her nursing care in the intensive care unit, and her recollections were mostly positive. Yet, as she elaborated on her relationships with nurses during her hospital stay, it became apparent that she was active in shaping the terms of these relationships. She maintained a buoyant approach to health professionals and found that her efforts to be a good patient were rewarded with extra attention. “And if you’re a good patient you’re going to get a lot more from them, not that you’re realising that you’re a good patient. But if you talk to them, make them feel comfortable or ... especially the young ones. And, ahm, but when I left [another hospital] my God, three of them came in purposely to say goodbye to me because they knew I was leaving that day on a Saturday, and which I thought was really nice. But I think when you give, you’re bound to get something back and, ah...then over the years that I’ve dealt with nurses with my mother, my father and my sister. ahm, it was basically the same thing; you know, if you give to them and they realise that, you know, this person’s a good patient or, ahm, you got her listening ear...” She engaged early in self care to reduce her nurses’ workload. During her account of her hospitalization, Emma made only one reference to unsatisfactory treatment, and this was quickly dismissed: “So anyway, as far as the care...it was excellent. I had trouble with one nurse, but that happens, it was nothing.”

Within three days of her surgery, Emma directed her attention to other patients around her. She compared her progress favourably to these others, but she was concerned to help with their care as well. She gave older and less able patients encouragement and physical assistance in the last few days of her admission. “There was another gal, she was sixty nine, I think or seventy. Her husband was really a nice man but I figured she'd have an awful lot of trouble when she went home. I'd say: Come on Anna, let's go, and you hang on to the railing. Because she kept saying: You only had your operation on Friday and I had mine on so and so, and LOOK at you, you're almost running down the hall! And I'd say: Oh, Anna, you're older than me...” [chuckles]. While such instances reassured Emma that she was doing well in comparison to others, volunteer visitors who had undergone ACBS and recovered well provided additional reassurance for the future. She said that the two women volunteers who visited her were “very attractive”; this remark reflected her own interest in good grooming and feminine comportment.

Seminars were available to inpatients so that they could learn more about diet, exercise and post operative self care. Emma took these seriously, reflecting a moral orientation towards self care; she felt responsible to protect the patency of her aortocoronary grafts since she was only to be offered one chance at surgery. “’Cause there's something every day that you've got to go to. And then a lot of [the other patients] said: I'm not going to that. But you have to, you have to go, you have to learn. And um, because there's so much that, you know, in order to help yourself, you've got to understand it. Me, I only have one shot at this, so I have to mind my P's and Q's.” This moral orientation set up a new arena of accountability. While her concern with attractiveness and concern for others stemmed from an accountability to comport herself as a woman, Emma was aware that her social status as a “woman with heart disease” was accompanied by an additional set of behavioural expectations. Overwhelmed by their
mother's brush with death, her daughters engaged in these relations by taking on caregiving and surveillance functions. Emma was discharged from the hospital to her eldest daughter’s home.

Tip

Tip was 67 when I met her at her home, a spacious bungalow in a suburb on the outskirts of the city. Initially, she had a quiet, almost hesitant manner and apologized frequently for her poor recall of medical terms. As the interview progressed, however, she became more animated and confident. Tip’s husband occupied himself in another room for most of the interview, but later joined us when Tip warmed to her expose of hospital care. He quietly listened and suggested further anecdotes of interest.

Tip had worked at a variety of jobs, including office work and wig making. Her husband was a retired auto mechanic. They had been married for 47 years and had two daughters. One daughter lived out of town with her husband and three children, while the other was single and lived in the city. Both Tip and her husband relied entirely on government pensions, and their income was between $15,000 and $20,000 annually. Both were comfortable with this amount, but Tip added that since they each took expensive medications, they were particularly grateful that drug costs were covered for senior citizens.

Tip described a family history of heart disease: her mother had angina and her father had died of an MI. When Tip developed shortness of breath three years ago, she worried about this family trait, but her doctor diagnosed bronchial asthma. Tip suffered progressive shortness of breath and chest tightness until her doctor sent her for a stress test two years later and learned that she had angina. Although treatment with nitroglycerine patches ensued, true relief of symptoms was never achieved. Tip’s condition became progressively worse until one evening, while bowling with friends, she experienced severe chest pain. She was taken to a community hospital and given emergency treatment for an MI. She was later transferred to a downtown hospital for an angioplasty. During angioplasty, a coronary artery was damaged, and Tip was quickly prepared for ACBS.

Tip was in terrible pain prior to the surgery and did not absorb the information given to her about the procedure. She relied on her family to make decisions for her. The days leading up to her surgery were traumatic for everyone, and Tip was aware that extraordinary arrangements were made so that her husband and daughters could be with her immediately before and after the ACBS. “But one [daughter] is up in, she lives up in [location] and she's got three children. So it was pretty rough. I think they had two or three different neighbours that had to come in, you know, periodically those days. an emergency baby-sitter right until August 12, one o'clock at night when I—they said I was--it was still touch and go.” She had never been hospitalized other than during childbirth and was as deeply affected by her family’s anxiety as by her own pain and fear.

In the early postoperative phase, Tip was troubled with pain, nausea and frightening dreams about being smothered. Her discomfort was aggravated by the
growing realization that she was not recovering as quickly as the others around her. Like Emma, she compared herself to other patients, but Tip’s comparisons were far from reassuring: “Everything went wrong that could possibly go wrong. But I know, like there were people that had the four... quadruple bypass and one man had five, and—after me—and they went home and they were walking around days before I was. I just couldn’t make it. I tried to get up and I just could not. And that’s why I felt that I wasn’t doing as well as I should.” When her 4 and 6 year old grandchildren were brought to see her soon after the surgery, she could not bear their concern and confusion. “The older two came to the hospital. I really wasn’t too keen on it at that point, and I really didn’t want them to bring them. Because they’re used to seeing Grandma happy and, ahm, you know, playing with them and playing with their toys and all that and games with them; and when they brought me—brought them down the hospital, I was connected to I don’t know how many tubes, you know. I think [husband] said maybe eight or ten of these things and they’re all connected to me. And a thing in the nose, you know, the whole bit. And they kinda looked at me strange, you know, that’s my grandma, you know, what’s wrong? But, ahm, and I said: Please don’t do that, take them—take them out. I don’t want them to see Grandma like this.” She felt herself to be unrecognizable as their grandmother.

When she finally began ambulating, Tip failed to recognize her own body. Unfamiliar sensations interfered with her ability to walk unassisted. She laughed nervously as she described her first few attempts to walk: “I think I had, ah, two—one—a person on each side [chuckles] and that still didn’t help, and then a walker as well; and felt very nervous, very scared, VERY scared. You know...what's going to happen [laughs]. I just didn’t have any feet and legs; they were just numb, you know.” Her vulnerability was accentuated by several negative encounters with nurses. Tip found it necessary to directly and indirectly influence the manner in which nurses conducted their work. In one such instance, Tip found that her aesthetic and hygienic standards were violated, and she insisted on better care: “And then one other time she took me into the washroom, the lady across had just been in and [the nurse] came back and she took me into the washroom and she turned me to sit me down. The seat was covered in water and things, the toilet wasn’t flushed and it was all dirty, it was all on the floor, and she turned me to sit me on that. And I said: WAIT a MINUTE! And I said: Aren't you going to clean that up? She took a piece of the paper towel and wiped the seat. And I said: FLUSH it! I'm not sitting on that! I had to tell her even to flush the toilet. And then she sat me—and I had no choice. I had to sit then. But I would—like I wanted that washed. Why should I sit on it?”

Tip gave examples of several instances where she and other patients or their family members exchanged atrocity tales about the conduct of nursing staff. She prefaced these stories with comments about the effects of staffing cutbacks and fiscal shortfalls on the structure of hospital care. Most nurses, she acknowledged, worked hard against major constraints to assist their patients in any way possible. It was clear, however, that a culture of mutual protectiveness united her with other care recipients and their families on the nursing unit. Tip described an incident where a visitor upbraided a nurse for refusing to assist a man who was not assigned to her care: “You could hear her all over the [nursing unit]. She lit into this nurse and just told her. She said: The man's in pain or he
wouldn't be ringing the buzzer. Can't somebody in there help?"

Despite Tip's unusually long hospital stay of ten days, she did not attend any of the informative seminars scheduled during that period. Initially, she was too nauseated to concentrate, and later she worried that she would be unable to tolerate sitting in a chair for more than a few minutes. She was given printed booklets that elaborated on the information presented in the seminars and read these carefully when she felt able to concentrate. Tip was discharged home with her husband, who assumed responsibility for the household with the help of their two daughters.

Emma and Tip had similar economic profiles and both had engaged in a variety of temporary and part time employment. However, their biographical and social patterns were dissimilar. These dissimilarities serve as the fulcrum of analysis of their experiences and activities during hospitalization. Tip's narrative featured an orientation towards family. Her identity and energies were invested in partnering, mothering and grandmothering. She described the satisfactions embedded in her long years of marriage and took great pride in the success of her daughters. She was socially active, but commented little on her relationships with friends who had no experience with heart disease. Tip had comparatively little experience with health care: her husband and children had escaped serious illness, and until recently her own health had been excellent. There had been some difficulty in obtaining a diagnosis of heart disease because her family physician had misunderstood her symptoms. Conservative management of her angina had been unsuccessful and her subsequent MI led to an emergency surgery. This disruption of her life was sudden and dramatic and her relationships with health professionals were portrayed as unsatisfactory and fraught with conflict.

Emma described her divorce as a pivotal life event but there were other biographical ruptures. Her identity had been configured by a need for self reliance, first in
childhood when her sister was severely injured, in mid adulthood following divorce and a period of caregiving responsibility for her dying father. She was fiercely independent, but gained emotional sustenance from a wide network of friends, particularly those in her various workplaces. In contrast to Tip, Emma seemed to resist the caregiving efforts of her daughters, particularly when these efforts bordered on concerned surveillance - Emma wanted to take care of herself. Her biographical experience resulted in familiarity with illness and health care. At several points in her life, Emma developed strategies for dealing with health professionals and became adept at cultivating cordial working relationships with them. She was hospitalized at least twice in the decade prior to her ACBS, once for hysterectomy and once following an MI. Although she purposely avoided preoccupation with her upcoming surgery prior to hospitalization, she had actively sought a surgeon who was willing to operate. For Emma, ACBS was a key to her future.

Both women were confronted with a discourse of risk and endangerment. In obtaining the surgery required to prolong their lives, they were dramatically separated from their homes, their social networks and the assumptive order that provided reassuring structure and meaning. However, the surgical intervention itself imperiled them and they required intensive monitoring and protection. They became temporary inhabitants of a locale where they were rendered unconscious, their bodies were opened and reconstructed, their bodily functions were regulated and controlled and they were subjected to intense scrutiny of their hitherto private or invisible visceral processes. They were physically entered into the discursive practices of the hospital setting. However,
neither was prepared to fully relinquish biographically constructed understandings of themselves and the respect they felt those identities entitled them to.

Emma’s extensive experience with health professionals and history of facilitating favorable working relationships gave her a powerful advantage. As the “good patient”, she cultivated harmonious relations with her nurses by facilitating their discursively defined labours. She did not garner this positive regard as a means to encourage additional physical care. Indeed, she avoided troubling nurses with unnecessary requests for help. Her aim was to achieve recognition as a social being who was worthy of respect and affection, and she expressed pleasure in her nurses’ extraordinary gesture of gathering to wish her well on her day of discharge. Tip did not have the familiarity with hospital care to proactively develop positive relationships with her caregivers, but she did at times confront nurses with her entitlement to dignified treatment.

Both narratives suggest the inaccuracy of Zussman’s (1993) assertion that hospitalized patients no longer share a microculture. They suggest that there was an inpatient microculture that was influenced by the discursive practices and lexicon of professional care. These influences included a focus on open heart surgery as a professionally orchestrated passage through profound danger into a gradual and carefully monitored period of physical restoration. The world in common was shaped by a shared project: the women’s continued survival and relief of symptoms through surgical intervention. It was the overwhelming responsibility of health professionals to ensure physical survival in the hospital. However, personal and biographical particularities were of secondary importance. Tip and Emma described supportive relationships with other
patients and their visitors on the hospital units which featured mutual care, protection and advocacy. The particularities of biographical identity were preserved by these relationships when all else threatened to disintegrate dignity. Thus, when the women were unable to assert their own social identities and preferences, as described above, other patients acted on their behalf. This informal network of personal caregiving flourished within an organizational form which coordinated the interchangeability of individuals and events (Smith, 1990a).

Within the hospital setting, bodies were contested terrain. In the immediate postoperative phase, neither Tip nor Emma had cognitive mastery because of the residual effects of anaesthesia and analgesia. They were invaded by tubes and devices that revealed their visceral workings but obscured the social and cultural schemas embedded within their inert bodies. They were rendered frighteningly unrecognizable to their loved ones, as illustrated by Tip's poignant anecdote about a visit from her grandchildren. Technology facilitated professional attention to the promotion of physical survival, which both women acknowledged to be a worthy objective. They temporarily relinquished mastery over their bodies to these caregivers, who deferred the issue of social survival. Perhaps this is why protection of dignity and selfhood became a major focus of patient culture. Group membership and identity was fostered by a common experience of ACBS.

As Emma and Tip gained strength, regaining control of their bodies was a pivotal activity. Walking unaided symbolized repossession, yet it also was accompanied by a moral imperative to attend to self care, or self management. The intensive, expert physical care that dominated hospital admission reinforced the discursive elements of risk and
responsibility associated with the diagnostic category, "heart disease". In order to fully repossess their bodies, the women received instruction in the requisites of self care and heart health. Nurses, physiotherapists and volunteers supervised initial attempts at ambulation, admonishing the women to resist the immobilizing effects of pain and lethargy. Both Emma and Tip were indoctrinated, through patient seminars and information pamphlets, into a regimen of self surveillance that conditioned reappropriation of their physical selves. As Emma pointed out, her new lease on life carried a personal cost: "And um, because there's so much that, you know, in order to help yourself, you've got to understand it. Me, I only have one shot at this, so I have to mind my P’s and Q’s.” Self management or self surveillance was the price of continued survival and in some cases, family and friends involved themselves in these monitoring activities.

**The Displaced Self**

As discussed above, the hospital experience eroded biographically constructed notions of selfhood. Displacement from the everyday activities and routines of home was one facet of this erosion. Many women described experiences of bodily detachment or dispossession related to the effects of anaesthetic and analgesics, as well as estrangement from bodies rendered unrecognizable by tubes, incisions, cables and other devices. Finally, intense monitoring and routines of care during the postoperative phase provided a standardized focus which erased particularized experiences of the body and biographical selfhood. Several women described efforts to reassert their everyday identities in this unfamiliar setting.
Displaced/ Misplaced Biographical Selves

Participants noted several issues in conceptualizing themselves within the context of the hospital experience. An overarching concern was the problem of resolving radical dependence and loss of personal control with biographical patterns of activity and responsibility. Encounters with fellow patients, volunteers and loved ones reinforced moral responsibility for managing personal health, comportment as a “good patient” and feminine standards of appearance and behaviour. The women did not simply struggle with “how to mean” in the hospital. They grappled with how (or whom) to be. In the rapid transition from early postoperative vulnerability to self management, the women were responsible for themselves and others, and they described social interactions in which accountability featured prominently. Resistance to the assault on biographical identity was embedded in these descriptions.

Information was exchanged during visits from volunteers who had themselves undergone bypass surgery. These visits were part of a programme developed by the hospital to help patients prepare themselves for surgery and recovery. The women spoke with male and female volunteers about pain management, exercise, emotional issues, lifestyle change and benchmarks of recovery; all valued these exchanges highly. The physical appearance of the female volunteers was remarked on by the women, as if the obvious vigour and attractiveness of these others attested to the attainability of feminine appearance, and hence feminine identity, after the surgery. The appearance of male volunteers was not described.

“So he sat down and he talked to me and he told me how he got along. He said he
- he had suffered from depression. He said he was all right after he realized what was wrong with him and the doctor put him on medication. And then he said he went at exercises too strenuously, and apparently there's a fine line. You can do too much or you can do too little. Oh, all the time I was in the hospital people would come in and say that they'd had heart surgery, oh, a year ago or something and ah, look at us now. And you'll feel like this. And it's encouraging. Really great... There were mostly men, but one day a couple came in - they weren't a married couple, they were just two people, one was a man, one was a woman - and the woman, I just couldn't get over her. She looked like just a picture of health, you know? Yeah, and it was encouraging to see her.” (BROWNIE 1722-1752)

***

“...there were a couple of people come in to see me at the hospital - I've never had so many people come to see me - just volunteers who'd had the surgery. Two very attractive ladies. And, um, I can't remember, one had it seven years ago and one had it five years, I think.” (EMMA 2209-2220)

***

“Well, they introduced themselves; they had the operation this time and now they're feeling much better. And the way we were feeling sometimes they came in, we were sick, and she say: Oh, another few weeks you gonna be fine. They say nice things, you know. Always nice things. So that makes us feel really good. you know, when they come in there, such people come.” (AGATA 478-484)

Social exchanges with volunteers and other patients provided a basis of comparison. By observing and listening to others, the women positioned themselves and their progress relative to others. Some comparisons reassured the women that they were in fact progressing much better than the other person or that they were a better patient. Other comparisons were more ambiguous, because the others were male or because the others' accomplishments threw their own progress into question. Many women attempted to draw conclusions about the differences between men's and women's experiences.

“And there was only three of us, there were these two men and me. This is why I knew the difference, because they would keep complaining about their leg and I would keep complaining about ... [laughs] INT: [laughs] About your chest? So
you had really only talked to those two men about what it was like. RUTH: I've never really talked to anybody else. There was no women there, you see, other than me who had it.” (RUTH 367-383)

***

“The lady in the next room said I was flirting [chuckle], because there was a man coming to get me all the time for my walks, it was fun, it was good. Actually, it was really nice to have someone to, you know, to sort of talk to, uh, who'd been...we'd been comparing our pain and our stitches [chuckle] and stuff.” (LUIGI 739-744)

***

“I didn’t expect the pain I had afterward. Because apparently a lot of people don’t have any pain afterward. And I said: I don’t know, there must be something wrong with me because [chuckling] I had a lot of pain. Like I was really sore, you know.” (MARGARET 901-904)

Embedded within anecdotes about comparison with others and exchanges of local knowledge with volunteers was the notion that there were embodied markers of progress and there were acceptable behaviours that promoted that progress. These denoted acceptance of moral responsibility, not only for one's recovery, but for improving one's health in future.

“So I was in bed one day, he [a volunteer visitor] said: Olivia, come on, you can get out of that bed. I said: I don’t feel like getting out of that bed. I said: I’m tired. He said: No, you’re not. He said: You just stick right there. And he went and got me a walker. You see, you’re supposed to walk and exercise, he said. He said: Now, you get up. I said: Oh, okay. So I got up and I walked around the...the halls, you know.” (OLIVIA 397-405)

The gravity and peril of the surgery and the postoperative period were expressed by the women in the retelling of anecdotes related by loved ones who visited in the hours following surgery. In those early hours, the women themselves were oblivious to their surroundings and their appearance. Indeed, some could recall very little about how they
felt and what happened to them while they were receiving intensive monitoring and care. 

In this regard, the women relied on others to reconstruct the blank periods in their narratives for them - they retold stories that had been related to them. Interestingly, it was these others who expressed fear of death in the anecdotes about the immediate postoperative recovery rather than the women themselves. This device allowed some to retain their composure in the narratives. It also indicates extraordinary helplessness and dependency: for a time, the women’s bodies - and minds - were out of their control and possession.

“And my boyfriend saw the thing in my mouth, they told me about that, but when he saw all the tubes and wires and things...Aaah! He thought I was dead. ’Cause I wasn’t talking.” (COOKIE 78-80)

***

“...well I don’t know. I was out about eight, nine hours I think. I don’t even know how long the operation took, about three or four hours. And he said he was so scared, he said, it just looked like somebody was dying and all he could see was this--my heart beating [on the monitor screen]. But he said the doctor told him that I was okay, don’t worry about me because I was very strong and I was going to be okay.” (OLIVIA 197-206)

These anecdotes reveal the turmoil experienced by loved ones and resonate with the themes of risk and endangerment. The women were no longer recognizable to these others, who had to be reassured that they were alive and recovering.

Resistance to the assault on biographical identity was therefore expressed through reassuring comparisons to others, recognizing moral responsibility for self care and depiction of the emotional uncertainties experienced by significant others. One issue embedded in relationships with significant others was a reversal of customary
responsibilities. One woman who was extremely sensitive to the narcotic analgesic given
to her for pain described a profound dependence on her daughter while the sedation
dissipated. Her daughter was in her second year of undergraduate studies, hence neither
she nor her mother were developmentally prepared for this alteration in perspective.

“So I -- all I remember is the doctor saying to the nurse to give me some
morphine. Then he repeated that and by the time they were done I was so pumped
up with morphine, I don’t know any more how I got up there. I won’t remember
any of that. Slept for 24 hours more or less. In the meantime I ate my dinner, my
daughter fed it to me and I never opened my eyes and she said...she said that was
so cute the way I was there opening my mouth every time she came with the spoon
and, you know, she was--she felt like a reverse...you know. I’m her mother and
she was--she felt for the first time that there was a reverse, ahm...” (OLGA 545-
556)

These experiences reveal the intricate connections among identity, embodiment
and social interaction. But above all, they were no longer in possession or control of their
own bodies. In surgery, they relinquished control of their bodies to health professionals.
Control was gradually reassumed in the postoperative course, but this process was
monitored and imbued with a discursive emphasis on a techno-medical organizational
idiom which facilitated the coordination of professional activity, but excluded
particularities of embodied and social experience. In the next section, I discuss the forms
of embodiment described by the women.

Dispossessed Bodies

The impression of physical peril and the constant, initially intensive, monitoring by
health professionals was infused with the same fragmenting and detached perspective that
was introduced in anecdotes about diagnosis. The physical self was endangered and
required protection, but those who were entrusted with the responsibility to protect the
women were also the initiators of painful and invasive procedures. One woman described an incident that bore elements of all of these issues. Pacemaker wires are embedded during surgery and are brought through the anterior chest wall for easy access during emergencies if cardiac pacing is required. Usually the wires are not required and are removed before discharge home from hospital. A physician removes these wires, often without prior administration of analgesic. The approach described by Ruth indicates that the physician invaded her privacy (her blue hospital gown was casually lifted to expose her chest) and disregarded her comfort (she was not warned about what would happen and the wires were removed without analgesic).

"And, um, he came in and he was just talking to Maria [hospital roommate]. and he turned around to me and he just lifted my blue thing and he said: Oh, you’ve still got that? And he just went...[short pause] The tears just came to my eyes, it was so...And normally I’m not like that. And that just took me unawares. He just yanked it right out. INT: And he just yanked out the wires? RUTH: Yeah, yeah. Right out! And he opened the curtains and left. And I said to Maria [imitates crying voice]: And he didn’t even say what he was going to do! And I find that unbelievable because they prepare you so much, you know?" (RUTH 1512-1538)

Many of the incidents described by the women were about invasive procedures or equipment. The strong, reliable bodies which had endured childbirth, physical toil, worry and heartbreak were visibly penetrated by wires and tubes. Private internal functions were made visible, and indeed were scrutinized by health care workers and visitors alike. The women were rendered precariously fragile, and connected to technological devices designed to promote their very survival. Some were amazed that hitherto invisible, even unimagined, aspects of themselves were now accessible to health professionals, who could interpret them better than the women themselves. Perhaps this observation explains their
hurt when slighted or caused pain by health professionals - and their gratitude to those who recognized and acknowledged their personal attributes. In some respects these professionals knew the women’s embodied selves more intimately than the women did, yet they remained oblivious to social identities and pressing concerns.

“Oh, it was terrible. I knew they were there, the tubes, I could see the tape. And then you could see the blood and stuff coming through the tube, going into whatever at the bottom of it. I didn’t like looking at that.” (COOKIE 675-678)

***

“And see, they put a tube in my back. I just woke up after the operation and they had put a tube in my back. They took an x-ray, they saw something on my lungs or something, I don’t know. And see, I didn’t ask, I was too do--you know. dopey you would say and, ahm, and then the nurse, she says: Well this happens eight out of ten times. I thought it was really nice of her so she--I would stay calm, I guess, she thought, so she froze it for me, and did whatever with the tube. I saw the tube when they pulled it out the next morning on the floor. So drainage maybe.” (GERT 492-503)

For some, the ultimate threat to physical integrity was the surgical procedure itself. One particularly disturbing aspect of the surgery received frequent reference: the splitting and spreading of the sternum to allow access to the heart. One educational television show allows viewers to watch common surgical operations, and some women reported seeing the aortocoronary bypass procedure or speaking with others who had watched it. After surgery, the sternum is reapproximated with wire and, during the early months of recovery, the knitting edges sometimes shift and grate slightly during movement of the arms and shoulders. Some women reported that this unpleasant sensation reinforced their feelings of vulnerability. Finally, the younger women in the group worried about scarring from the surgery and discussed the techniques used by their surgeons to limit the visibility
of the scar tissue. Although veins are often taken from the legs to be used in the aortocoronary grafts, some women particularly appreciated it if their surgeons used internal mammary arteries instead, because this procedure avoided leg scars which would be visible when skirts were worn.

“Well, it was a bit scary. really. You know what scared me the most, and I guess I should have realized that: the saw. I heard the saw in this video. You know they do cut through your breastbone. How else would they get in there but with the saw?” (BROWNIE 1578-1587)

***

“... they clipped me all up here and up here. So I said: How come I got clips? Oh, they said, you’re stitched too. They wanted to make sure because I was diabetic that they would heal.” (OLIVIA 298-301)

***

“That’s why I was -- when [husband] told me when I woke up on the Friday that I didn’t have anything taken out of my legs, that [surgeon] had taken both vessels out from under the breast bone, I said: Oh, thank God. But I had no idea at this point what the stitches looked like. [laughs] So of course there was no stitches on the outside, just on the inside. I don’t know how they did the skin on the top. I had heard in the hospital that they had a new procedure where they could stitch all underneath and glue the top layer, and I don’t know whether that’s what they did or not.” (LAVERNE 1481-1491)

The struggle between the social obligation to be a model patient and the inclination to succumb to sensations of fatigue and discomfort crystallized around the issue of ambulation. The moral responsibility to move about and promptly become upright and active was introduced and reinforced by others. Nurses, volunteers and family members cajoled and helped them to take their first steps. The women were “held up” and “supported” by others as their perceptions of distance and effort were distorted by weakness and drowsiness. Many felt pressured to leave the reclining position and assume
a more active posture. This activity is intended to protect patients from the untoward
effects of immobility, such as pneumonia and venous stasis. Again the language of risk
and responsibility was entrenched in interactions with professionals.

Two women articulated strong opinions about the moral value of activity and its
effect on morale. Their comments present one definition of feminine strength as located in
the ability to endure physical hardship or suffering. Convincing themselves and others that
they were able to assume activities independently helped these women to resist feelings of
fatigue and malaise.

"Because when you get up and move around, you get your mind off of being too
sick to get out of bed. I like the idea of getting up and I was always one of these
that would get up anyway." (EVA 922-927)

***

"I stood for my shower too, because I was determined I wasn't sitting down to
have a shower. [laughs] That was only my determination, nobody else's. And the
young girl, the young student nurse helped me. She -- she had to do my hair and
wash my back and that because I couldn't -- I couldn't reach up far enough to do
my hair yet. And, ah, she, you know, and she's there: Are you sure you don't need
more help? Do you want to sit down? Do you feel okay? And I'm fine.
[laughing]" (LAVERNE 537-546)

The presence in the second anecdote of the young nurse is crucial because she is the
anxious witness to Laverne's determined efforts to stand upright for a shower. The
narrative accomplishment is to underscore Laverne's strength. Despite the extraordinary
surgical invasion of her body, she has recovered enough of her old vitality to surprise a
student nurse.

Physical vulnerability was apparent in loss of mobility, pain, constant professional
surveillance, operative wounds and the presence of technological devices. Surgery
occasioned rapid reversals in capacity for activity. ability to perform self care and attention to appearance. The simple acts of walking or showering required self discipline; accomplishment of these acts became a marker of progress towards recovery of one's self as an active being. The women regained possession of their bodies with each attempt at everyday tasks of self care. But more distressing were losses of cognitive acuity and emotional composure following surgery. Descriptions of the emotional and cognitive experiences of hospitalization underscore the departure from the everyday. The issue of not recognizing the self extended to a mistrust of perceptions and mental faculties. Dispossession of emotional and cognitive faculties was marked by extraordinary confusion, and preoccupation with negative emotions. Those who were able to recall their feelings described fear and worry associated with a sense of risk and endangerment. Others recounted bodily manifestations of emotion that were unfamiliar or unprecedented. Some embodied sensory experiences that defied logic were labelled as dreams or hallucinations.

“I guess I was sort of in a fog and sort of closed my eyes at certain points in the (preoperative) video [chuckles]. And it really impacted on me after I was home that, gee, that was pretty serious!” (ANN 183-190)

***

“I don’t remember too much of anything to tell you the truth. They had me so doped up. I have these, like flash backs, and I wonder if I remember this or did I dream it. But it was scary.” (EMMA 1799-1806)

***

“I was so scared. They said they had never seen anybody so scared. I wasn’t acting scared, but they knew. It was terrible. INT: What kinds of things were you afraid of? COOKIE: Just afraid of dying. And, I don’t know, just afraid of dying.
And I thought: Oh, I probably won’t. So I didn’t get anything ready, didn’t tell my kids anything: This is yours or that’s yours. I was trying to be brave! [soft chuckle]. Yeah. So.” (COOKIE 65-73)

***

“And when I was looking at this woman I saw her, she was lying down, then all at once she sat up straight this way, you know, same hairdo and everything, and ... another thing was funny, right above her head...now this sounds strange...right above her head I saw my son’s face as plain as day. His hair was parted, and his glasses were on and all at once he disappeared. Now why would that be. I really did, you know in my...hallucination. I saw that...I saw his head right over, right over this woman’s head.” (BAMY 556-561)

In contrast to the responsible biographical selves who had positively influenced the lives of others around them, the hospitalized women were, in their terrible loss of bodily competence, dependent on others to gather and interpret information about their physiological selves. Leder (1990) observes that “the world itself shifts with a shift in the visceral” (p. 52). With the surface body, the surrounding world is sensed, explored and acted upon. The surface body projects into the world through intentional action and provides a spatiotemporal anchor. However, Leder (1990) proposes another bodily dimension which recedes from awareness and remains beyond conscious control: the viscera. The surface body is visible and instrumental to intentional activity, yet the viscera are secluded and beyond conscious control. Only in the most dangerous of circumstances are the viscera visible, and under ordinary circumstances, their functions are discerned through secondary signals such as the pulsations of the heart or the noises of an empty stomach.

Leder (1998) also argues that medical discourse about the body is marked by neglect of the social schemas embedded within the body’s surfaces. Vivisection and
autopsy have permitted extraordinary knowledge about anatomy and physiology, but these procedures are performed on corpses, which are inert, objectified bodies. The object body is fragmented into categories which divest it of vitality; these categories form an abstract, textual foundation of medical knowledge. In this discourse, the inert body is enshrined, but the lived, social body is irrelevant. Operation and anaesthesia, then, temporarily render a person inanimate as the viscera are exposed. Under these circumstances, the body is entrusted to the skill and care of professionals and their technology. Its owner relinquishes control, and indeed, is temporarily incapable of managing personal survival.

Leder does not refer to the political issues that flow from this arrangement of social relations. The lived or surface body is the medium through which the world is known and engaged in. It is and bears the identity of the person. To render the body inert, in discourse and deed, threatens integrity. As the participants point out, survival is a worthy goal which justifies extreme and endangering measures, yet they also describe resistance to social misrecognition in the postoperative course. Their struggles focussed on reappropriation and mastery of their physical capacities. They worked within informal social networks that enlivened them and facilitated repossession of their physical selves.

**Reactivating and Repossessing the Displaced Self**

The traumas of displacement and dispossession did result in a brief period of inactivity, but subsequent efforts were directed towards reactivation and repossession of responsibility for the traumatized self. All patients were expected to spend some of their time during the postoperative period learning about self care and lifestyle management. However, the women, as noted above, also engaged in reciprocal caregiving activities that
were continuous with biographical patterns of gendered caregiving. Those with previous caregiving experience actively structured their relationships and interactions with health professionals to achieve desired outcomes. With these activities, they gradually regained responsibility for self care.

Learning About the Problem from a Displaced Position

There is widespread recognition that lifestyle factors contribute to heart disease, and many hospital services consider patient education an important focus of cardiovascular care. However, study participants received little personalized teaching. Indeed, the assumption of most of the group teaching sessions they described was that certain universal truths apply to cardiovascular health: people should eat less fat, exercise consistently and in certain ways, and manage stress more effectively. It appeared from the women’s accounts that teaching proceeded without assessment of individual barriers or approaches to dietary management, exercise or relaxation. Teaching took the form of a set of prescriptions for self care that excluded consideration of local conditions or biographical contexts. Teaching was displaced. It occurred in a location where a generalizing set of discursive relations obscured particularity. Women and men of various ethnoracial, socioeconomic and developmental strata composed and were taught as one group: they were patients.

Because it was initiated on the unfamiliar terrain of the hospital, learning was also limited by the hospital division of labour and the priorities of care identified by each discipline. Although nurses, dieticians and physiotherapists considered patient education an integral part of their work, all were heavily responsible for physical patient care.
Teaching was often accomplished during regularly scheduled seminar sessions. There was a preoperative session that gave information about the surgery and postoperative care, and there were several "homeward bound" classes for recovering patients. Patients were encouraged to bring family members to the classes. These sessions were occasionally postponed because of holidays or staffing limitations. Because seminars were not offered every day, and because there were only a very few days following surgery when the women felt well enough to sit through an entire class, many missed the group sessions entirely. Furthermore, the sessions were conducted in English and the pamphlets distributed to patients were available in English. However, it was these pamphlets that were most useful to the women when they returned home.

"They didn’t have the diet [class] then. The dietician I saw [in community, after discharge] gave me some things to follow though. [pause] I used to be in Weight Watcher’s but I don’t know if that’s...[pause] that’s hard to do.” (COOKIE 337-339)

***

“Yeah, that was the last day when I go home, you know, I should--because I wasn’t feeling well and then the classes, my daughter came there and the classes was late, so I didn’t--I missed that class. I missed that class. INT: Did they give you the book though? The booklet? AGATA: Books? Oh they don’t give me the booklet. No, no, they don’t give me. I think the--they were so busy, you know, so nobody come. That’s okay. And so, I didn’t...” (AGATA 660-681)

***

“And then I got these booklets and all that and like for example, this...this one here, I found it--like I told you that I cleaned up a few things, threw out a few things because I’m looking for a bill. And that’s when I came across this thing here; I didn’t see that before, I don’t know how it could have been hiding on me like that. And if I have...still I should have had that from the beginning. And you know why I could not remember even having that? Because the day I got it I was still...you see I was over Easter in the hospital. That was not good for me at all
because the physiotherapist—or what is that called? INT: Physical therapist, yeah. OLGA: This girl, she came to talk to me on Thursday, one day after the operation in the stepdown unit, and I still was singing on morphine there. So she must have given me that then that day, maybe even explained about it but, you know. It was Easter. Now Friday was a holiday. Then came Saturday, they don’t work Saturdays, then was Easter Sunday, Easter Monday. The next day I went home. And just before when I was already dressed waiting for my son to come, she came back to me; that’s the next time I saw her. And she was telling me that they have now in the little room there where they showed us the tape and that they had some tape to show and they had some whatever, I don’t know because I didn’t see it. So I find that these people should not be.. You know, nurses have to work too. Why these people are not working on holidays? And when she gave this [booklet] to me, you know, she could have given me maybe $1,000 and I .... [pause] INT: You wouldn’t have known the difference? OLGA: Yeah!” (OLGA 904-96-3)

Four of the health professionals interviewed acknowledged that many patients were not able to attend the seminars because of the timing of seminars and shorter admissions. They referred to a “re-engineering” process that was intended to streamline the cardiovascular programme and improve efficiency. One of the issues considered in the planning stages was the inefficiency of the system of patient education. Reorganization of inpatient education would reduce overlap in the content offered in seminars by the various professional groups and decrease the amount of time devoted to patient teaching by individual members of the interdisciplinary team.

“...for those people, they are unfortunate, they would really be disadvantaged in having a lack of exposure. It’s literally a lack of exposure because they don’t have OT’s or dieticians, there is minimal physiotherapy coverage over the weekend, the long weekend. So with the re-engineering process as well, one of the things that every one of us is trying to do is perhaps we’ll just streamline the classes and just do them every day, seven days a week, or maybe we’ll have one kind of class from just everyone, as opposed to everyone holding separate classes. If there’s problems then we’ll give individual referrals.” (Physical therapist #1)

***

“There’s a much shorter time period before discharge now. Say five years ago, I
probably would be able to see eighty or ninety percent of patients at the physio class. Now most get to the nursing class, but fifty to eighty percent get to our class. And a lot less get to the nutrition class. We’re designing it now so that there could be a multidisciplinary focus in the future. There will only be one class and we can all take turns teaching it. It would be one generic class that all patients would be expected to get to. And we may still offer a few other classes that patients can come to if they’re interested so they can get a lot more specific information related to certain topics. And have a lot more teaching packages and stuff. In the cardiac centre the plan is to have videotapes and packaged types of teaching things that would be available for the patients and their family members. There would be a kind of library available to people at the sitting area. ‘We’ve had to redo the slide show for patients at discharge.’ (Physical therapist #2)

However, it is apparent from descriptors such as “generic” seminars and teaching “packages” that a standardized format was planned, where individual attention would be reserved for patients with special needs or problems.

A dietician informed me that patient teaching was a secondary priority on her list of responsibilities. She was responsible for the dietary needs of all patients on two nursing units, as well as a stepdown unit. As many patients had special nutritional requirements because of diabetes or other health problems, this kept her occupied during most of her working day. Seminars and individual teaching were often difficult to blend into this workload. A nurse who was responsible for conducting “homeward bound” seminars for inpatients explained that her shift was specially staggered to allow her to teach a group of patients at the beginning of her workday, and then take on a full patient assignment for the remainder of the shift. The two physical therapists who met with me were accustomed to assisting postoperative patients with their early efforts at ambulation, respiratory care and special physical therapy needs in addition to patient seminars. It was clear that no one worker could state that patient education was a sole preoccupation.
Several assumptions were embedded within this arrangement. First, it was clear that the main purpose of care was to promote physical survival and recovery so that patients could be discharged home in a timely manner. Secondly, education and learning were matters that could be attended to at times that were convenient to the schedules of the professionals who were responsible for these endeavours. Thus, sessions conducted by physical therapists would necessarily be offered only on those days and at those times when a physical therapist was available to teach. Thirdly, the content of seminars consisted of a series of factual guidelines about specific practices associated with better cardiovascular health; that is, the learning was assumed to be cognitively based. Thus, if patients missed a seminar, these facts could be conveyed in written form through the use of booklets and fact sheets. Fourth, much of the content was selected by health professionals and it was derived from professional literature. The content was assembled with the universal or generic patient in mind. Finally, it was presumed that following prescriptions for a healthier lifestyle and more effective self care was a matter of conscientiously applying the cognitive information supplied by health professionals.

In learning information about healthy lifestyle choices and self care, the women also gathered that they had a moral responsibility to take better care of themselves. As previously noted, this understanding preceded the surgical experience. Olivia recalled thinking after her first myocardial infarction: “Oh my God, what have I done to myself?” (OLIVIA 236). It did not matter to her that she had diabetes, which was beyond her choice or control. It made no difference that she had never smoked and took dance classes and regular walks prior to becoming ill. She still blamed herself. Many women
perceived the teaching they received as universal prescriptions or orders which would enable them to walk the moral high ground of cardiac risk reduction.

“Well I knew my do’s and my don’ts, so I did when I did come out.” (RUTH 2 1262-1263)

***

“Yes they had a class, we all went to that. And, um - what was that about? - oh, it showed us what we should be doing and what we shouldn’t be doing...” (BROWNIE 1640-1644)

***

“So I feel that being informed is important. I think that reinforces your lifestyle changes that you do have to make.” (ANN 1637-1641)

***

“...yeah, yeah, I went to one session...and, uh, they said what to do and what not to do and...all that.” (BAMY 442-443)

The preoperative video was mentioned by most of the women. Some remarked that their anxiety made it difficult to watch and absorb the contents of the video. Others attended with family members who wanted to better understand the surgery. Some of the women were unable to watch the preoperative video because they were scheduled for surgery on an emergency basis and there was no time for preparation.

“But it’s funny...we were. I don’t know, went to look at the video before the operation. The night before, cause this all came up so suddenly. And um, my husband and I really had trouble watching the video. And um, it was only after a friend sent me a book on the eight steps to a better healthier heart, or something, that I read the full description of what it entailed. I guess I was sort of in a fog and sort of closed my eyes at certain points in the video [chuckles]. And it really impacted on me after I was home that, gee, that was pretty serious! ... Well the reason we found it - of course it was a very personal thing - many years ago now. oh ten years ago, my husband’s stepfather, um, was undergoing chemotherapy. And we literally watched him die. And he was on the ventilator and all that. And that came back when we saw that in the video, for both my husband and I. So, it
came back. And I think that sort of traumatized us both.” (ANN 170-220)

***

“Yeah, and there was not much time to -- so there I was not prepared for that. It was just that tape that they showed in the hospital the night before, that’s when I had my first information. INT: And what did you think about that tape? OLGA: Ah, that they should make a new one. [laughs] That it must be from when they first started doing bypass surgery. [goes on to describe technical flaws in the video and the equipment used to screen it] Eh, okay honestly I didn’t think too much of it because I didn’t get all the information that I wanted.” (OLGA 841-870)

There was thus some indication that the video did not prepare the women for the sensory experiences they were to encounter after the surgery. In the emotional turmoil beforehand, it was possible that the details of the video were forgotten; after the surgery, there were cognitive barriers that prevented accurate recall of the video. Some were not satisfied with the information they had been given about the surgical procedure itself and complained that they did not understand what had been done to their hearts and bodies during the operation.

“INT: What kinds of things didn’t it prepare you for, then? RUTH: Well...for all the pain afterwards. The pain afterwards. It didn’t. It didn’t give you anything about that afterwards.” (RUTH 1800-1807)

***

“I had no idea how it was supposed to be done. Nobody told me how, except I asked my new family doctor to please show me a little bit about it. I was very, uh, that’s something I was very disappointed with. I asked when I was in the hospital the last time and if they would show me or some pamphlets about it. I didn’t know bypass, I didn’t know how it would work or what they would do in bypass. the doctor finally showed me...Just how it was done. Bypass what, you know? Bypass [laughs] you know? Like I mean, you want to know well before you have the surgery. Like a lot of people don’t want to know nothing. But I, myself, wanted to know. I had no idea what they were gonna do.” (GERT 103-122)

***

“But still I like to know more about that, you know. I’ve never heard about this.
what's it called, memory...memory? INT: Oh, mammary artery, yeah... OLGA: I'd never heard about that and I just can't picture how this all works, you know? I'd like to know these things. It's my body that's all that done to, you know. I'd like to know that. Unfortunately I don't know...nothing.” (OLGA 1195-1209)

Although situations where learning could occur were structured into the activities of caregiving in the hospital, several of the women explained that they had obtained information from other sources. Two were discharged from the hospital to rehabilitation hospitals, where they observed that caregiving activities placed greater emphasis on teaching (RUTH, SONIA). Much of the learning they described was more experiential and interactive than that which occurred in hospital. Two women saw bypass surgery on an educational television show and felt that this helped them understand the intricacies of the surgery (BROWNIE, MARGARET). Useful local knowledge was often transferred from patient to patient or in conversations with family or friends who had themselves undergone surgery.

“And then it hurt so bad and they didn’t--I didn’t know what to do! And then I remember my sister-in-law saying - she had an operation in, ah, year or two ago- and she says they gave her a towel to put on her chest and have it tight. So I remembered; so I didn’t have a towel or anything to I grabbed the pillow. See they didn’t tell me anything when I was in the (hospital). If they would just told me, you know, like or...I never even thought. So I grabbed the pillow quick and then held it tight.” (GERT 544-554)

At least three were given reading materials by family or friends who wanted to help them obtain the most meaningful information possible (ANN, LAVERNE, MARGARET). One woman, worried about her lack of knowledge about a low cholesterol diet, scheduled a session with a dietician in her community and paid for this service (COOKIE). Several others followed this strategy of seeking explanations later, when they were able to exert
some control over the location and pace of the situation, and when they were sufficiently in possession of their physical and cognitive faculties.

Comments indicate that the women were actively involved in structuring learning activities, and they were often selective about the knowledge they sought. Occasionally they avoided information when it was disturbing or when they felt too ill to think clearly. Although the health professionals around them in the hospital had already organized teaching sessions and content around specific institutional priorities, the women themselves identified individual priorities that were often satisfied through less formal means. In effect, there was an informal network of information exchange that involved interactions with family, friends, fellow patients and former patients. Information was also easily accessed from the print media and television. The advantages of this informal network were clear: learning could occur at the women’s convenience and it was often located within the material and personal context of the home.

Caregiving

The motions of ordinary life were recalled throughout the extraordinary experience of hospitalization when some of the women formed caregiving bonds with other patients. These bonds were frequently reciprocal, so that each would help and remind the other to perform self care activities. Vigilance and emotional support were common reciprocal activities. Roommates would at times summon nurses for each other, commiserate after painful or unpleasant procedures or remind one another to perform prescribed activities associated with being “good” or responsible patients. Not all of these bonds were reciprocal, however, because some women took more responsibility for comforting.
helping and motivating others who were obviously in need of more attention after surgery.

This activity had the secondary effect of reactivating the social and biographical identities which were threatened by the displacement and dispossession which flowed from institutionalization. For example, Emma observes that her caregiving work with an older woman patient is simply a part of her repertoire of responses.

“I gave her a lot of help, you know. I think this is why. You know, I gave her so much help, she phoned me a few times after. And I called her a couple of times just to see how she was doing. And, but, I was the second youngest one. There was a woman there forty seven. And, um, she kept calling me The Kid. Whether or not it’s the type of person I am, and I had been around a lot of sickness. And, not with myself, but my family. So it’s nothing for me to say, to offer, even if I can hardly walk myself...” (EMMA 1948-1965)

An element of familiarity was restored in a context of displacement, as Brownie suggests below when she says her mutually helpful relationship with a roommate made the hospital seem “just like home”. Indeed, her comment that the nurses did not “bother” the two women as the women engaged in mutual care suggests professional intrusion was not desired at that point.

“Because if I didn’t do it, the woman in the next bed would do it and that would remind you. And vice versa, she’d say: Oh, yeah, you’re using your toy [spirometer], I’d better use mine. And, uh, she couldn’t sleep at night, and sometimes I couldn’t sleep at night and we wandered around the halls and we discovered the kitchen. And we made hot milk and ... The nurses don’t bother you. They said: Oh, you can’t sleep tonight? So [pause] that’s what we did. Just like home.” (BROWNIE 1811-1827)

The help of other patients was particularly important in the transfer of local knowledge about self care:

“I think they were all relaxed, the ones I talked to anyway. ’Cause the one lady before I was, ah, when I came in, she was going home the following day and she explained to me about different things. And it worked really good. You need that
kind of a guidance, I think.” (GERT 579-584)

This activity further elaborates the existence of an informal economy of care and information exchange which existed parallel to the formal structures of care. Those with the benefit of merely a few days’ more experience and healing offered physical assistance and helpful knowledge to fellow patients, who would in turn aid others when they were able. While the participants changed over time, the network and activities remained consistent.

Care of the Dispossessed Body

For most of the women, the major physical challenge of the postoperative period was the struggle to regain the capacity to perform routine activities of self care. Located within their accounts were issues of moral responsibility to self and concern about the relentless workload of nursing staff. Descriptions of the difficulties encountered during early attempts to walk, as reported in the section on the embodied self, indicate dispossession of the body and lack of control over previously taken for granted functions. Reactivation included regaining the capacity to act in ways that assisted in repossession and reconstruction of the self.

The transition from dependency to self sufficiency was described as a moral necessity. This seemed connected with the teaching arrangements and social transfer of knowledge that have been described above. However, some accounts suggested that resuming responsibility for personal care was also perceived as part of a social responsibility to others. Nurses were seen as overworked and possessing problems of their own, and some anecdotes imply there was a social obligation to avoid contributing to
that burden. There was an awareness of a division of labour and hierarchy of priorities; physical care occupied a lowly position in this organization of tasks. Gradual improvement in physical abilities was gratifying and raised the spirits; achievements such as being able to walk as far as the bathroom opened the possibility of going to the bathroom without help. Symbolically, reaching the hallway and walking the corridor was a re-entry into the social world where others could be encountered.

In the anecdote below, Emma stumbled to find terms to describe her earliest experiences with repossessing the right to get out of bed independently. There was a subtext suggesting she was not at liberty to leave her bed without supervision, yet there were equally powerful reasons (she argues defensively) to avoid burdening the nurses.

“I was--I was supposed to call a nurse. Well I always feel they’re so damned busy, they’re short-handed, if I can struggle to get to here by myself, I may not--Maybe I’m not supposed to, but if I can then--For some reason I was never near the window, I was always next to the bathroom, so I only basically had to go from here to there. INT: Then step down and turn here. EMMA: Like four steps and turn and I’m in there, like, you know. Ah! So anyway, I got in the bathroom and I started feeling faint and--Oh, God! So I pulled the chain and the door was open about this much, so this face came in the door and I...it sounded like a female but I knew it wasn’t...he said to me: You okay? And I says: Well, I got in here and I tried to save a nurse coming to me, but now I feel faint. And I know I’m not supposed to be doing this but don’t give me the devil for it.” (EMMA2 1456-1474)

Tip described her gradual return to mobility, including her elation when she was able to reach the hallway. She, too, spoke of a responsibility to resume self care quickly in order to relieve nurses of some of the burden of her care.

“You know, I walked maybe from here, a few feet, the first time and then that was it, back again; and then I was able to get to the bathroom. That helped too, and then finally out the door. [laughs] I said: Oh, oh! [laughter] It felt good to go outside the room - the room door and that corridor. And then a few feet outside
each day. And then finally I did get around to going around the nurses’ station.” (TIP 329-337)

***

“And then at night time, oh boy! At night time if...depending on who was on, if you, ah, like you like to get yourself washed and your teeth done and go to bed, a lot of them wouldn’t do it. They’re changing shifts, you know, do reports to write. Well I know they do have a lot of reports; but, ah, people need help too” (TIP 1026-1032)

Self care also involved structuring the way others delivered care and looking out for one’s interests. These activities were less visible and intensely social in nature. At the furthest extreme were situations where the women challenged the soundness of decisions made by health professionals.

“And I said: Excuse me, nurse, I think there is a mistake here. I’m the one that should get the intravenous. No, she gave me such a look, that I felt, okay, she will say anything. And the other lady, I heard her, she was arguing, says: No but I don’t remember, they took it out already, they left it for a short while, but I don’t think I need again the intravenous. Are you sure?, the nurse says. Yes, yes, she says. And she goes (unclear) with her tool and she could not tell her, she was the nurse and she knew what she was doing, so you can’t tell her otherwise. And after a little while, -- and I was afraid to mention it because she answered with such an energy and I felt so down, like I said something I shouldn’t. So sometimes you find yourself a sensitive position. Then they realize hours later that I was the one that was supposed to get it, not her.” (SONIA2 713-729)

Emma described some of the ways she developed positive relationships with her nurses.

“I -- I’ve got a good memory so I remember their names so when I see them the next time: Oh, hi, Maryann, how are you? -- or something to that effect. And I call them by their name. And there’s one time when I was in (hospital) one patient said to me: God, Emma, how can you remember the nurse’s name? Because I take the time to try -- to remember so that they feel more comfortable with you.” (EMMA2 1589-1596)

Olga described her experience of not being accepted as knowledgeable in matters associated
with her own care.

"Like I have my own little blood tester and I did it—I did tests myself in the hospital too, you know, and I called them, I said: Look, my sugar is 23.9 and I know that if the sugar is that high, the healing process is being slowed down too. So I have come down now, it took a while to come normal again, my sugar. They didn’t give me the right medication either in the hospital. Kept on telling them that. I don’t know why they do that. I mean I have a specialist that looks after my diabetes. He prescribed that medication for me and I realize, I’ve been told in January already in the hospital they didn’t give it to me either, and I told the nurse, I said: This is what I have to take and why don’t you give it to me? The nurse said: Well I have to speak to the doctor. They thought I gave them the wrong information; because I’m taking this one pill, apparently it’s really the limit of what you can take. And I know that. That’s what I’m taking and that is what is controlling my diabetes." (OLGA 1251-1271)

In each of the above three examples the women reveal local knowledge about self care and social situations of dependency. They describe ways of dealing with health professionals and properties of these relationships. Sonia explains that continued protest over a nurse’s mistake is a pointless waste of energy when one is feeling tired and depressed following surgery; the balance of power was clearly not in her favour. Emma found that the effort of learning nurses’ names was reciprocated with more personalized, attentive care. Olga had extensive experience with managing her diabetes through diet and medication. She understood that the correct dosage of medication was crucial to maintaining the physiological processes of wound healing. Yet she was not viewed as an expert by health professionals and her insistence that she was being improperly medicated while in the hospital was ignored. Attempts to structure and improve the care received from health professionals had mixed results.

Displacement from the familiar locations of the everyday bore substantial implications for the activities pursued by the women during their hospitalization. Illness and surgery had
temporarily resulted in dispossession of their bodies and bodily functions. For a brief period, they were unable to perform the simplest of functions unassisted. They were to regain possession of their physical selves in a brief period of time: the average length of hospital stay was five days after surgery. The tasks associated with this repossession were learning how to minimize risks associated with heart disease, regaining physical mobility, and structuring relationships with health professionals. As displaced persons, the women were located within the everyday working world of health professionals. Learning within this context was accomplished from a point of reference other than their own concrete, everyday understandings. Mobility was renegotiated under conditions that differed from those of the assumptive worlds to which the women were accustomed.

Although the experiences and conditions participants encountered were extraordinary in comparison to their own notions of everyday experience, this world was entirely routine, and routinized, to the nurses, doctors, physical therapists and others who inhabited it on a daily basis. It was a world where bodies were restructured and care proceeded in a sequence that rarely varied. The primary intent of all activities within this world was to minimize danger and prolong life. The women were entered bodily into a set of discursively based relations that preceded them and that was subject to forces and influences of which they had little knowledge.

The Social Relations of Displacement

In the hospital setting the women’s relationships with health professionals were characterized by several contradictions. Although the physicians, nurses, and others who cared for the women possessed remarkable knowledge about the women’s internal physical
health - knowledge which the women themselves did not share - these same health professionals did not appear to recognize aspects of the women which constituted their personal and social selves. This contributed to contradictions in many interactions between health care workers and the women. The women always dealt with these professionals in the hospitals or in offices: they were displaced from their own local worlds and subject to unfamiliar priorities and idioms of the institutional context of health care. Many remarked that their contact with cardiovascular surgeons, cardiologists and nurses was brief, impersonal, and highly focussed on discrete physical fragments of their selves. According to one woman:

"I mean, doctors are doctors. You know, they're not your friends. And it's different with your GP, you get to know him because you have this back and forth. But with these people, I mean, in all likelihood, after I see her, I'll never have to see her again." (BROWNIE 1086-1093)

There were tensions between the intimate and the impersonal, and dependence and detachment. Some women remarked that, amidst a constant stream of attending physicians, medical students, nurses, physical therapists and dieticians, those who were purportedly the most responsible for their care and survival were the least often encountered.

"The two women that I was in with, the one woman never, had not even seen her cardiologist in a week. And the other one, almost the same thing. The cardiologist and the surgeon. But neither one had seen either one of these doctors prior to their operation." (EMMA 2087-2096)

Emma mused that it would be comforting to feel her cardiologist took an interest in reassuring her about her progress after surgery, but she concluded that this would be a deviation from the fragmented structure of institutional health care. In the hospital division of labour, her cardiologist was not the appropriate person with whom to discuss personal
issues such as worry and depression. She concludes that she would be better advised to confide in a psychiatrist, whose concerns would more reasonably align with the metaphorical, emotional functions of the heart.

“I think I guess, like I say. I think if [cardiologist] had— but [cardiologist] had the opportunity to come and see me and he didn’t do it. You know like he really did. I know he’s a busy man but he could have taken five minutes to come up and say, I’m here. Come with his clipboard, even though it’s blank and say, ‘Gee, everything went well’ and this and that, you know. And he could have been a little more—but he didn’t do it. I mean that would have been a nice thing I think. Had he done that, he would have made me feel just a little bit more, ahm... But maybe we don’t... maybe we’re just reticent to talk to them, you know. I don’t know this person. I didn’t want to start to sob and say that like my, you know, and pour out what I was really feeling. He didn’t have a... he wasn’t a shrink or you know.” (EMMA 893-906)

As displaced persons, the women found that a perplexing collision of idioms, whether emotional/technical, concrete/abstract, or personal/ institutional meant that many interactions with health professionals were at cross-purposes. Questions were misinterpreted, while some forms of knowledge received greater emphasis than others. When Luigi reflected on all that had happened to her in the months before her surgery (unexpected myocardial infarction, abandonment by her husband for a younger woman, re-entering the workforce) she became tearful. When a surgical resident entered her room, she asked in despair what had happened to the sane, predictable life and future she once knew:

“But those doctors, there are so many different doctors coming in to see you constantly, and they’re very impersonal; and one day I just sat there and a doctor came in and he looked at me, and he was just a young fellow and, ah, and I had just started to cry and he didn’t know what to [chuckles]. I said well: “What’s happening to me? What happened to me? Like, what’s going to happen to me?” Like, he said: “Well, you’ve had...” and then he got very clinical. Told me about how the operation was done. And so that’s fine and I -- so he laughed and I’m just, I guess and I’m just going hoo, hoo, hoo, but I’m just sobbing and he turned around and came back and he patted me on the shoulder and said: “Everything will be fine, you know”. And he turned around and went back out. Like he didn’t know quite what to do with me.
because I got personal, or because I said: Hey wait a minute I’m a person here and what is happening to me.” (LUIGI 819-830)

Luigi’s story highlights the dislocation she experienced in trying to find a place for her emotions. The hospital offered a discursive world in common that emphasized the physical imperatives of survival, but excluded the affective fallout of a momentous proximity to death.

The women indicated that they wished to confide in physicians or nurses but at times this hope was overshadowed by the immediate pressure to manage and maintain satisfactory relationships with a variety of health professionals. Some of the more vulnerable women were taken aback when they encountered actions which they interpreted as unkind or thoughtless. These often implied a lack of recognition of the women’s true social value and worth and stripped them of coherent identification with their biographical and sensuous selves. Cookie described her bodily experiences of being entered into routines where fluid intake was restricted and where specific measurements were needed at specific times.

“And my mouth was so dry. It was so dry. I was trying to convince them to give me a drink of water. And those nurses: “No, you can’t have a drink of water, only chipped ice.” [pause] Yeah, but they used to weigh us in the morning at six thirty or seven o’clock. And you’d be so sore. And they’d be trying to help you up and they’d be pulling you up, because they didn’t know where you were sore really. Oh I tried to tell them: “Don’t bother, nothing’s changed since yesterday!” [chuckle] But they’d be: “Oh, come on, you have to, you have to!”” (COOKIE 582-592)

At the other side of these incidents were priorities that competed with sensory discomforts. These priorities were associated with monitoring and protection. For example, the most accurate indicator of fluid retention is body weight, particularly when it is compared to a baseline weight obtained prior to surgery. Fluid retention may threaten cardiac function and result in complications such as pulmonary edema, a condition where fluid collects in the lungs.
Cookie's nurses were collecting measurements of body weight to be textually inscribed in her chart for her doctors to evaluate. They were transforming aspects of her concrete bodily self into numerical indicators of her postoperative progress. Cookie’s experience of this process was one of discomfort and irritation. Her body was not her own possession, to govern as she chose.

Although many dismissed as inevitable the disjuncture between the perspectives of professionals and their own standpoints, the women expected to be physically protected from pain, injury, filth, infection, and death. There were anecdotes about ways that professionals caused them pain or aggravated existing pain by performing procedures or insisting that the women ambulate.

"And anyway, he came in, this doctor came in, and he said to myself and the woman that was in my room with me: Well I’m the guy that has to come and take those wires out. He says: I’ll be in later today. And we said: What were they for? And he says: Well, they were for - um, what do you call them? - the pacers - I guess maybe if you run into trouble, they’re ready for all emergencies. And uh, but then the wires had to come out. So he says: Oh, I’m pretty good at it, I’ve got my PhD in wire removal. [chuckles]. INT: So how did it go? BROWNIE: Well, it hurt. A lot of the things hurt. But that’s what they had to do." (BROWNIE 1140-1163)

***

Until my daughter whatever she cooked she brought me something. Even an extra piece of bread just with a little bit of butter on it and milk with an apple or...They should be more aware and especially, you know, in the hospital they should know about the diet. So the dietician came up and she took down whatever I told her, okay, okay, and then they sent up the wrong food. It’s terrible." (SONIA2 783-789)

***

...a tube here, a tube there, a tube there and here, we had, ahm, the heart pump in there. So when she took these out she said this--she had to freeze my stomach ‘cause she was gonna hurt. Because she pulled the three of them all together. And they didn’t take this one out until I was coming home. INT: So she froze your stomach when she took the chest tubes out. OLIVIA: But this--these two, the doctor come
and said: I’m just gonna pull these out. He said: “It’s just a little wire.” I said, okay. And oh, my gosh!! INT: It did hurt? OLI: I said: “Oh, my Jesus!” I said: “You told me it wouldn’t hurt! Oh, did it hurt! It really hurt.” I said: “I don’t like you.” He said: “Well nobody likes me today anyway.” So that’s about all.” (OLIVIA 272-297)

Some narratives touched on ways that women resisted the dispossession associated with being entered into a routinized relations of care. Often this resistance took the form of enlisting the aid of a nurse as an advocate, encouraging a professional caregiver to relate on a more empathetic or personal level by invoking memories of their own female relatives or through use of humour.

“When the nurse came in [Maria] (roommate), she said, um, to the nurse: “What a way to treat her…he just yanked those right out!” So the nurse, she just went right out and got him. And brought him back in. And he apologized to me! As a matter of fact he apologized three mornings. INT: Really… RUTH: Because the day I was leaving he came in and I said to him: “You know, if you have a mother, you wouldn’t want anyone to do that to her, would you?” He says: “I have a wonderful mother.”” (RUTH 1547-1567)

***

“Yeah, I had ninety staples in my leg. The nurse, she counted them. In the two legs together. INT: How long did it take to remove those? BROWN: She was pretty good at it. Some I must say didn’t hurt. She said: These won’t hurt you at all. And I said: How many have YOU had removed? [chuckles] But some of them hurt and some of them didn’t. Some of them hurt where there was inflammation.” (BROWNIE 1168-1180)

These anecdotes demonstrate the contradictions associated with the displacement and dispossession experienced by the women as they were entered into relations which depersonalized them, but were ultimately intended to prolong their survival and improve their quality of life. The women described violations of their privacy, comfort, personal cleanliness and dignity in the hospital. In the everyday location of home, this treatment would be considered extraordinary. However, as displaced persons, the women were subject to the
relations and conventions of an institutional context that differed markedly from those of the home. The knowledge, idiom and courtesies of the everyday were out of place in the hospital, where even the practical understanding of the constituents of personhood were fragmented and textually mediated as “personal histories” on patient records. These additional anecdotes indicate that the biographical identities of the women were subordinated to a totalizing focus on cardiovascular function during the processes of diagnosis, surgery and treatment. Ironically, despite this intense attention to the physical body, sensuous experiences such as pain and thirst were obscured.

**Displaced Relationships with Others**

For families and close others, surgical reconstructions of the women’s hearts and intensive scrutiny of their visceral bodies represented extraordinary departures from the everyday. Anecdotes about the responses of close others during the period of hospitalization revealed the emotional suffering and helplessness of loved ones. As explained earlier in this chapter, missing information about the immediate postoperative period was supplied by others who had visited during that period. While the women did describe their own feelings about the surgery, they were displaced from or dispossessed of their bodies during the immediate postoperative period and could not clearly recall or articulate what happened to them during that period. It is possible that some experiences were simply “unspeakable”. But more was revealed when they recounted the experience as told to them by their loved ones. It is through the eyes and voices of these others that the gravity of the situation was realized.

“He (husband) just...he’s been great. But he was terrified. INT: Was he? TIP: Oh, my! Yeah. The three of them actually went through an awful time. Sitting waiting for four or five hours to see if I was gonna come out of it. They were just beside
themselves, all of them.” (TIP 808-822)

***

"Course, you know, your son, ahm, he's...they don't do that much around the house anyway, okay, so I don't even worry about him most of the time. But he had no idea what we were going into when we went into this. And my daughter was well prepared because she was at the hospital with me on the Thursday night and watched the movies with the-- the lady in the room about going into surgery-- and she was aware of what was gonna happen. While my son, when he seen me on the Friday in the recovery room, he was totally shocked. He thought, you know, it was like going in for a hangnail; oh, this is gonna be easy, no problem." (LAVERNE 993-1004)

***

"INT: When did you first get up after the surgery? R: Well, I got, ahm, I'm not sure when they got me up. I think my daughter would know better than me.” (AGATA 244-247)

Agata's daughter was thus more familiar with some details of Agata's hospital experience than Agata herself was. In many cases, significant others became the oral historians who carried memories of the perilous hours after surgery. Laverne's son, about whom she ordinarily would not worry, was typical of many family members; his recollection of his mother's immediate postoperative hours was emotionally traumatic, and this trauma was impressed on Laverne. She was not only unable to care for herself during this period - she could not shield her son from the impact of the sight of her in the recovery room.

The turmoil experienced by others was the basis for outpourings of love and support - or for avoidance. For example, while some husbands were continuously present at the hospital bedside, others were physically unable to tolerate confrontation with the mortal frailty of their wives. Displacement exacerbated the helplessness and worry of these closest companions, for the hospital setting is so powerfully associated with the most fearful of human experiences.

"Oh, for my husband, it has been very difficult because our boys are away from home and married and have families of their own, so it's just the two of us and it was very
difficult for him. And he doesn’t like to go to the hospital to begin with anyway, so he’s in there [chuckles] and he hums, you know, so he doesn’t have to ... he avoids what he doesn’t, what bothers him.” (ANN 367-381)

“My sister was there when I woke up. But I did not remember it. I don’t remember, Like I had the operation on Tuesday and Tuesday night she was there. But I don’t remember. But my husband wasn’t there. He is very--gets very nauseated if he sees all the tubes and so he couldn’t be there. Yeah, he passes out, he passed out at [hospital] so he’s no good there. They took him down and checked him over. But anyway, so my sister was there, so that was nice.” (GERT 521-529)

The unprecedented vulnerability and proximity to danger was traumatic to others in the extraordinary world of the hospital. Laverne’s earlier anecdote indicates that orientation seminars were available to family members as well as patients. Her daughter found that these seminars helped prepare her for the sight of Laverne immediately after the surgery, while her son did not attend and was deeply distressed by his postoperative visit. In quotes cited at the beginning of the chapter, Olive and Cookie were mistaken as dead or dying by their partners, who had to be reassured by health professionals that progress was actually satisfactory. The seminars and reassurances served as the maps or verbal directions that assisted these others to develop an understanding of the unfamiliar terrain of the women’s inert bodies. Paradoxically, this alien territory was formerly the most beloved and familiar of bodies. The world in common explained by health professionals had the power to erase or preserve another more predictable, everyday world.

Concern for significant others was based on more than a simple awareness of the emotional distress felt by those nearest and dearest. In many cases, an informal network of family, friends and neighbours was actively involved in providing help and sustenance to immediate family. The women were acutely aware of and grateful for the work and
coordination that was going on "behind the scenes". However, for some, uncomfortable feelings of dependency and obligation were aroused by this intense activity. For lone women or those women whose husbands could not be present, female family members and their families maintained a presence by visiting and learning what they could do to help. The women were aware of the inconveniences borne on their behalf, and as Ruth's comment indicates, this awareness threatened biographically constructed understandings of the self as independent and intent on the needs of others.

"And I mean, they [daughter and son-in-law] were down at [hospital] every night to see me. That's a bit of a trip. Especially coming from work. They weren't getting their dinner until ten and that at night. I know they don't mind. But you just feel yourself...I've always been so independent, I guess." (RUTH 305-316)

***

"But [son and daughter-in-law] were both there in the morning, and [son] came down, and [daughter-in-law] came as soon as she got a babysitter for the little girls." (BROWNIE 1483-1487)

***

"But one [daughter] lives outside Toronto and she's got three children. So it was pretty rough. I think they had two or three different neighbours that had to come in you know, periodically that day, an emergency baby sitter." (TIP 131-135)

***

"My husband, they kept him in eats all the time. Well one of them lives down the street here and the other one with the girls just lives over on [street name] here above one of the stores and he'd just alternate back and forth. One of them would have him for supper one night and the other the other night. And then if he didn't come home on time for supper, he stayed down at the hospital or something, they used to bring up a great big bowl of soups and stews and everything else; all kinds of casseroles. And when he'd come home they'd be sitting there waiting for him. No we did very well, I mean and my family really stuck with us, you know." (VI 715-727)
Clearly these extraordinary efforts were intended to honour and preserve the ordinary worlds of activity which were ordinarily coordinated by the women. These endeavours prevented disintegration of the local and everyday which carried the spatiotemporal conditions of each woman’s selfhood. In contrast to the intense biomedical focus on physiological survival, the activities of the local network were focussed on social survival. Two systems of care were delineated in the women’s accounts.

Among the most positive anecdotes about health professionals were those in which this supportive work of families and friends was recognized and given priority, despite rules or workload demands to the contrary. These professionals (often nurses or aides) were highly regarded and remembered warmly.

“And I found that the two nurses that I had were excellent. Your family’s only supposed to stay five minutes and they let my kids stay longer, which my kids thought was great.” (EMMA 1883-1888)

***

“My children and my sister and my friend, who were all there, I’ll have to tell you the story about this gal...this nurse, on Wednesday night, I guess I barely remember, but my kids say she was a HOOT. Big woman and she wore a CAP. INT: Wow! [laughter] LUIGI: a nurse’s cap, well you NEVER see a nurse’s cap. Anyway, she was just hustling around and looking after me and she looked at the children, before they left that night. And she looked at them and said: And YOU will be here at six o’clock tomorrow morning? And the kids said: Well, yeah. She said: You had better be, my patient isn’t going down to that operation as an orphan. [chuckle] That’s right, that’s exactly right. They said that she was just like AMAZING, they had never seen anything like her. Now I wish that I could...but they obviously gave me something to calm me...or else I was tuning it all out...because I was terrified...I don’t know. I truly wish I could remember more of her or even her name.” (LUIGI 643-661)

These instances stand in sharp contrast to other anecdotes which describe the disorienting effects of displacement into the social relations of the hospital. These professionals were
noted by the women as remarkable in their recognition of a need for the sustaining presence of close others. The power of institutional rules of visitation to disperse and dislocate loving bonds was subverted by the nurses who permitted Emma’s daughters to remain with their mother longer than the usual five minutes. Luigi’s nurse understood the power of displacement to “orphan” patients during the moments of their most profound need for love and encouragement.

Close others were often encouraged to attend seminars and teaching sessions with the women. This ensured that close others were aware of the many tactics available to maintain cardiovascular health after surgery. This further orientation of others to the world of heart disease could augment the women’s efforts to learn self care. As several of the health professionals I spoke with explained, it was hoped that family and friends could remind the women of desired behaviours and support them in their efforts to change. Samara found that her husband’s attendance at some of the sessions was helpful because of her poor recall of instructions given during her hospital stay.

“He (husband) reminds me of things. You know what, when you are in the hospital, I didn’t have any guests for a week, so I got to all the classes. So you’re listening. But your mind is...I don’t know what it is, the morphine, or what it is...your mind is not working clearly. They show you the slides, and you’re watching, but you don’t remember anything. I don’t think anyone can remember. Your brain is still sleeping. Even when I ate, I’d think: What did I eat? INT: You couldn’t remember. SAMARA: And you don’t remember what they say to you. The doctors, they would come around and after, you don’t remember what they say. I didn’t remember how many doctors, or their names. The nurse would come in and half an hour later I would be thinking: What happened? What did she say?” (SAMARA 394-403)

Ruth explained that her apprehension about a preoperative teaching video was alleviated when her niece and her niece’s boyfriend attended with her. She was reassured by their
interest in her experience - they wanted to understand the world she was about to enter. The
video served to textually mediate this common understanding among health professionals,
patients and families.

"The video, yeah. Doesn't show you all the gory details, but it shows you the basics, and it sort of makes you feel, you know...of course you're very nervous, anyway. Doesn't matter what you see or do. But I thought it was quite good. It was interesting. You didn't have to go unless you wanted to. But I went to it. As I say, I have a niece...she happened to be visiting me with her boyfriend, he's a doctor and the three of us went in and looked at it. And then my daughter, my son-in-law, and my sister, they were in the night before the operation, and they went in and looked at it as well. Because they wanted to understand what I was going through." (RUTH 1760-1782)

Thus some families and friends as well as patients were introduced to discursive elements
which included a medicalized world view of the body and health habits. Awareness of risk
and danger were counterbalanced by a moral solution: self care with attention to the
foundations of heart health.

Discussion

Goffman's (1961) conceptualization of the "total institution" describes how individual
identities of inmates become subsumed to the structures and practices of institutional settings
such as asylums, prisons, monasteries and hospitals. The concept applies to the experiences
described by participants in this study. Loss of access to personal belongings, conformity to
a uniform style of dress (such as blue hospital gowns for both men and women), dependency
on hospital workers for necessities of life and the disruption of daily temporal habits by the
hospital's 24 hour schedule are changes that eroded personal identity. The women became
identified by a totalizing medical preoccupation with cardiovascular function and
physiological survival. In effect, the virtual identity "woman with heart disease" coordinated
professional activities, replacing the personality or biographical identity of the bearer of that diagnostic title.

Location and identity are not the fundamental issues, however. The women were radically displaced. They were removed from the familiar routines, spaces and relationships of the home and inserted into a discursively driven process, or set of processes, which preceded them and operated beyond their control. As displaced persons, the women were learning a new world, not as outsiders, but as insiders to a set of institutional relations within which they did not fully understand how to mean. Some, such as Emma, had learned through repeated biographical experiences how to protect their own interests within this milieu. Others, like Tip, were less experienced as insiders to this discursive order. Paradoxically, the elements of uncertainty and danger which accompanied the diagnosis and language of heart disease justified the extreme displacement and peril precipitated by hospitalization for surgery. Consent to surgery constituted an extraordinary leap of faith wherein the women entrusted others to monitor and even control their bodies and bodily functions. Thus, one of the most striking aspects of displacement was a marked experience of bodily dispossession.

Bodies were a preeminent concern within the hospital relations and particular features of bodies were highlighted by therapeutic and monitoring procedures. Cookie’s weight was regularly noted in her chart, for example, but the discomfort she felt when getting out of bed to be weighed was an experience that was excluded from the record. The women were unable to recognize or understand their bodies within this set of relations. Surgery changed the surfaces of their bodies with the addition of surgical incisions, pacemaker wires and chest tubes. Monitoring devices connected the women to mystifying tracings on screens.
Endotracheal, nasogastric and urinary catheter tubes extended from orifices that were normally the women's personal domain. Intravenous and central lines pierced their skin. Anaesthetics and analgesics intensified this bodily dispossession, rendering the women inert during surgery and drowsy for days afterward. These changes were also deeply distressing to those who visited the women after the surgery.

The discursive elements underpinning these relations were supported by diagnostic identification of a pathophysiological problem in need of remedy or repair. Surgical repair involved drastic endangerment, but it also extended the possibility of survival and improved quality of life. They formed the basis of the world in common shared by the women and the health professionals who worked with them. The women had damaged hearts which could be repaired. The health professionals, in turn, all had particular fields of expertise which converged upon the project of repair. The work and consciousness of these professionals was informed by a technological and scientific tradition that narrowed attention to certain aspects of the human body and excluded others. Their work was complex and had been routinized by many repetitions. The women valued this expertise and experience highly, for it increased their chances of survival. Thus they willingly, albeit somewhat fearfully, submitted to the displacements of hospitalization.

The material and embodied conditions of illness and surgical intervention resulted in relationships of extreme dependency. These, along with the discursive emphasis on repair of a cardiovascular problem predisposed a particular view of the women's bodies as vulnerable and flawed objects rather than as repositories of knowledge, sensation, agency and personal history. Indeed the women themselves could not recognize their own bodies and responses
after the surgery, remarking on disturbing alterations in cognitive and sensory function. Simple activities such as walking, going to the bathroom and showering could not be undertaken without help. Indeed, these activities were forbidden in the early days following surgery unless there was supervision and assistance. The women’s bodies appeared to be in the possession of the health professionals who monitored and facilitated progress. For women like Tip, the final displacement came with the failure of close others to recognize the wives, mothers, grandmothers or friends they formerly depended on - they were no longer recognizable within the discursive constructs of the everyday.

These implications of displacement spurred efforts to protect, regain or reconstruct a position of comfort as an insider. Although this was a common theme, each woman relied on different strategies according to her biographical experiences and social circumstances. Advantages and disadvantages conditioned each approach. Emma, with her long history of caregiving and dealing with health professionals, regained a modicum of normalcy by helping other patients and by carefully managing her relationships with nurses and physicians. Brownie bonded with a roommate to create a home-like milieu and reasoned that health professionals were not there to be her friends but were to provide expert physical care. Sonia, an elderly holocaust survivor, conserved her strength by choosing not to disagree with a nurse who spoke to her “with an energy” that suggested the possibility of an argument.

Dependence on health professionals for continued survival and physical well being being promoted tolerance of a particular set of discursively driven relations which erased particular aspects of embodied human experience.

Coney (1994) explains that routine monitoring of body tissues and functions in adult
women constructs a surrogate identity which is inscribed in the numeric or pictorial records of laboratory, mammograms and PAP smear results. Similarly, the study participants were "women with heart disease" and, as such, possessed textually inscribed virtual selves which were recorded as angiography findings, surgical reports, EKG tracings, hourly flow sheets, and countless other texts. Their physical progress was intensely monitored. Morgan (1998) predicts that medical surveillance achieves greater prominence when individual members of the culture internalize, use, actively support, and demand the use of medicalizing concepts, discourse, and practices and when they not only comply with but seek out active involvement in medical technologies, claiming medical discourse and vocabularies as their own (p. 96).

A medicalized consciousness develops, establishing medical idioms within lay discourses about self care, moral responsibility and health (Kaufert, 1996; Lupton, 1993; Morgan, 1998). For example, concern for their continued survival served as a powerful incentive for the study participants to accept medical interventions and prescriptions for heart health. Many understood the latter as a moral imperative to change risky or dangerous behaviours. Once their hearts were surgically repaired, the women were obligated to maintain patency of their bypass grafts. This duty to the self was undertaken in conjunction with a discursive emphasis on extreme peril. The discursive tenets of self care located health care in the home, assuring that threads of the medicalized world of the hospital entered into the weave of the everyday.

Lupton (1993) explains that the medicalized concept of health risk "has a 'forensic' property, for it works backwards in explaining ill-fortune, as well as forwards in predicting future retribution" (p. 430). Attribution of risk, and blame, thus serves to maintain social cohesiveness by maintaining internal control over the personal habits of populations. Thus,
she posits, among health professionals there exists the opinion that

...anyone who has a [heart attack] must have lived the life of gluttony and sloth...We seem to view raising a cheeseburger to one’s lips as the moral equivalent of holding a gun to one’s head” (Marantz, 1990, quoted in Lupton, 1993, p. 430).

In addition, information about risk reduction is conveyed to the public by intermediaries such as scientists, health professionals and the news media. These interest groups benefit from their position as brokers of valuable advice, and their social position in turn enhances the credibility of the information they offer (Lupton, 1993). Lupton would argue that the women who participated in this study were indoctrinated into a discourse that conceptualized the body as a “regulated object” (Lupton, p. 433) to be subjected by its owner to a programme of self management.

However, individual health professionals were not simply furthering their own agendas by pursuing educational activities, nor were they deliberately enforcing mechanisms of social control. The several professional participants in this study seemed genuinely concerned that patients have access to knowledge that would help promote better cardiovascular health. Their stated purpose, after all, was to remedy or repair cardiovascular damage. They expressed frustration with the structural limitations associated with their teaching responsibilities and hoped that efforts to rationalize health education in the hospital would bear fruit in the near future. Distortions and omissions in many instances were attributable to the higher priority assigned to direct patient care activities and the limitations of staffing patterns. And, finally, both the health professionals and the women acknowledged that the postoperative phase was not the ideal time to expect patients to absorb and retain information. The use of printed information sheets was one solution to this dilemma, and a second
approach was to encourage families to attend seminars so that they could supply missing information or reminders as required. A special seminar had also been created to address the information needs of families, in addition to the seminars designed for patients.

In this context of time pressure and competing priorities, teaching is viewed as a neutral transmission of highly condensed, immutable information (Lather, 1991). Anderson (1998) observes that this form of education flourishes within institutional settings where unequal power relations persist between professional and client. In these interactions, the culture or lifestyle of the patient is problematised, although the discursive and moral underpinnings of the very notion of health teaching escape critical examination (Anderson, 1998; Lupton, 1993). In the present study, this approach to teaching flourished in a context of displacement; the material and discursive conditions of the home were not apparent in the hospital. Furthermore, teaching was imbued with an understanding of the body that was peculiar to the discursive foundations of professional practice within the hospital. The body, conceptualized as at risk and damaged by a specific and textually documented pathophysiological process, was not considered the mediator of sensory and gendered experience of the world. Thus teaching emphasised the prescriptive tenets of heart health but obscured the experiential aspects. The participants interpreted these tenets as a series of “do’s and don’t’s” - a moral discourse.

These activities were not recognized or conceived of as what Lupton (1993) would refer to as social control or Morgan (1998) calls surveillance or medicalization, yet the language, knowledge and behaviours of health professionals do diffuse into everyday life. Theoretical concepts such as surveillance are perhaps distant outcomes of the discursively
driven processes described within this chapter. However, the extraordinary dislocations borne by the women whose stories inform this research, and the radical measures undertaken by health professionals on their behalf are directed towards the preservation of life. The world in common constructed by these two groups was dominated by a discourse of physical danger which prompted investigation and repair of perilous damage to the cardiovascular system. The women were displaced into this world as insiders with varying degrees of experience or naivete. Like Alice in Wonderland, they struggled to reconcile themselves with the organizing principles of a different, often incomprehensible, place within which activities proceeded seemingly oblivious to their distress.
NOTE TO USERS

Page(s) missing in number only; text follows. Page(s) were microfilmed as received.

239-242

This reproduction is the best copy available.

UMI
The respondents returned home, their persons altered and marked by the surgical experience. The task of gradually reinterpreting everyday patterns began with relocating and repossessing the physically healing self. The women were geographically relocated when they were discharged from the hospital. In more familiar surroundings, they were faced with a need to relocate themselves and their dispossessed bodies. The extraordinary events of hospitalization and surgical repair radically displaced respondents from their active, biographically recognizable selves. On return to the sites of their everyday worlds, respondents were confronted with an embodied disjuncture; their bodies and their physical health needs no longer aligned with the material conditions and priorities of homemaking. Conflicts and paradoxes were abundant. The local world of home reminded them of their biographies of supportive work on behalf of others, yet the moral responsibility to protect themselves and their own health promoted a contradictory set of objectives.

As Morgan (1998) carefully points out, medicalization of the everyday and the local follows diverse patterns. Although inhabitants of the local world may actively seek out and adopt medical knowledge and advice, competing expectations emanate from multiple discursive sites and social locations. Conflicts develop as medical prescriptions are taken up among normative gender, cultural, class, developmental and occupational assumptions. However, Smith (1999) urges us to avoid segmenting individual women into what Bannerji refers to as victims of “discrete determinations” (p.42). Self management of health is taken up differently within various contexts, but an elder immigrant woman, for
example, does not have or articulate three separate experiences associated with self care. Treating each facet as a distinct topic divests the analysis of the complexities of "general social context, content and dynamism" (Bannerji, 1987, quoted in Smith, 1999, p. 42). It would distract us from understanding the discourse of personal health management in this instance as a field of socially organized activity wherein agency and courses of action are accessible and regulated textually.

Elaborating further, Morgan (1998) explains that activities of family caregiving and surveillance of personal health management are manifestations of the medicalization of the everyday world. These tasks are interpreted and enacted in distinctive ways which correspond with the particularities of context and consciousness. Yet these tasks are mediated by an overarching system of discourse into which people enter and participate.

Self care and other care direct our attention to the textual coordination of multiple sites of conduct. Study of self and other care from the standpoint of women

...locates us in bodily sites, local, actual, particular; it problematizes therefore, the coordination of people's activities as social relations organized outside local historical settings, connecting people in modes that do not depend on particularized relationships between people (Smith, 1999, p. 75).

For Smith, the social is not a system of meaning, but rather something that happens. Context and consciousness open (or close) access to the possible courses of action inscribed in text.

As pointed out in the previous chapter, medicalization is a theoretical concept which encapsulates a particular phenomenon: the infiltration of the local or private sphere by a form of consciousness which introduces medical surveillance into the everyday. As
this consciousness pervades social life, more and more aspects of human experience fall under the domain of medical practice (Morgan, 1998). Yet the women who participated in this study did not concern themselves with these issues. They were absorbed in their embodied and sensuous efforts to relocate themselves within an interrupted habitation of the everyday. Changed and marked as “women with heart disease” they returned to worlds of activities, events and material conditions which presented different possibilities and contradictions.

Case Studies

Two women who participated in the study illustrate these differences. Although they represent disparate developmental, cultural and socioeconomic backgrounds, each concerned herself with balancing management of the home and family with management of self care. Each responded to challenges in different ways that reflect the conditioning influence of contextual distinctions. Eva was concerned with her own spousal caregiving responsibilities as the demands emerging from her aging husband’s failing health competed with the needs imposed by her recovery from surgery. Samara was anxious to represent herself as a fit and vital homemaker and mother of two young boys while simultaneously infusing her anecdotes with the idiom of medicalized self care.

Eva

Eva was a Canadian-born 75 year old who, after a long period of widowhood, remarried two years prior to her hospitalization for ACBS. Despite the many health problems that plagued the newlyweds, Eva prized the companionship and support gained from what she considered to be an exceptionally compatible and rewarding relationship. She and her husband lived in a rented two bedroom apartment in an older, but well maintained building on a busy commercial street. The couple’s annual income was under $19,999.
Eva's biography was one of caregiving and persistence despite daunting hardship. Throughout her narrative, Eva never portrayed herself as an unfortunate victim; instead, she accepted all as the will of a God in whom she placed complete faith. She left school to help care for her younger siblings when her mother fell ill with cancer. Eva remained responsible for the household after her mother's death and she never finished her schooling after Grade seven. Her first husband was diagnosed with CAD in his middle years and eventually was too disabled to remain employed. Eva worked as a store clerk to support her family, remaining responsible for managing the household and caring for her increasingly debilitated husband. When her daughter fled from an abusive husband, Eva took her in and helped care for her small children. For many of these years, Eva suffered from painful symptoms of rheumatoid arthritis, which eventually led to knee surgery and bouts of mobility limitation. At about the age of forty, she first noticed early signs of heart disease, including shortness of breath and fatigue, but attributed them to stress and worry.

Eva managed by relying on a dispositional optimism sustained by her deeply religious belief system. She recovered well from her first ACBS at age 65, by forcing herself to ambulate and become independent as soon as possible. She took great pride in her early discharge home. Several years later, she met George when they were admitted to the same orthopaedic unit for surgery. His health problems soon became her preoccupation as his spousal caregiver. Indeed, when she was admitted to hospital for her second ACBS, he was also in hospital for treatment of phlebitis. This segment of dialogue describes her foremost concern when discharged home after her surgery:

"INT: How did you feel when you first came out of the hospital? EVA: Well I was worried about George, because he came home the day before, and he was home a week and his leg was getting worse. And we didn't know what was wrong with it at the time."

George was readmitted to hospital within the week for care of recurrent phlebitis. Eva was to receive home visits from a physical therapist to assist her in adopting a programme of exercise, but she soon found that her caregiving responsibilities interfered with this treatment:

"EVA: Okay so, there was also a therapist was supposed to come in for me [chuckling]. And um, I told her I wouldn't be able to see her that week, because I used to go up to the hospital every day and walk through that tunnel...I got all the walking I needed [chuckles]. INT: Oh, yeah! EVA: And back home again, you know. Back home. I stayed four hours with him and came back again at night. Now you know, I was doing this before I went into hospital for the surgery. And then he came home a week later, they used heparin on him. And he has to see a specialist...oh, my goodness [brief pause]...tomorrow. Tomorrow. I think. My calendar is just full of people coming and people going and us going to the doctor's."

Indeed, Eva's narrative was replete with references to the rigours of spousal caregiving. She found that her discomforts in the first four weeks at home were in part associated with the responsibility for physical care.
There was just, I think, the constant running, and that. And then of course, putting on those elastic stockings for him. INT: 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]."

However, in no way did Eva exhibit resentment or anger related to this responsibility. Indeed, she expressed only loving concern for George’s wellbeing and pride in her ability to monitor his regimen. She was convinced that her hard work would be rewarded:

“But you know, I tell you, I think the Lord is with me. Because I firmly believe in positive thinking for one thing. And prayer. I was just telling George the other day, that I truly feel that this is going to be one of our best summers. I truly do. It’s going to take a little while to get there, but we’ll get there.”

Eva was the recipient of Home Care, Meals-on-Wheels and Wheel Trans services. While remaining grateful for these supports, Eva looked forward to having greater control over her home and the quality of the cleaning chores. She had plans for managing the housework chores, including the means to delegate tasks which would prove stressful for her healing heart and arthritic shoulders:

“I want to get all the home help out so I can get busy myself. I know I...what I’m going to do is have a lady come in myself. Privately. For two half days if I have to. And she can do the vacuuming and the laundry.”

On her arrival home, she did all of her own grocery shopping using a wheelchair to carry her purchases home. She explained, “I do everything I possibly can for myself. You’ve got to keep going.”

George was not expected to participate in these tasks, nor did he appear to concern himself with his own medication regimen:

“I mean, he has to have blood tests every solitary Monday they told him. And they always call me back...the last two weeks, 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.”

He did accompany Eva on occasional social visits to a seniors’ centre and both enjoyed these outings tremendously. Eva referred often to her friends at this centre, but spoke rarely of her children or other family members. She had no informal caregivers or helpers, but possessed a resourcefulness born of many years of chronic illness; hence she was well connected with community services.

Within this busy schedule, there was little time for her own needs, yet Eva was already very aware of dietary and activity restrictions recommended by health professionals. She had learned about these aspects of self management following her first ACBS and continued to follow them. She was convinced that her own dietary habits contributed to her CAD: "Well, I could understand me having cholesterol, because I am seventy five and I probably have eaten things that are not quite the way I should.” She described the “healthy heart” menus that were prepared by the Meals on Wheels programme with evident satisfaction and explained that, four weeks after returning home from the hospital, she was feeling energetic enough to contemplate cooking for herself.
Samara

At age 38, Samara was the youngest study participant. She was a bubbly, cheerful woman who graciously welcomed me with tea and homemade delicacies. Born in Turkey, she was the daughter of a diplomat and was raised mainly in England. She immigrated to Canada with her husband and had two elementary school-age sons who were born in Canada. Her family income was over $60,000 annually and they lived in a large bungalow in a suburban area far from the city core. Samara was employed part time by her sons’ school as a lunchroom supervisor, but she was upgrading her education to pursue a career in translation services and ESL instruction.

Although Samara had been diabetic since childhood, smoked heavily and had a strong family history of heart disease, CAD was not suspected until she had a myocardial infarction following a quarrel with her husband. She complained of “atypical symptoms” such as back, right arm and jaw pain to her family physician for over a year before emergency hospitalization for MI. After three weeks in hospital, she returned home to “keep quiet” in order to limit her cardiac workload. Her condition deteriorated to the point where she was unable to get to the bathroom without assistance and her mother travelled from England to take care of Samara and manage the household. Surgery was recommended and Samara welcomed the opportunity.

Samara described many bodily discomforts that appeared within the first four weeks after discharge home, but she was extremely pleased to find she felt more energetic. She was able to do all of her own personal care for the first time in months. With great pride and a mischievous smile, she revealed that she had begun doing housework again.

“SAMARA: Oh, I did the work. Believe me, I would even vacuum the house. INT: You would even vacuum the house? SAMARA: Oh, [giggles] then lie down. I sit on the floor to do it, doing the corners, all around. It really helps to sit down. I don't really move around much. I just use the arm that doesn't hurt. It doesn't bother the other side. INT: When did you start doing that? SAMARA: Oh, after three weeks. Now I'm doing everything, cooking, I even carry the laundry basket up and down.”

Samara explained that her husband had told her not to do housework, but she was not comfortable with this restriction. After her long period of dependency she anxious to resume the activities which defined her as capable and independent. Within the first week of homecoming, she began taking on small tasks, pacing herself to conserve energy.

“SAMARA: Yes. I don't like sitting down and having somebody do things for me. So I said to him: "Bring the dishes, I'll wash a couple of cups" Then I sat down five or ten minutes. Then I did some more.”

Samara described her husband as nervous about her health, and mentioned that he had attended all of the hospital’s patient education seminars with her. She remembered very little about these sessions, but her husband monitored her diet, exercise and homemaking activities. Although he had ostensibly forbidden housework, there appears to be some slippage in the terms of this injunction:

“I'll vacuum the house or vacuum the room when he's not here. If I can't do it, I'll
tell him to help me.”

Samara clearly retained responsibility for coordinating housework, deciding which tasks she could comfortably do and seeking help with or delegating heavier tasks to others. Within her description of household activities no one else actually directed maintenance of the home. Nevertheless, a transformation occurred in some aspects of the division of labour. From Samara’s perspective, this change was concerted around the perceived fragility of her health. For example, her children were more willing to accept assignment of chores than had previously been the case:

“Kids are kids. They’re helping too actually. Doing dishes or make the beds. They take their laundry baskets up and down. And whatever they have to do. Set the table. It’s nice to see them. Before they wouldn’t do anything at all. But now they do...They want to help. So I will get better.”

Because Samara had suffered an MI during an emotional quarrel with her husband, the family attempted to restrain outbursts and her husband took responsibility for disciplining the children:

“He changed. not completely, but he changed some of the things. you know. Like when the kids are fighting and he stops them, he didn't do that before. I was the one who was saying "Stop it, behave yourselves!" But now he does this, I don't have to. He says if I scream or yell or something, I'll have another heart attack.”

Concern with personal health management was evident in Samara’s narrative. She blamed her years of cigarette smoking for causing her heart disease and wondered how she could have persisted in view of her other health problems. The moral responsibility for self care is an evident theme in these reflections:

“I don't know what to say. I didn't have to smoke, nobody pushed me. I didn't have any family problems, financially we were okay. Nothing to light the cigarette. Nobody said "Do it." It wasn't helping me, it was killing me...High blood pressure, high sugar levels, and I was killing myself.”

Self management included balancing her own dietary needs as a diabetic with hypertension and heart disease with the preferences and requirements of her family. Samara carefully rationed her own meals from the foods prepared for her husband and children, concluding that the key was in cutting back on portion sizes and eliminating some foods entirely from her diet:

“If you cook for everybody...see, I don't use any butter or anything. If I cook fish, I just broil or bake the fish. And the next thing is boiled vegetables, or salad, and boiled rice or steamed rice. That'll be fine. So, nothing. I don't even use salad oil, no. Nothing. No salt. Because I have high blood pressure as well. That's fine, the combination. [pause] I don't have to have everything they're having. They can have a little bit more. They like to have macaroni. I don't have to have that always. And I'll have one slice of bread. So that will be fine with me. I need the grain as well. That's fine. I'm not complaining about the food. As long as you cut.”

As a diabetic, Samara was accustomed to monitoring her diet carefully and found these adjustments easier to articulate than most other participants. Yet the implications of this dialogue are clear: certain foods are to be considered toxic by people with specific health
problems. Samara’s narrative indicated clearly that all activity was enacted with prior deliberation about her physical and emotional needs and those of her husband and children. A routine could no longer be assumed within the household; all were watchful of Samara’s health.

It is striking that both women had legitimate claims for assistance. Eva was living with a sick husband who required physical care and help with his medication regimen. Samara had two elementary school-aged sons who required mothering and a husband whose occupational demands did not permit him to attend to her health needs on a continuous basis. Eva received meals, homemaking services and limited supervision of her efforts to incorporate exercise into her daily round of activities, but she did not receive any assistance with George’s direct physical care. Indeed, it occurred to none of the host of health professionals associated with the couple that applying George’s elastic antiembolic stockings might aggravate Eva’s incisional pain. She herself solved the problem by consulting a surgical supply outlet, whereupon she obtained a device that simplified the task. Samara’s healthy husband and children could perform household work and assist her with self care, although it was obviously her role to marshal and coordinate this assistance.

Responsibility for the household and for self care were managed in complex ways in each case. An hierarchical ordering of need placed George’s needs before Eva’s own requirements for rest and comfort. The therapist whose work with Eva was deferred by George’s hospitalization accepted the precedence of George’s need for a spousal caregiver over Eva’s need to establish a self care regimen. The lack of home nursing care for George indicates the implicit expectation that Eva would be responsible for his needs. The presence of homemaking and food services relieved her of responsibility for
maintenance of the home. Love and concern for her husband, along with a biographical identification with family caregiving, encouraged her unquestioning acceptance of responsibility for his care. Although she was ostensibly a recipient of home care services, Eva filled a major breach in these services.

Samara also dealt with conflicting implicit and explicit directives. A biography of homemaking and childcare in the context of a young family, as well as a recent history of extreme incapacitation, conditioned her joyful resumption of everyday household work. She was uncomfortable with dependency and was profoundly relieved to feel more energetic after surgery. Although her husband had expressly forbidden her involvement in housework, she implicitly retained responsibility to ensure the work was indeed accomplished. It was her role to delegate activities or to request assistance with certain aspects of a task. She was free to disobediently resume forbidden activities in her husband’s absence from the home, although she hastened to explain how she attended to bodily positioning to avoid discomfort and strain on her incision. This care to portray her awareness of her bodily requirements demonstrates the discursive salience of a moral responsibility for self care. In all her pursuits, self care and homemaking were in competition. For example, she directed her children to increase their participation in chores, and weighed their dietary needs and preferences against her own regimen, but weathered their complaints about these changes. Although her husband attended health education seminars with her in hospital, his role in many ways appeared supervisory: he reminded her of things, he forbade certain activities, and he monitored the behaviour of the children. As head of the family, he could prohibit some household pursuits. yet he did
not take this work on himself on a voluntary basis. Surveillance was his contribution to Samara's health management, but it remained her responsibility to solicit his direct assistance.

Both Samara and Eva used terms of personal responsibility when they discussed the antecedents of their heart disease. Samara explained that by smoking, she was really "killing" herself, and Eva mused that in her seventy-five years of life she had surely eaten high cholesterol foods. Once surgical repair was completed, prevention of further damage was a personal and moral obligation. They described self-care measures to prevent further disease and worked to incorporate these changes into their everyday routines. But it is clear that the women were relocated within sites that were not coordinated by a discursive emphasis on their health needs. Eva persevered with spousal caregiving despite the pain originating from her surgical incision - her body was changed in ways that prevented smooth resumption of her previous activities and incorporation of healthful exercise patterns. Samara's increasingly complex dietary restrictions were incompatible with the tastes and preferences of her family. As homemaker, it was her project to reconcile these incompatibilities.

These two narratives indicate some influences that condition women's experiences in the early days at home following ACBS. In the following sections, I discuss in greater detail the issues surrounding embodied identity, activity, relationships with health professionals and with significant others during the first four weeks after return from the hospital.
Relocating the Self

As seen in the previous chapter, many of the study respondents experienced hospitalization as a profound displacement into unfamiliar social territory. They were confronted with bodily dispossession and effacement of particular aspects of their biographical selves within discursively based relations which converged on survival. Return to the familiar social environment of the home raised contrasts between the biographical and post-surgical self which were at times disturbingly evident, or occasionally, reassuringly dispelled. The women reacquainted themselves with their bodies and attempted to relocated themselves in a biographical continuum which had been threatened.

Repossessing Vulnerable Bodies

The dialogue about the earliest weeks at home after surgery was sprinkled with complaints of pain, unusual sensations in and around operative areas, sleep disturbances and fatigue. The women learned to distinguish, for example, between ominous chest pain and "healing" chest pains. Bodily repossession did not occur independently, however. The women learned to decipher symptoms and sensory experiences by consulting health professionals. They developed a new consciousness of their bodies. So soon after surgery, their bodies were still in danger of injury, infection or obstruction of aortocoronary grafts. The problem had been named and surgically remedied, but danger remained perilously close.

Many spoke of how the weight of their breasts intensified pain at chest incisions and some explained that larger breasts aggravated the problem by pulling at the wound
edges in some positions. This uniquely feminine problem arose because at night most could not adopt a prone or side lying position because their healing sternums and ribs became sore with the pressure of arms and mattress. Consequently, most adopted a supine position. Unfortunately, while lying on their backs, many of the women found that the weight of their breasts pulled the margins of their incisions. They had been advised in the hospital to wear an old, comfortable bra to bed and many followed this advice with some relief of discomfort. Discomforts related to the proximity of the breasts to the incision were almost universally remarked by respondents and health professionals as a major experiential difference between male and female patients.

“'You know, when I lie down at night, I would love to sleep on my side and I can't because this is sore and this is sore. 'Cause the pain I have here...INT: From the ribs? RUTH: Yeah. And then when you lie on your back, this sort of...look. INT: Oh, there's a bit of pulling. Yeah. RUTH: So even if you have the bra on it still tends to go over. Especially if you've got a heavier bust.” (RUTH 207-224)

***

“I think with being a woman, okay, like the men wouldn't have to worry about this. But it's right in between my breasts. And of course, as soon as I take my bra off, when they fall down this way, it's okay. But when you go to bed at night, they stretch apart and it [incision] opens automatically; and there's not--other than wearing my bra to bed every night, I don't think there's anything I can do about it. He [family physician] said it will eventually close and as long as it's not infected, and it's not, that's all that matters. I don't care [laughs].” (LAVERNE 717-729)

***

“Yes, and I've heard from a number of women that the bodily experience is different. They are always slightly embarrassed to bring this up but they talk about the difference that having breasts makes. And they feel that it brings special problems in the post operative period that aren't sufficiently addressed in any teaching initiatives. They wanted to talk about it and waited for someone to raise the issue, but it never came up.” (Specialist in Women's Health)
Laverne’s physician minimized her discomfort and the failure of portions of her wound margins to approximate. She relearned from her physician the “acceptable” topography of her physical self: open areas were no longer considered serious unless certain details were present. However, the danger of infection was heavily reinforced by the explanations of her surgeon and family physician:

“But yeah, ‘cause it was funny. I went to the doctor again the following week. I had an infection, I have a little hole right in here that is keeping open. I don’t know why. Okay, it’s not infected any more, but I did get an infection. And so I went to my family doctor and I was in tears. Because [cardiovascular surgeon] had told me two advantages -- now I didn’t have any veins taken outa my leg, I had two vessels taken out from under the breast bone -- and he had told me two advantages are it lasts longer, because it’s more elastic than the vein in the leg and he said that I don’t have the operation with the leg to worry about. And this is nice because from what I can understand from most of the people that were on the ward in the hospital, that was the worst part. So I didn’t have those two to worry about. But he said, if it doesn’t drain properly it could get infected. And that means that, you know, if we don’t take care of it quickly, it could mean that the bones might go mushy rather than healing properly, which means that they would have to go back in, re-break them and re-do them. And of course, as soon as he said that I--there’s no way. So here I am in the doctor’s office the following Monday in tears because I’ve got a bit of infection here and I said to him, I don’t want to go back to hospital [laughing]. I said I couldn’t handle that; that would just be awful. And he said: You’re not going back in the hospital, don’t worry about it. [laughs] So he gave me some antibiotics I took for ten days and it’s not infected now.”

(LAVERNE 685-717)

The importance of self-surveillance was impressed on Laverne by her surgeon during an exchange which highlighted the relative advantages and disadvantages of a particular surgical approach. She was watchful for signs of infection, but could not decipher the relative implications of a small open area in her sternal incision.

There were cosmetic worries among all of the younger and some of the older women, indicating possible developmental variations in the interpretation of the healing
There was an interest in concealing scars and even minimizing them with vitamin E creams and oils. The women had difficulty recognizing their bodies as their own, because their appearance had been altered irrevocably. Reference to discursive standards of sexual attractiveness fractured notions of feminine selfhood. Luigi noticed very different approaches to operative incisions among men and women and commented on this in terms that suggested that her feminine attractiveness was at issue. Not only did she worry about noticeable scars on her legs and chest, but because one leg had become edematous, she had to wear a supportive antiembolic stocking, which she considered unsightly.

"INT: So the men come in with their scars and they're kind of showing them off? LUIGI: It's very...yeah...They're very, like you know: 'Look at me!' And they're sort of strutting their stuff. Where with me, I'm saying, 'What sort of creams can I get [chuckle] to, you know...' I mean the scar's just...it's going to be...you know [chuckle] it's something I'm going to worry about, you know// INT: You don't like having it there? LUIGI: Oh, God, no. Like I mean it's going to totally...you know// INT: Yeah// LUIGI: I mean, and I have to get this SOCK, for the leg. I'm going around in this ugly black sock. I mean, mind you, swollen foot isn't so great instead." (LUIGI 3-20)

She later spoke of her scars in a manner that suggests they served as a metaphor for the recent upheaval in her life. Her heart had been broken literally and figuratively and she was concerned with not one, but two healing processes:

"The big concern is these scars, will they ever go away, umm...you know...[pause]...I don't know, can I just get on with my life?" (LUIGI 57-59)

Other women also spoke of their scars. Some could associate certain marks with particular aspects of the hospital experience: tubes left marks as did surgical incisions. Scars were considered ugly or unattractive and efforts were made to conceal or minimize them. The respondents noted that their body surfaces were altered forever, and the
healing of these punctures was monitored anxiously. Sometimes this concern was well founded - four developed wound infections that required medical attention and nursing care.

"And I’ve got all these little holes. All these little holes all over the place! Oh, yeah...it’s um, funny. I wasn’t conscious at the time of, well, I knew the tubes were in, because I knew when they were taken out.” (ANN 874-881)

***

"And now I have to wear, like, high things...like where I work we wear these things and it’s like...INT: Oh, like a vee neckline? COOKIE: A vee neck. So I guess I’ll have to wear a shirt underneath that. Something high, see? INT: Oh, to cover the top part of the incision? COOKIE: Yeah, see it’s high. that’s high. Yeah, you figure, your heart’s just right there, why can’t they just open a little bit down there? And the vein in your leg, they cut from here to here. And you figure, oh, couldn’t they just have taken less?” (COOKIE 731-744)

***

"I wouldn’t tamper with it because it looked so ugly looking and this great big black scab that was right over the top of it. We didn’t know what was underneath and I wouldn’t touch it to find out. But nobody else wanted to either, even any of the nurses that come in and they look at it and they say: ‘Ohh, that’s an ugly looking thing!’ I said: ‘It sure is ugly’. And it smelled terrible [laughs]. But anyway we went down to see the surgeon, she’s...she did the job and did a good job in cleaning it up.” (VI 490-499)

***

"I was out last Sunday and there was a nurse there and she tells me: ‘You go and get yourself some vitamin E cream’. But the girl in the druggist said the cream was just for like face and that. Well I got the--this is just pure oil. And what I was doing, I had some vitamin E capsules and I was just taking the top off of them, and it’s the same thing. And I paid $9 for the little...a little jar of vitamin E oil. But it will help me in my...in my scar.” (OLIVIA 313-333)

Repossessing vulnerable bodies continued as the women learned to interpret the meaning and causes of discordant bodily messages. Deciphering sensual experience was
mediated by physicians, nurses or written materials authored by medical authorities.

Apprehension at times accompanied the appearance of new symptoms, especially if the women combined them with an ominous possible cause. They had not yet begun to trust the durability of their reconstructed and reclaimed bodies.

“Oh, one thing I should mention, about two weeks after I had the bypass I got excruciating pain in my shoulder, there. INT: On the left side? ANN: On the left side. And it was like nothing I had ever experienced before. I hadn’t shed a tear through any of this, but I was in tears! So I phoned my dear family doctor and she immediately booked me into the hospital for tests. Because they were afraid of, like, clots in the lungs? INT: Oh! And what happened? ANN: But the tests proved negative, fortunately, and they attributed it to...it was inflammation in the muscle but they attributed it to the arthritis more than anything, because I had been off my arthritis medication since the surgery and I had been weaned off Tylenol #3, which had kept the pain at bay I guess. So that’s what it was attributed to. So once it was established that there was no problem with the surgery or anything, that set my mind at rest, and I was able to go back on my medication.” (ANN 1385-1422)

***

“So I’m you know, what I’m feeling is in that book that [cardiovascular surgeon] sent around...that you’ll feel the bones move and you’ll hear the ...it’s crunchy...like. It’s a weird...it scared me. That’s only been happening in the last week” (LUIGI 842-847)

***

“I was so very sick, I was so nauseated. SO nauseated. INT: Really? GERT: Ohh, hoh! Oh, since I came out of the hospital. I was even nauseated in the hospital. Oh, was I feeling nauseated! Bringing up. So last week, ah, a week ago Thursday I phoned [cardiologist] and, ahm, anyway he said to go off digoxin and it’s been good ever since.
INT: So it was the medication. GERT: The medication. INT: And you feel okay now. GERT: Oh! I’m fine now. Oh, I’m so much better, it’s unreal.” (GERT 279-301)

***

“It’s a very--the first time I described it I described it as a clunk: you know when
you have a car that gets a clunk? [laughs] My husband is a mechanic [laughs] so of course, I clunk, I don't click. And then when I read the book it said clicking so I thought well maybe that could be better described as clicking [laughs]. But what does it make—it makes me feel like...makes me think the bones a going against each other, okay, and like I said to [family doctor], I said do they take x-rays after so much time to see if it's healing properly? And he said no, he says: We just assume it is. I said: Well what if it goes on clicking forever? I said: does this mean it's not gonna heal? [laughs] He says: Don't worry it's gonna heal. [laughs] I don't want to click forever.” (LAVERNE 767-782)

These repossessed bodies were variously described as possessing deteriorating or damaged parts, as having been repaired or patched, and as unreliable or unfit to perform the biographically defined daily round of activities. In such statements, bodies were referred to as unrecognisable others; bodies were barriers to unrestricted, confident involvement in life. The women, and occasionally others in their lives, were protective of these unrecognisable and uncooperative bodies. This uncertainty was sometimes discussed with family physicians, surgeons or other health professionals; these others variously offered reassurance or reinforced the women’s qualms about their fitness to proceed with daily routines.

"Cause my, funny enough, my family doctor, when I was talking to him...I went to him two weeks ago...and he said to me: I don't know what to put here for you return to work. He says: I think I'll put a question mark, and then I'll just put a certain month and then we'll play it by ear. Cause I had said to him about this part being very stressful. You know, cause I, being in this pain, I couldn't see myself going out onto [street], standing at six in the morning, waiting for a bus. INT: Yeah, that would be hard. RUTH: I thought, oh, will I ever be able to do this again?” (RUTH 728-747)

***

"And it was very sore. Yeah. And I guess I was really kind of depressed. Because after, ahm, I'm not used to not feeling good, and I really, ah, it really depressed me that it took me a while to get back on my feet, like to really feel good; to be pain free, sort of.” (MARGARET 244-249)
Despite misgivings about their bodies, many of the women were concurrently beginning to feel glimmerings of wellbeing by the fourth week at home. Some felt a surge of vitality still earlier, and these were often the women who, because of severe angina and debilitation before the surgery, had the most to gain from the procedure. They began to entertain the realization that their bodies, however marked and unreliable, were beginning to feel far better than they had prior to the surgery. Some began to carefully test themselves by setting reasonable goals for activity, then taking on more challenges. Cookie, for example avoided walking uphill until she could negotiate a considerable distance on level ground. Responses to new accomplishments were closely monitored and evaluated. Tiredness was benign, but pain was worrisome and indicated immediate cessation of an activity.

"So I’ve been walking. I’ve been walking in the mall - it’s so nice not to have the angina. You know? [chuckles]" (ANN 526-530)

***

"But see, I had to set a goal for myself, where I was going to end up at when I left here, so I was going to go to [shopping mall]. And I could go there and relax and have a coffee and then come back. Now I can go anywhere, now the weather’s nice. I can just walk anywhere. I’ve been avoiding hills, but I got off the bus one day and came up this one. INT: How did it feel? COOKIE: Fine, fine. I was tired, but I didn’t get the pain or nothing, so...I was tired, though.” (COOKIE 415-424)

***

"Oh, man! Can’t believe. A whole new way of life now again. No pain, no, you know other than...now I’m just great. I can move mountains now [laughs] you know. Oh, man, it’s wonderful.” (GERT 1267-1270)

The prospect of functioning at a higher level than they did prior to surgery brought feelings of joy to many of the respondents. However, several reported dysphoric
emotional states as well, particularly as they incorporated recent experiences into their biographical understandings of themselves. A problem had been found and named. The remedy required drastic measures and dramatic displacements. A discourse of endangerment intruded upon the temporal ordering of biography. Within this series of events, the continuity of selfhood was lost.

**Relocating the Biographical and Social Self**

In the first weeks following surgery, the women described the emotional work related to relocating themselves within their biographical and social life courses. Feelings of depression and worry were common. Life review was a common strategy to explain present feelings and behaviours by recalling past events. Biographical features and patterns reappeared in dialogue, often as the women related stories of past hurts, hardships and struggles. These were stories of resistance and survival, as if the women were convincing themselves they would survive once again.

Sonia was uncomfortable with audiotaping during our first meeting, but my fieldnotes describe a portrayal of lifetime struggles and hurts, which culminated with the recent death of her husband. Luigi told of a childhood in foster care, after her mother became unable to care for her. Both Luigi and Sonia attempted to project themselves into an uncertain future by reminding themselves that they had survived previous heartbreaks. These were stories of social and geographical relocations: persecution as a social outcast, childhoods in hiding or successions of foster homes, immigration, divorce, widowhood.

"Sonia became tearful several times during the interview, but carried on by avoiding the topics that bothered her most. She said little about her husband other than he had been very ill with emphysema before he died, requiring oxygen and
medication. She says she has not yet adjusted to his death and is very sad still. She says she finds the recovery from surgery hard because she feels isolated and lonely all the time. She also became tearful when talking about her girlhood. Her family was among the Jews who were persecuted during WWII and they were in danger many times during the war. They moved frequently. Her schooling was interrupted and she never finished high school although she proudly stated that she and her sisters studied independently as much as they could. She attributes her health problems in her later years to the troubled years in Germany; osteoporosis, thyroid disorders, peripheral and cardiovascular disease have often intruded upon the relative comfort and security of her later years. She says her life has been ‘very hard sometimes’. She did not wish to end the interview when she became tearful because she said she felt better talking about these things and she did not want to burden friends, who had already heard these stories.” (SONIA 214-246; interview not taped at respondent’s request)

***

“I thought my future was, you know, pretty well established after 29 years of marriage. INT: Yeah. LUIGI: But now I have a whole new future, and I don’t know what it is, that scares me. I’m a bit frightened about the whole thing, but it should, could be interesting too. Yeah, I have...it is...has been a lot. It has been a year from hell. It really has. INT: Um hmm. It HAS been tough. LUIGI: I figure if I survived it there’s not much I can’t handle or cope with.” (LUIGI 895-905)

Luigi spoke of survival on physical and social terms. Relocations of the self were profoundly disturbing and threatened annihilation on more than one level.

Several women agreed that isolation and boredom were major contributors to dysphoric moods. Activity restrictions meant that they were located within a limited geographical and social context. They had been accustomed to active participation in the social world and were suddenly sequestered within the home as they recovered. Inactivity encouraged them to dwell on worries, physical symptoms and past events. Some seemed to lose contact with the present as a temporal anchor and drifted between past struggles and future uncertainties. Ironically, Eva (who attributed her level, often cheerful, disposition after surgery to positive thinking and faith in God) was the busiest of the
women from her first day of discharge home, making daily trips to visit and care for
George in the hospital. Those with less eventful family lives found they spent many hours
alone while others were away from home at work. Lone women like Emma (EMMA) and
Luigi (LUIGI) could expect to see children and friends on a frequent basis, but they
usually led lives of solitude during the first four weeks at home. They missed the
occupation that biographically structured responsibilities afforded.

"And um, I’m finding it boring, um, I do a lot of knitting, but I haven’t done that,
sat all day, done that for years. And I’m finding it...um, and there’s so many things
that I can’t lift or do. And you get very, very anxious.” (EMMA 646-653)

***

“But there’s a girl upstairs comes down at coffee time. Mostly it’s the company.
You’re here alone and there’s nobody to talk to. And you’d phone somebody and
they weren’t home or they were busy, and ...My brother, he’d talk to me. He’d
come over and talk to me all the time. You know. INT: So you were feeling bored
and lonely. COOKIE: Bored and depressed and thinking something’s going to
happen and you’d end up back in the hospital.” (COOKIE 457-464)

***

“Actually I don’t have a life sort to speak at this present time. I’m bored out of my
MIND. I uh, and I’m ready. I feel so GOOD. I’m ready to go and I still can’t do
anything until I see [cardiovascular surgeon] I think, and have my stress test. Then
I’m going to call and ask them to start putting me back to work. I don’t have
a...It’s not like I have a husband come home at night, or family to get dinner ready
for. I mean, I don’t even have like...two loads of wash a week [chuckle] you know
like...// INT: //Yeah.// LUIGI: //And I cannot...I am an avid reader. And you think
I can read? You think I can sit down and...I can’t concentrate on anything. I find
I’m constantly worrying about my future. INT: Yeah. LUIGI: But I think once I
start living, getting in the present and get going [chuckle] I won’t worry so much
about my...But now I have all this time on my hands and I worry all the time
about...yeah.” (LUIGI 873-893)

It was apparent that the women were relocated within a discursive milieu which
identified men and women according to their respective propensities toward activity within
the home. Formerly smooth-running aspects of life became suddenly problematic when the women returned without resuming previous routines. Their statements reflect discursively based understandings of gender. Men were identified by their need to be directed, their predisposition to “chip in” but not take full responsibility and their inability to “see” work that needed to be done:

“But it’s, ah, you know, it’s really difficult when it’s--when it’s reversed. So it’s surprising to see. Because a lot of men they go to work, you know, they come home and yes, they care. I’m not saying they don’t care; but they are just totally lost when it comes to something like that; like what did you used to do around the house? How did the cleaning get done? [laughs] You know? A lot of them are like that. I can’t say [husband] is like that because he has had his times of chipping in and whoever’s home first starts dinner.” (LAVERNE 1217-1227)

***

“Yeah, I don’t know how to explain it. Like men--[chuckling] I don’t know if it’s just me or not, but men, they don’t see anything that has to be done. They, ahm...and you have to sort of say: This has to be done, this has... You have to sort of think for them all the time. It’s not that he wouldn’t do it, but you have to, ahm, say: This has to be done. Or, you know: Why don’t you, you know, look after the...that light that’s out over there...call an electrician or something? You have to tell them all the time, because they don’t--they’ll put things off. I don’t know whether it’s just me or not, but I find that. And it really...really bothers me sometimes because, ahm, if he would just look around and see the different things that have to be done and just take the initiative and just go and get--do them instead of, ahm, me having to say: You have to do this. Because I have enough to think about. I don’t need all, you know, all this. Really!” (MARGARET 1017-1033)

Women were identified by their need to have control over the home and housework, their fundamental responsibility for coordination of the home and their superior competency in matters of homemaking:

“INT: And so did he need any help with that, like instructions or...? GERT: Yes. Tell me and I’ll do it for you, sort of thing. INT: Okay so you sort of direct traffic. GERT: Right, yeah. INT: How do you feel about doing that? GERT: That’s the
only thing you have no control over when you’re not well... I find, you know. Like when a man is sick, ahm, you still look after the house, the washing, everything, you know, shopping and everything. But now he has to do it and he’s never done it before. And that was the worst. So let somebody else do it. When I used to do it myself... it was very hard for me.” (GERT 247-264)

***

“He doesn’t work that much [overtime] these days, but he’s even more tired now than when he worked 12 hours a day. Yeah, and so who else is gonna do it? I think all these things are better for men because they get served anyways. You know. But women they... things totally get screwed up they’re not -- if you’re not in charge, you know.” (OLGA 1541-1547)

Embedded within these observations is the assumption that men and women have different understandings of the domestic space. To these women, home is not a domain where men actively coordinate the minutiae of everyday/everynight comfort and survival, but minutiae are coordinated or orchestrated by women with the needs of men in mind. Men assist as required, but they do not have a base of knowledge or expertise to coordinate a household singlehandedly.

Some of the women attempted to relocate or find their social selves in the wake of profound disruption. They were concerned about being labelled in negative terms - although they themselves were sometimes the ones who were applying those terms to themselves, indicating pervasive normative assumptions. They worried about burdening others or complaining too much. At issue was a highly valued sense of independence. They defined themselves according to their ability to look after others and had difficulty accepting reciprocation of care; some even felt pressure to play hostess to or entertain caregivers. Asking for help was particularly difficult and some longed to regain their “old selves”. Others rebelled against the surveillance and concern of close others, who
monitored resumption of activity and personal health habits. The introduction of a medicalized discursive element to intimate relationships precipitated subtle changes in power relations or social locations.

"I know they don't mind. But you just feel yourself...I've always been so independent, I guess. INT: Yeah. RUTH: Yeah, 'cause I've always, I live alone, so I've always looked after myself pretty well, you know." (RUTH 313-322)

***

"I guess any problem I have is with myself. I hate asking for help, because I've always been independent. But when people phone, you know, they say: I'm going to the store. Well, I say: Okay, fine. If they're going, I don't mind. INT: So if the offer is couched so that it's not an inconvenience...BROWNIE: Yeah! Well, I haven't so far phoned anybody and asked them to get me anything. But they have phoned me. So that makes the difference. [chuckles]" (BROWNIE 309-325)

***

"And, especially the type of person...which my daughter and my GP and I had a little discussion yesterday. About: Well, your mother is a very independent person and always been a goer, always did everything on her own. Which I've had to do for a long time [since divorce], because I had to raise my youngest daughter till she was finished high school. And then she lived with me for three years after that. And, ahm, so, to have someone like, I know they love me dearly. But um, you know [chuckles]. And they're SO afraid something's going to happen" (EMMA 653-675)

***

"...my sister comes over, she's old, she's 16 years older than me. she comes over. You can't do this, you can't do that. You know. Like I mean she's hovering over me like...INT: Oh, really? GERT: Yeah. So I mean, she went to a couple of meetings [at the hospital]. She says 12 weeks of not doing much, walking, but nothing strenuous or something. INT: So what kinds of things does she say you can't do? GERT: Ah, lifting; of course I know that, I can't lift. But I'm supposed to sit and do nothing, so she says. But I don't think so. Because in the book it says you can do things, you know, because the more active you are the better it is. When you sit around it can't be good for you; you get stiff and, you know." (GERT 863-889)
"Anything I needed she was there. They were always here when I needed -- in fact, they were sometimes here too much and I'd tell them to go (laughter). You sort of want to be by yourself. I'm the sort of person that likes to be...like I don't mind being by myself if I'm sick or whatever, okay, I find I rest more that way. Could think more or whatever, you know. I feel when people are around I have to entertain them sort of, yeah." (MARGARET 322-333)

As "women with heart disease" the respondents attempted to locate themselves in relation to others with similar health problems. Several respondents discussed their progress with others to establish consensus on their rate of recovery. They compared themselves to similar others they or their family and friends knew. Advice, reassurance and information were passed on in this manner. Some instances were cautionary tales that served to warn these women about the pitfalls of certain behaviours. With similar others as a point of reference, they positioned themselves as lucky or disadvantaged, hardy or weak.

And I have a cousin who had a bypass identical to mine three months before I had mine. And she just lives around the corner from my daughter. so I would go...and she'd say: You know you make me sick, you just totally make me sick! And I'm: Um, why? She says: Because LOOK at you! You're up and you're going! [chuckles] But then she's go at lot more problems, she's diabetic and she's a lot heavier than me. And so there's three strikes against her. you know." (EMMA 518-534)

"My aunt went through open heart sur -- well, bypass surgery a year ago January. In fact they were doing a balloon on her and they burst the artery. And so they had to do emergency bypass. And she had a triple, I believe. And so they took the veins out of her legs and it was an emergency. But the way they closed her up was just absolutely awful. It was like a rope, okay, and like about this thick, and they sewed so much of the muscle up here that she couldn't put her head back. She was like this all the time; and it's just taking...now she's doing acupuncture and cortisone shots to be able to get the muscle to loosen, relax. So I know -- I've been very lucky. I consider myself very lucky; I haven't had to go through any of
that stuff.” (LAVERNE 1439-1457)

***

“I think my mind is relieved that I’ve had it done because like I say, we have such a strong history in our family, with my mother and my father with heart disease, you know. And it seems that nobody gets past 59.” (MARGARET 955-959)

Throughout the process of reclaiming their physical selves and relocating their gendered, social and embodied selves, the women sought members of their social networks who had some specialized knowledge. Often these were friends or family who were members of health care disciplines. The advantage of knowing these others who straddled the abstract world of health-related knowledge and the particular worlds of the women themselves was that these “consultants” were available at any time.

“I talked to my niece who’s a nurse and she keeps telling me that it’s long. it’s going to be long, and she tells me: You have to. you know. accept this…it’s a long period.” (RUTH 32-39)

***

“...this leg was all swollen up. I said: Oh, my leg is so BIG, there’s something wrong. I’m crying, I woke him up: They’re going to cut my leg off! He looks at me: Who? [chuckles] I’ve got a friend who’s a visiting nurse. so she said to come up, and she said: Oh, that’s fine. But I know if I didn’t go up there, I’d have been awake all night or in emergency. She looked at my incision and she says: Oh. that’s lovely! I says: Really? She says: Not even a bruise! I says: Was there supposed to be? [exhales] It’s weird.” (COOKIE 641-649)

In summary, relocating the physical and biographical self included recognition of the surgically transformed body and reintegration of biographically established patterns. Yet this reconstruction was not accomplished as a feat of personal reflection. It was a social endeavour that unfolded in particular social and geographical locations, which because of their biographical familiarity, were structured by discourses about gender and activity. It was further interlaced with a medicalized discourse and was occasionally
mediated by health professionals or close others with specialized knowledge or related experiences. Ultimately, it was clear that in relocating themselves, the women were learning. They were learning to mean with a new idiom that encroached upon the language of gender and home.

**Locating Help**

After the intense contact with a variety of health professionals in the hospital setting, some women described feeling vulnerable and afraid in the early days at home when professionals were relatively inaccessible. In less than a week most had relocated from intensive postoperative care (which entailed around the clock nursing attention, temporary mechanical ventilation, chest tubes, urinary catheters and a variety of technological monitoring devices) to hours of complete solitude at home. They were unable to entirely trust their bodies to carry them through their former routines, and had been warned against many activities. Some confided that, paradoxically, they were afraid of death at the very time when recovery seemed irrefutable: the day of homecoming.

"Because you're coming out of the hospital, when I come out of [hospital] I was afraid. Because, hey, these doctors and nurses all know what they're doing and if anything happens to me, I'm right there. If I hadda gone home from there, I would've just withered up and died." (RUTH 338-347)

***

"But the only thing I found - that's what I was going to say - is once you go home you're sort of cut right off, okay." (LAVERNE 548-550)

A cardiovascular surgeon had observed this crisis in many of his patients, as had the social worker and clinical nurse specialist I met with. These professionals spoke of crises of meaning, such as confrontations with mortality and the emotional significance of
open heart surgery. Yet their descriptions of events also implicates the problematic of relocation.

"What people go through is adjusting to the notion that they’re getting in touch with their own mortality, surviving heart surgery and then all of a sudden they’re dumped out of hospital five days later. And they realize there’s a whole lot of questions they didn’t ask, didn’t know to ask, hadn’t even thought of yet. And they have no mechanism to be reassured around all of that." (Cardiovascular Surgeon #2)

***

“So there’s an abrupt shift from this intensive preoccupation with survival - with what has happened to their bodies in surgery and afterwards. They find their faced with an additional set of worries at home. One of our patients, an Italian woman, was anxious about going home after her surgery. We met with her and her husband before discharge, to answer questions and provide some reassurance. Her husband wanted to know how soon she could start doing the housework again. Not if she should, or what was absolutely not a good idea for her to do ever again. Just: ‘How soon?’ And it has occurred to us that we have a long way to go in helping people out with these issues. Phone follow up is a start, and within the present fiscal limits it may be all we can undertake. Social work has support groups that meet here on a regular basis and cardiac rehabilitation is very important. But they phase in later in the recovery process.” (Clinical Nurse Specialist)

Access to reassuring information was limited by the abrupt relocations involved in discharge from the hospital. The home was not a site where health education by health professionals could be easily located. Instead, patients were to return to the hospital or rehabilitation settings when they felt well enough to travel from home.

A common theme was a sense of confusion about whom one should most appropriately contact for help with various questions and problems. The fragmentation of services that resulted from medical specialization meant that the women had been in contact with several different medical specialists over the course of their illness and surgery. While in hospital, the women were inundated with visits from a variety of
specialized health professionals, but following their discharge home, they engaged in
frustrating searches for the appropriate health professional to deal with problems that
arose during recovery. The anecdotes about these searches were highly convoluted and
reflected some frustration when the health care system proved difficult to traverse. Often
the search for help commenced in consultation with those in the social network who
possessed “cosmopolitan” perspectives. These helpers were poised at the intersection of
the local and institutional worlds because they knew the particularities of the women’s
lives and problems, but also understood the more abstract and general medical
perspective. Successive consultations were likely to branch out to physicians.

Interpretation of physical signs and symptoms was thus accomplished by a variety of
consultants.

“That week after you first came, I had the incision open, the pus was -- it was
yellow -- [NT: Oh, yellow... RUTH: Because my niece is a nurse at Sick Kids, and
her boyfriend is a doctor -- and my daughter...of course, my daughter panicked,
she -- and I said to her : You know what, that’s where the smell comes from”
Because it’s yellow, because that’s the first thing my niece’s boyfriend said on the
phone. He said: Well it is infected because if it had been clear, it would be okay,
but because it’s very yellow, it is infected. So whenever I -- he said to me, he said
to my niece: Get her to the doctor, either take her over to hospital again, or get her
to the family doctor. So I went to my family doctor. You know what the family
doctor said to me? He said: Ruth, you shouldn’t be coming to me. And I said:
Excuse me, if I can’t come to you, who can I go to? [laughter] I said: I tried to get
[internist]. I tried - my daughter even phoned [surgeon’s] office and
[cardiologist’s] office. But he gave me the antibiotics, and then he said: Ruth, go
to your cardiologist. I said: Excuse me, which one? I said: We phoned all of them,
we can’t get any of their offices. So he said: Well go to [specific cardiologist].”
(RUTH2 346-373)

***

“That had a big scab over it and we didn’t know what was under it and the scab
turned black, and it was an, oh, an ugly looking thing. And so we didn’t know, we
didn't tamper with it but I said to [husband]: Well, I think we should keep it cleaner. So anyway, before going to bed at night we'd make -- we'd put the dressing on and everything and fix it up, and then...and [chuckles] when I said to him: We've got to do something, I can't stand the smell. I thought it was sticking out. So we tried all over trying to get a hold of either the surgeon or one of the doctors and do you think we could get hold of one of them? And finally -- the family doctor we had, he was going away for a week and before he went he wanted to see me. So I went down and we showed it to him and he said: Well, I'm going away for a holiday, I'll be back in a couple of weeks. The nurse turned around that he had and was very nice and she said: Well, if you have any problems you call me. And I said: Alright. So finally I said to [husband]: You know, let's call her. So he called her and got her on the phone and explained to her we figured it needed cleaning and that we couldn't get a hold of anybody to do it. So she said: Well I'll see what I can do for you. So anyway, she phoned and phoned and she got the surgeon on the line and asked if she could see me. So we went down there just about a week ago and she looked at it and she says: My gosh -- that needs to be cleaned up! And I said: I know, but we can't get anybody to do it. She says: Everybody's gone on holidays. [chuckling] INT: That must have been really frustrating for you! VI: It was! It upset me because I didn't know what to think. Well then, she turned around and she said to the nurse: Can you get me a tray with some tools so I can clean this up? So she got the tray and everything, and she worked on it, cleaned it all up and she did a beautiful job on it. And I got to go back and see her again soon.” (VI 387-434)

The considerable work of locating the correct physician often culminated in travel to that professional’s office. Like health education, physicians’ care did not usually take place in the home.

Gaps in communication and knowledge became more apparent to the women after several weeks at home. Several were unsure about when to arrange follow up visits with their various physicians, and as indicated above, it was not always clear which physician should be consulted when problems arose. Some of the respondents wondered how to become involved in cardiovascular rehabilitation programmes; although information booklets distributed in the hospital contained some information about the locations of
several programmes, some women either did not have the booklets or were unsure of how to obtain a referral into a programme. In two cases, a need for specific information about diet was identified but the dietician’s fee was considered a barrier.

“And you know they have the rehabilitation down there, don’t they? INT: Yeah, they do, at [hospital]/ RUTH: // I think they do at a couple of hospitals too, there’s a list. Now, it’s probably going to be six weeks before I see him. INT: Yeah, it’s usually at six weeks they like to see you. RUTH: It’s him I’d ask about it? INT: Sure, ask him to refer you. RUTH: Or does he have to suggest it to you?" (RUTH 2295-2307)

***

“And I hope sincerely that I’ll be able to get into a monitored cardio...cardiovascular exercise programme. I don’t know, my cardiologist probably could arrange something. I don’t know how these things work.” (ANN 644-652)

***

“And you don’t know what to eat. Don’t eat that. Don’t eat any animal, don’t have any animal fat. But...[long pause] that book she gave me has foods to avoid, and foods to cook. So, like I say, I go back in May, but it’s awfully expensive. I mean when you think of it. She said I’d need three or four visits, but it’s fifteen dollars. Each week. Then with the exercises, it’s two hundred and thirty. The whole thing.” (COOKIE 402-408)

***

“So I’ve never had like I said, high cholesterol in my life, so I’ve no idea what you’re supposed to eat on a low cholesterol diet. Nobody gives me a diet. They’re just giving me a pill. And I don’t like this. I don’t mind taking the pill for a certain length of time, but I would rather diet at the same time and get it down and know that this is gonna help rather than taking a pill. So, ahm, I phoned [family doctor] and on Friday he gave me two sheets. Now it’s not like a menus plan or anything like that, but it does tell me what’s high in cholesterol and what’s low in cholesterol and how much you can eat and so on and so forth, which is really good. So I feel much better, okay. So I figure I don’t know what I need the dietician for. Ahm, they have a dietician over at the [professional building] but it costs you sixty dollars thereafter for every visit. And I thought well I really don’t need to pay sixty bucks out, all I need is for somebody to tell me what I can have
on a low cholesterol, low animal fat, which is cholesterol I assume, diet. Somebody tell me what I need here [laughs].” (LAVERNE 586-607)

Information transfer, as Laverne indicated, might simply occur in the form of printed lists which guide food choices. However, she implied in her statement that a higher order of information might include menu plans. She was prepared to create menus by applying information given to her by her family doctor rather than paying a dietician to teach her more about a low cholesterol diet. Her assumption was that further teaching would consist of further presentation of similar lists of forbidden and acceptable foods for her to commit to memory. Her task was to do the considerable and embodied work of translating this information into menus and meals within the context and location of her home.

Thus, in contrast to the intense surveillance by health professionals in the hospital setting, many of the women found useful advice and assistance to be relatively inaccessible once they were at home. Those who lived at a distance from Toronto’s wealth of services were at a disadvantage. Samara, Gert and Laverne were unable to locate nearby cardiovascular rehabilitation programmes although they were motivated to attend.

Laverne approached her community hospital for assistance in planning her low cholesterol diet, but was told that because she had not been a patient at that hospital, she was not entitled to their services. She eventually purchased books about healthy diets for people with heart disease and decided not to pay a dietician for further advice.

Thus, although health professionals assisted the women to understand peculiar physical experiences and were, in theory, available to assist in the event of problems, many
of the respondents found genuine help difficult to access at times. Most accepted the moral responsibility to improve personal care and many were encouraged by significant others to do so, yet individual teaching was absent or expensive to access. Health professionals were no longer easily available to provide direct physical care once the respondents were discharged from hospital, but they were also less available to provide the information the women needed to care for themselves in the locations of their everyday routines. Within the first four weeks after returning home, many were motivated to consider changes in diet, exercise, and other patterns of self care, yet applicable knowledge was conspicuously lacking. In the next section, I examine the impact of this and other issues on personal care, learning and homemaking activities.

**Embodying Conflicting Idioms**

Anecdotes about the organization of activities in the home indicated that gender is a by product of work within that location. From these accounts it was apparent that the social organization of gendered activity in the home was a continual embodied process, guided by discursively generated principles. A gendered, biographically schematized body was required to do this work. However, the women were newly returned from a location which schematized their bodies in a radically different light. Their repossessed bodies had been reconceptualized by an unfamiliar discourse which dictated specific forms of care and attention. These unprecedented dictates comprised a new idiom which interlaced imperfectly with the language and embodiment of home. Consequently some women experienced disjunctures as they attempted to reconfigure their personal health habits while accommodating biographically developed patterns of gendered homemaking.
Self Care of the Repossessed Body

The major theme of self care activities within the first four weeks at home was one of self-protection. Self-protection involved arranging the conditions necessary to promote healing and changing patterns of self care to prevent occlusion of the restored coronary circulation. The women relied on a variety of information sources to accomplish self care: printed materials given to them in hospital, published resource books such as specialized cookbooks, and advice from family, friends, professionals and others who had experienced surgery. Considerable thought, problem solving, learning and coordination occurred during the first weeks at home.

There was a consensus among health professionals that women were at risk of resuming homemaking chores too soon after surgery, but little agreement on the repercussions involved. While a cardiologist explained that resuming housework at four weeks following surgery would not harm most women, he would caution against “physical labour”.

“Nothing that will harm them, but the sternum hasn’t healed completely so it’ll be sore. I usually tell people after about four weeks to get back to whatever, as long as its not physical labour. I’ve even had them go back to their old jobs. And regular housework would be fine as long as its nothing heavy. But they can’t harm themselves at that point.” (Cardiologist)

A physical therapist noted that the issue was not necessarily one of physical harm, but of priorities; a woman who began doing housework as soon as she felt able would be too fatigued or too busy to attempt to relearn embodied patterns of self care through exercise, for example. This view was supported by a clinical nurse specialist.

For example, a lot of women are supposedly the mistress of the house. But
because they're sick, the laundry isn't being done properly, no one is doing the cooking. They've got a lot in their heads. They feel they need to be looking after everybody, but they're sick, they can't do it. So their focus is that they need to get back in shape to do the work at home. And if and when they do recover to a stage where they can actually do a little more, they tend to spend more time working around the home, household dishes, and problems and chores than to actually think about going out and doing exercises. (Physical Therapist #2)

Finally, an occupational therapist informed me that there could indeed be physically harmful consequences when women began doing housework soon after surgery.

"Mainly things that involve pushing, like vacuuming, or a lot of women like to get down on their hands and knees and scrub floors, it's not good enough to do it with a mop, and that can cause problems with sternal healing. You have to wait twelve weeks a lot of times until the heart and sternum have healed. So most work is okay, but you have to modify it and not do as much at once and maybe avoid things like vacuuming, scrubbing floors, things that will cause strain on the sternum." (Occupational Therapist)

She provided a detailed description of the diagnostic indicators used to determine which activities would prove harmful, explaining that a cardiac stress test would demonstrate the MET levels that could be best tolerated by individual patients. These levels in turn could be used to determine those activities which were too demanding.

So for instance, someone might have a training MET level of four, it shows them that definitely carrying groceries up stairs is going to be way too hard for them. And I talk about that as a guideline and it's a warning flag to them. So it's something that they can use to decide what they can modify to make it a lower energy cost. Like toweling off after a shower can be a four, so they might need to modify by sitting down or putting on a robe instead. INT: So even toweling off can be too much activity for some people? RESP: Yeah. Because of the arm work, and a lot of times it can be quite vigorous. So then we just talk about ways to modify it." (Occupational Therapist)

Each worked from a different vantage point as a frame of reference. The cardiologist, from his position as one who was not accustomed to performing household work, did not conceptualize it as "physical labour", and therefore did not think a woman
could harm herself by doing housework four weeks after surgery. The physical therapist and clinical nurse specialist were deeply involved in teaching risk modification following ACBS. They knew from personal experience that housework was time consuming and exhausting, and held the concern that it could detract from self-care activities by leeching away energy and time. Likewise, they explained that the orientation towards the requirements of others distracted women from their own needs. The occupational therapist was concerned with specifying the metabolic workload created by particular activities and by assisting individual patients to design patterns of daily living that would avoid compromising their cardiovascular systems. Her opinion was likewise consistent with her practice and situated understanding of cardiovascular health.

This example illustrates how members of various health professions activate the discursive concept of self-care in relation to their situated understandings of the term. Each approaches the term with a unique point of reference grounded in professionally demarcated interests and bodies of knowledge. As noted earlier, the social act of naming and recognizing a concept creates a focal point around which seemingly divergent understandings such as these might find a common ground:

This is a social act implicating more than one consciousness; each participant could perceive things differently; their perceptions are coordinated in it. Knowledge joins consciousnesses whose perspectives are necessarily divergent, giving us what is known as known in common. (Smith, 1999, p. 128)

The component of self-care referred to in these discussions with health professionals is that of physical activity. This term is known in common by the speakers. The term serves as a point on a map which invites each speaker to locate the complement of that point
within the real world and tell how they recognize it. Each speaker knew how to activate the term, or how to mean with it, but none activated the term on the basis of experiential familiarity with the real world terrain of the resumption of physical activity following ACBS. Instead, each activated the term on the basis of specialized fragments of codified knowledge extracted from that terrain, but not fully embedded within it. Women who approached these various health professionals might receive somewhat different advice from each.

Deciphering and prioritizing divergent advice about self care was not the only challenge faced by the women. The study respondents also described various approaches to resumption of activity following ACBS, but these approaches were nested within the terrain of the everyday world. Each woman considered the problems presented by her healing body, competing priorities, gaps in assistance and biographical precedents as she learned self care through experience. Each would recognize the struggles of the others as similar to her own, and yet manifested in different ways.

**Promoting Healing**

In the weeks following surgery, there was a concern with the healing body. Pain appeared with certain movements and activities, and the women learned to avoid situations where they might be jostled or where they could pull or strain healing tissues. They avoided fatigue, extremes in temperature and strenuous activity. Sleep became particularly problematic, because careful propping and positioning was required to ensure pressure was not placed on tender incisions and ribs. Movements were guarded and slow, particularly when undertaking activities that might pose an increased cardiovascular
workload.

“Yeah, yeah, I take the bus up and get on the Lawrence Avenue bus and it takes me where I want to go. I’ll wait until I get a little steadier on my feet for I’m just a bit shaky if I step on the wrong thing or someone can push me. Wouldn’t take much for someone to push me over, you know what I mean?” (BAMY 663-665)

***

“But now I am doing everything by myself. But not rushing. Not rushing. Because still, I get myself excited or something, it gives me a jumpy heart. And then I get tired and I don’t want to have that. I don’t want to upset myself either, because then I get a jumpy heart...BOOM. BOOM. BOOM.” (SAMARA 310-312)

***

“There is—you know what I found I did? I took books and put them under my bed and I was able—I was sort of up on a slant, my head was up on a slant, so I wasn’t having to put like four pillows under me. I’d still put like about a pillow and a half under my head. But I found that really helped me. And, ahm, and I just—oh, I’d put pillows all over me, all around me, you know. Because I would sort of lean on one pillow and, yeah, like I was surrounded in pillows, yeah.” (MARGARET 296-304)

***

“And I couldn’t walk for the longest time. And going up the stairs, oh my God, to go to the bathroom, I come up there and I felt like I’d run a marathon, and my heart would really beat like hell, and, ahh...INT: So it was hard at first to get around the house, even. OLGA: Yeah. And I...I used to—I have a old...old lady friend and she always goes backward down the stairs, and I said I must try it going backwards down the stairs too. And you know, it really worked.” (OLGA 1477-1488)

Self protection thus required changes in posture and movement that physically distinguished the women from others. Olga, for example, learned to negotiate stairs more comfortably from an elderly friend. Margaret and others surrounded and supported themselves with pillows. Samara attended to her heart rate and rhythm to recognize in her “jumpy” heart signs of stress in a manner that would not occur to a healthy woman. The
reclaimed physical self required extensive attention; these protective activities marked a
nurturing attunement to the self during physical activity and rest.

**Changing Lifestyle Patterns**

It was apparent that most of the women were highly conscious of their own health
correlated behaviours. There was an awareness of recommendations from health
professionals, and the women's descriptions of their attempts to follow these prescriptions
demonstrate a continuing preoccupation with the moral imperative to preserve the patency
of their reconstructed coronary circulation. Professionally generated prescriptions for
healthy living were integrated into daily routines. However, daily routines were originally
predicated on biographical patterns which applied precedence to the concrete physical
needs of others. There was a bifurcation between the prescriptive requirements of a
medicalized discourse of self care, and the discursively and biographically conditioned
activities of homemaking.

a) **Diet.** The women orchestrated the particulars of their own healthy diets. There
were several barriers to this pursuit. Although some spouses apparently encouraged the
women to eat or avoid particular foods, the women were the ones who actively gathered
the necessary information about diet. As noted previously, few had attended sessions on
diet or met with the dietician in the hospital, so some engaged in searches for information
once they felt well enough to concentrate on the problem and generate solutions. In many
cases, the dietary preferences and practices of their loved ones had to be taken into
consideration. Furthermore, the women were frequently tempted by the nutritional
indiscretions of others.
"And it's funny, because I was at my sister-in-law's, um, New Years' morning and they were all going out - my daughter had a party here and I didn't want to be in the way - so some of them were staying at home, and I went over and stayed with them. And the next morning they had a fry, as we call an Irish fry. And I'll have just a little wee bit. INT: What's in an Irish fry? RUTH: It is done in the grease, your sausages, your eggs. And we have what we call potato bread and soda bread, which is Irish bread. And we fry that as well. And I haven't had one of those in a long time. And I had a little bit. And even after I had that, I kept saying: I shouldn't had that. But it was only a little bit. But you see, it does really get to you, you think you're not keeping up sometimes. And then when you realize, oh, I ate that, then you felt sort of, a little bit guilty that you did eat it. And the same... I love chocolate. INT: Oh! [laughter] RUTH: That was my weakness. INT: Um Hmm? RUTH: And I've hardly had any...And then I think: I guess I'll have one little piece. And if I even took that one little piece, I'd feel guilty, too. Having it. So I try. I try. I pretty well...now I don't say I don't. I try not to// INT://Oh. yeah, yeah...// RUTH: But it is hard. Especially when you're not supposed to eat it, that's when you want it all the more." (RUTH 2108-2159)

***

"Some friends of mine give me this low fat, low cholesterol book when I came home from the hospital. And it's very basic too. The recipes are easy to follow. I've just got to get...I haven't been driving yet. I have a car, but I haven't been driving yet. I feel fine to drive now, but he's sold his truck, now he's driving the car. INT: So the car isn't always available to you. COOKIE: Yeah, yeah. So I'd just like to go...if you go with somebody who's driving you, they're just kind of waiting for you, right? INT: Umm hmm. COOKIE: So I'd just like to go and get a few things out of the thing, the cookbook, and go and get them." (COOKIE 358-370)

***

"Ahm, I had an appointment with my doctor the following day and he asked me if they put me on a special diet and I said well, they told me low animal fat. So I said: 'Explain to me, what do they mean, low animal fat?' Of course, he's a real joker, and he said: 'Well I think it's animals that are only this high.' [laughter] And I said: 'You're such a smart ass.' And the only thing I can think of is we have to cut the fat off of everything. Okay and of course I didn't realize that you know, wieners are no good for you and so on and so forth." (LAVERNE 656-667)

***

"And, ahm, I eat properly, I don't take sugar any more, I don't put salt in my food,
I use herbs and I just don’t eat—I don’t eat anything that’s fat. I stay away from the fats although I have, ahm, I try to have the good fats which I should have. And my cholesterol has been good, and my blood pressure is fine, and so I guess I’m fine for a while [chuckles]" (MARGARET 463-470)

Adhering to a diet that reduced the risk of coronary occlusion therefore required management of cravings for forbidden foods as well as an understanding of which foods were poor choices. It necessitated the ability to shop independently, as Cookie explained. Buying for unfamiliar recipes takes longer and might inconvenience friends who volunteer transportation. Practices associated with food preparation are also adjusted. Salt, like fat and oil, intensifies flavour, but its intake is customarily limited in those with hypertension, so Margaret used herbs to add interest to low fat dishes. Frying is inadvisable. Visible fat can be removed from meats, but fat is also hidden within certain foods.

As Ruth’s anecdote indicated, self management was required. Cravings are held in check and guilt was the penalty for transgression. She stammered out that she rarely allowed herself to eat treats like sausages and eggs, or even chocolate, but when she did eat them the moral impact of her actions clearly called for guilt. Self management was thus a prominent feature of medicalized self care, as well as careful surveillance of the contents of available foods. Although a few women, like Margaret, were able to make these adjustments in the early weeks at home, most, like Cookie, did not feel well enough or had not the supports necessary to do so.

b) Exercise. Virtually all of the women were aware of the need to follow a graduated programme of gentle exercise at home, and all discussed their interpretations of this directive. Those who had suffered from angina prior to the surgery described
exercising with joy and enthusiasm. Although their healing bodies imposed temporary discomforts and sensory disturbances, the freedom from shortness of breath and angina held a promise for the future. However, there were barriers to exercise. The first interviews took place in the winter months. The women had been warned against venturing outside in extreme temperatures to avoid placing undue strain on their hearts. They also dreaded falling on ice, or even the potential physical strains of attempting to maintain balance. Many simply walked in endless rounds within their homes or relied on others to transport them to heated indoor shopping malls for walks. Walking alone in the pleasant surroundings of parks was not always considered safe, so partners were sought or public places were preferred. For some, pain and depression limited enthusiasm for physical activity, and there was a need to self-motivate. The women struggled between knowing what they “should” do to promote long term health and what they felt comfortable doing to promote short term comfort.

“And um, well, the weeks have gone. You know, I’ve been doing a lot of walking. The carpet’s wearing out [chuckles] but I have to walk! INT: Well, that’s what everybody does this time of year...what else can you do? ANN: Yeah, to get a little bit of exercise. But I have rheumatoid arthritis so I’m restricted somewhat in some of the exercises, especially in my shoulders. So it restricts me a bit that way. So I’ve been walking. I’ve been walking in the mall - it’s so nice not to have the angina, you know?” (ANN 509-530)

***

“I used to walk in the park down here. Can’t walk now alone, because the further in you go the worse it gets. I’d just walk all over the streets. Looking in windows, that sort of thing.” (COOKIE 412-415)

***

“And I feel guilty if I don’t walk in the morning, and if I don’t walk in the morning,
if I wait until the afternoon I don't get to walk, you see. Or if I get too many interruptions, so if I don't, the phone starts ringing and, ah, and so I do it, ahm, I find that first thing in the morning is my time and I—that three hours, four hours, I just—my most important time is in the morning.” (MARGARET 550-557)

Most comments illustrated that the women were anxious to avoid occlusion of grafts or other problems related to immobility. Guilt feelings were often associated with failure to adhere to recommended exercise routines or goals. Changes in mobility or comfort (such as “stiffening up” or “soreness” of arms or legs) were carefully attended to as the women monitored their own efforts. Some of the respondents, like Eva, did not protect certain times for exercise. Instead they considered their caregiving or homemaking activities part of their exercise regimens. However others took an approach similar to Margaret’s, guarding their exercise schedules and dedicating these moments to self care. Medical discourse indeed brought a moral imperative to self monitor or to submit to the surveillance of others, but in encouraging a focus on personal health needs, the discursive emphasis on self care also introduced the transformative possibility of self nurturance.

c) Learning. The women’s descriptions of their self care practices indicates that learning was occurring on interdependent but distinct levels. As noted earlier, the respondents developed repertoires of strategies for dealing with physical discomforts: pacing activities with rest, awareness of body alignment and positioning to prevent discomfort, and avoidance of situations that might result in injury or pain. This local or embodied learning often built on the cognitive information offered at hospital seminars or by individual health professionals, but this information was incorporated or embodied in
particular ways. Gathering information, once out of the hospital, was often frustrating and
tiring. Accessing answers to questions demanded persistence and creativity.

Mere possession of information, in itself, did not represent the end of the learning
process. Application of knowledge about exercise or about diet and nutrition required
practice and embodied understanding of abstract principles; in other words, experiential
learning was required. As the above quotes on exercise indicate, experimentation was
common until a routine evolved. Samara, for example, cajoled her children into adapting
to a new way of eating.

"I like to eat fish and vegetables. On Saturday, we didn’t even eat meat or fish or
chicken, nothing! Just the vegetables. You know, different kinds of salad, boiled
vegetables with just a little bit of salt and pepper. Just that. But the kids... [laughs]
They don’t want to be chubby. But: Eww, yucky! I don’t mind. But once in a
while, I like to eat meat, say chicken or fish, or whatever. I don’t fry them. I just
roast them in the oven or I’ll boil them or steam them.” (SAMARA 196-202)

Laverne had to develop different shopping habits: few people forget to buy eggs when
grocery shopping, but Eggbeaters are not routinely purchased. Over time, established
preferences and menus facilitate habitual patterns of grocery shopping. New items
disrupted routinized shopping practices and food gathering became a series of awkward
backtracking through aisles and return trips for forgotten ingredients.

“But from what I can understand, those Eggbeaters are supposed to be really
good, and that’s the only thing I forgot to pick up last night, those artificial eggs.”
(LAVERNE 854-857)

Learning entailed rearrangement of local, embodied, often implicit understandings as well
as the absorption of cognitive information. It was accomplished over time, and
respondents approached the task at various paces. Sonia was feeling too tired and
emotionally depleted to embark on such an intense inventory of her daily routines, as did many of the women at the first interview. Margaret, on the other hand, gleefully described her new approaches to eating, her job, and exercise.

**Homemaking**

There were often conflicts between the discursive tenets of self care and the local practices of homemaking. Respondents repossessed and deciphered their surgically repaired bodies within settings where they were accustomed to exerting an active presence. Earlier in this chapter, it was shown that there were prominent discursive understandings of how men and women acted in different ways within the home. The women were relocated after a brief sojourn in the hospital, where an unfamiliar discursive emphasis on survival and self care prevailed, back to their homes, where habitual schemas of activity had evolved over time.

A very few of the women had outside help with housecleaning: Sonia and Eva had low cost homemakers through the Home Care programme, while Brownie had always employed a “cleaning lady”. Agata also periodically employed a woman to clean her house and was assisted by her daughter with laundry and other chores. The remainder depended on the help of family members or close friends. Ruth and Emma each stayed for most of the first month with their adult daughters and their families. Ruth described her own need to be more helpful to her daughter and son-in-law, who both held demanding jobs, but followed her daughter’s directions and suggestions regarding the work she did and the meals she prepared. She did not coordinate the chores in her daughter’s household:
"And then, last night, when my daughter come in... and every night's the same, them two come in, and they work so hard, you know, they're stressed out in their jobs, because everybody is. Three o'clock, you know, my son-in-law went to bed. Because, you know, he had to have a report done for today. You know they don't need this. To come in, and me like this, they don't. So I try to... I try to, uh, keep myself cheerful, you know. I do get up and I'll peel some potatoes, and I'll put a little bit of meat on and I'll phone my daughter in the afternoon to see if she'd like me to make something or start something, because I figure I'm well enough to do that." (RUTH 90-111)

Emma was uncomfortable with her daughter's protectiveness. She preferred to coordinate her own household and returned to her own apartment where she immediately experimented with vacuuming:

"And I started vacuuming, which I shouldn't have started. But I just rolled my vacuum, it's not too heavy and vacuumed around. Then my daughter comes over and she gives me shit. [chuckles] But like I said, I'm not one to, I'm not used to people, like, living with family. But that's the hardest part of it. The adjustment." (EMMA 548-559)

Ann, Tip, Vi, Gert, Laverne and Olivia did little housework during the first month and watched with varying degrees of comfort as their spouses took over the chores. They expressed some reservations about the appearance of their homes, their own feelings of inadequacy in watching others do the work. They felt they were coordinating or directing the work.

"Like when a man is sick, ahh, you still look after the house, the washing, everything, you know, shopping and everything. But now he has to do it and he's never done it before. And that was the worst. So let somebody else do it when I used to do it myself... it was very hard for me. INT: It was hard for you? GERT: Very hard. INT: What did it feel like when you...? GERT: Useless." (GERT 259-272)

***

"But nobody else did it so, you know, what are you going to do? And, ahh, like he is tired even so he doesn't work that much those days, but he's even more tired
now than when he worked 12 hours a day. Yeah, and so who else is gonna do it? I think all these things are better for men because they get served anyways. You know. But women they...things totally get screwed up they’re not--if you’re not in charge, you know. INT: How do things get screwed up? OLGA: Oh, by quite simple. The shopping, oh, my God! This is like a disaster, you know. They buy things you don’t need and the things you need they’re not here. Then my husband went to buy big packages of ham, you know, Bulk Barn type of stuff, and I don’t like that because once you open that you have to eat that fast or else after a few days I don’t want any of that any more. So I rather buy small packages and, you know, stuff like that. That’s for me is screwing it up [laughing] you know. I didn’t want it. I fed it to the ducks after. you know. And, ahm, another example is I hear her [family dog] she doesn’t have her dog food, and I can’t buy it. it’s too heavy for me.” (OLGA 1539-1563)

Olivia was the only woman who consistently declared complete comfort with her husband’s participation in homemaking. She described a partnership arrangement whereby she easily relinquished responsibility.

“I don’t do no heavy work, I don’t vacuum, I don’t wash, you know. do the washing. INT: Has it been that way for a long time now? OLIVIA: Long time. INT: When did that first begin? When did it first begin that you stopped doing those chores and he took them on? OLIVIA: When, ah, I first had my heart attack. But then I went back to work after; I was home for six months, and I went back to work part-time.” (OLIVIA 432-446)

***

“INT: I’m just wondering if there was ever any discomfort between the two of you because he was doing housework? OLIVIA: Hell, no! [laughs] INT: You’re glad to be rid of it? OLIVIA: Oh, yes. No, he’s very, very good. I’ll do...he gets up makes breakfast in the morning and I’ll get lunch, and I’ll just tidy around because it has to be done, I’ll just get the brush and clean off the chesterfield and I help him make the bed. And what I do is I’ll cook supper and wash the dishes unless I’m really tired, and I’ll go lay down. I lay down nearly every afternoon, and he just carries on. And he’s full of arthritis, too.” (OLIVIA 484-500)

Cookie and Samara were laundering, cleaning and vacuuming by the third week at home despite their partners’ helpful overtures. Cookie’s comments indicated that homemaking was accomplished using knowledge that was experientially acquired and
carried in embodied practices.

"But I didn’t do any housework for a long time. He was doing it. But then I said: Oh, God, I can’t watch this any longer! He wasn’t doing it right. I started washing the dishes, then I started cooking supper, but I wasn’t lifting. I was just standing around cooking supper. INT: So at what point did you start doing the housework? COOKIE: Oh, second week I was home."

***

"INT: Laundry? What about all that carrying? COOKIE: Oh, I’ve got a bundle buggy and I just use that. The only thing is reaching into the machine, is all. He was doing it, but he wasn’t doing it right, again. Too much soap, one day he came back and everything was white. He used too much soap powder. ‘How do I know how much to use?’ he says.” (COOKIE 452-457)

Laverne’s anecdote about her husband’s newly acquired expertise with a string mop indicated that tactics and skills were embedded within the doing of housework. Her laughter indicated her surprise on discovering he could not only judge independently that the floor needed to be mopped but could select the appropriate mop for the task.

“He even pulled out [chuckles] we have that mop there because I have three dogs and when it rains, of course they tend to leave little paw prints all over the place. So that does as a little quick wipe up. But he’s--I was lying in bed one day and he’s got chairs up on the table and he’s got everything all pulled out and the string mop from downstairs, because he says: ‘I like the string mop like you do rather than this one.’ [laughs] And it’s just--it’s so funny because he would never, that’s one thing he would never really do unless I asked him. He would never pull out a mop and say, ‘Okay, we’re gonna clean the floor today.’ So it was so funny, I was sitting there just killing myself, he says: ‘Don’t you laugh.’ And I said: ‘It just seems so different to have you say ‘I like your string mop better’.”’” (LAVERNE 1147-1163)

Several of the above quotes indicate that the women identified the household as an area where they normally exercised some authority. Their spouses might attempt to do housework, but their shortcomings in completing these tasks indicated a lack of knowledge about cleaning, laundering, or shopping. The teasing and laughter about
Laverne’s husband and his skill with a mop indicated its extraordinary nature; from Laverne’s standpoint, men do not usually discuss the relative merits of string mops and sponge mops. Gert felt she was not doing enough or was “useless”, indicating a sense of gendered accountability for housework. This accountability was apparently so strong that Samara proceeded to vacuum the house three weeks after her surgery. Like Olga, Samara found that despite her husband’s protestations, there actually was no other person available to do the work. In contrast, Olivia and her husband had a long history of sharing housework and she felt no pressure to do heavy housework.

**Employment**

Two of the women returned to some of the activities of employment within four weeks after returning home from the hospital. Laverne did some paperwork to lighten the load of colleagues who had taken on some of her job responsibilities in her absence.

“I couldn’t--like I’ve got all kinds of work from work that I can do now, and it takes up, you know, a lot of my time, which is really nice. I do it when I feel like it, I do it if I’m not tired, and it’s not stressful. But I’ve waited until the fourth week before I started doing anything - it was even hard to sit at the table and even concentrate.” (LAVERNE 448-456)

Margaret and her husband owned a business where they had worked together most of their married lives. During the our first interview, she stated that one of the advantages of owning a business was that she could chose her own working hours and go in any time she wished. She had recently begun going in to work for a few hours at a time.

“Like I...when I’m tired I come home, you know. I go to the store at eleven o’clock and we close the door by six anyway. You know, at five o’clock we leave, you know, it can be done tomorrow, whatever is to be done.” (MARGARET 541-545)
Both women struggled with the same feelings of obligation to return to employment as other women did with reference to housework. Laverne was concerned that her co-workers of many years would carry a heavier workload in her absence. She sought to minimize that burden by doing some paperwork at home. Margaret worried about her husband coping at the family store in her absence. In both cases there was an emotional attachment as well as a business relationship, therefore conflict between care of others and care of self extended into employment. Each defended her decision by explaining the work was not stressful or that she was pacing work activities in a sensible manner. For both women, the narrative accomplishment was to achieve a balance between accountability for the wellbeing of one's co-workers and accountability for personal health needs.

**Emotional Work**

Some of the women described invisible activities of emotional management. This was often other-centred, even when the work seemed focussed on self: the women were concerned to allay the fears and distress of their loved ones. By managing their own emotions, they could maintain a more comfortable emotional environment for others. The extraordinary dislocations and peril experienced during hospitalization deeply affected family members and dramatically changed the manner in which families were embodied together. Relocation within the local world of family and friends brought the anomalies of repossessed bodies into sharp relief. Some women were aware that their efforts to protect themselves from pain or injury changed the character of loving bonds between themselves and their closest ones. Hugs and picking up grandchildren were threats to comfort as
sternal incisions healed, and yet the avoidance of these gestures created discomfort of another kind. At issue was a conflict between the embodiment of identities as loving wives, mothers and grandmothers, and the need to protect the healing physical self from pain and injury. Most struggled to overcome this conflict by reassuring others of their wellbeing and continued affection. These comments illustrate the extent to which intimate social bonds are embodied or accomplished in part through physical expression.

The women reassured others by demonstrating their fitness to resume customary activities. Ann and Cookie reported that they concealed problems from loved ones, trying to maintain a visibly cheerful demeanor:

"...because these things you don’t want to, you don’t want to--you’ve put your family through enough already [chuckles] and you don’t want to worry them with other problems. You know..." (ANN 353-359)

***

“So he was home both weeks with no work. He would have been off anyway. But he was...he’d see me frowning and he’d be: Do you have pain? I’d say: No. He was good though, he was much better than I thought he’d be. INT: What did you think was going to happen? COOKIE: Well he’s very, he’s got a very fast temper. He’s an alcoholic, but he’s quit now for four years. But anything, those pills the doctor gave me that gave me headaches, he was just wild. In two minutes, his temper’d fly. So I’d be crying and trying not to let him see.” (COOKIE 624-634)

Tip and Gert longed to demonstrate affection by hugging, which aggravated sternal pain:

“And I have three grandchildren which I--I’m not allowed to pick up. That...that bothers me. INT: Yeah? TIP: Yeah, [grandson] is seven months now; and I can sit and hold him, but I can’t pick him up. I’m not allowed to yet. I’ll be glad of that when I get to it again. [laughs] yes. Because he’s so--he comes over, you know, grab on--hold up his arms for me to pick him up but I can’t [laughs]. And [granddaughter] said: ‘Grandma, are you gonna come out and play with us?’ And I said: ‘Yes, I am. Ill sit in the chair, you guys can have some fun.’ And she said: ‘Oh, Grandma, I’m so glad to see you walking around!’ I mean, I guess it was alright then, you know.” (TIP 779-785)
***

"INT: Has there been any other change in your relationship with him? GERT: No, none. Just kinda miss hugging. [laughs] You know, all that sort of closeness, yeah." (GERT 1214-1217)

Emma explained how the decision to physically locate herself at the home of one daughter instead of the other following surgery was imbued with emotional pitfalls:

"And then by the week, I was, ahm, ‘cause when I was recuperating from my heart attack, I spent some time up north with my daughter, and when I came down here...my grandchildren were: Well, you can stay up there at Auntie’s house but you can’t stay with us! And I had to sort of, you know, make everybody happy.” (EMMA 499-509)

In addition, Luigi pointed out that her decision to return to work was made with some intention to provide convincing evidence of recovery to her anxious adult children:

"Yeah, back to work. I want...I can’t stand being around all day. I want to get back to work. I want to alleviate the stress and the concern of my kids. I mean, when they see me up and going and bopping and [chuckles] working and, you know...” (LUIGI 64-68)

Finally, some women were particularly distressed when they were involved in emotional family situations and lacked the energy to mediate or stave off discord. Their distress suggests that emotional management was an everyday facet of their household responsibilities as demanding as cleaning and shopping. When they inadvertently hurt or upset others, it was evident this in particular created intense self recrimination. Most examples involved children for whose emotional wellbeing the mothers felt responsible, even into their early adulthood.

"But it was about three weeks after I guess, and [son] was just fooling around and he was standing beside me, my sister was here, it was on a weekend, maybe it was only two weeks after, and he was just fooling around and he was going like this. INT: Oh, sort of tickling with his fingers, yeah. LAVERNE: It just drove me nuts. I mean like I don’t need anybody touching me. okay. INT: At the incision?"
LAVERNE: Exactly. And of course I yelled at him and swore at him and told him not to be such a stupid ass [laughs]. And of course he says: ‘Well you don’t have to swear at me.’ Which I didn’t and he was right. And then he walked out and went out to work on his car. And my sister says: ’Did you see the look on his face?’ And I felt really bad and I was in--I was in tears too, okay, because I didn’t want him to hurt me. And he says, he says: ‘I’m sorry, I forgot.’ I said: ‘Yeah but you forget and it hurts ME.’ So it was unfortunate, it was just a stupid incident but anyway, I got off the bed, put my housecoat and slippers on and went outside, put my arms around him and gave him a hug and said: ‘I’m sorry. I said: I really didn’t mean to yell at you.’ He says: ‘I didn’t mean to hurt you.’ He said: ‘It just--I forgot, I was just fooling around.’ And I said: ‘I know that.’ I said: ‘And I’m really sorry I hurt your feelings.’ [laughs] I think he was sort of not in tears but, you know, close to it. I thought: Oh, God!” (LAVERNE 1318-1350)

Laverne’s story highlights several themes. As noted earlier the physical discomforts during recovery were intensified by activity, repositioning and physical contact with others. Consequently, vigilance and self protection altered close social relationships as habitual physical expressions of affection were avoided or deliberated. Emotional work and affection are to some extent embodied, thus recovery from major surgery not only alters emotional relationships because of stress and worry, but because habitual patterns of physical touch are disrupted. Responsibility for the emotional wellbeing of family, especially children, meant that respondents were not free to simply protect themselves. The manner in which self protection was accomplished affected others and therefore was the subject of self monitoring and practical tact. Grandchildren were refused hugs, but were invited to cuddle on the sofa. Apologies were in order when teenaged sons were chastised too sharply for causing discomfort during affectionate teasing. The balance between self care and care of others was at its most sensitive in the realm of emotional work.
Caregiving

Two of the women returned home to resume some caregiving responsibilities.

Seventy-nine year old Bamy and her partner had caregiving responsibilities for an elderly boarder. This work had been taken over by her partner in her absence, but she resumed some of the companionship and meal preparation duties within the first month after surgery.

"INT: What about your boarder. He's been with you a long time. Is there a lot of work involved with him? BAMY: Well, in a way, yeah. He eats a lot, he's always hungry. Night and day, yeah he's always hungry in the morning. he eats a big breakfast, and he eats a big lunch and eats supper at night and he eats again before he goes to sleep, he says it's because he's got diabetes, he gets hungry. And they say with that Parkinson's. my sister told me her husband's sister-in-law said she could never get filled up, she had Parkinson's for a long time." (BAMY 698-709)

Eva resumed care of her husband immediately after returning home. Despite monitoring of the situation by home care nurses, she found it necessary to watch over her partner’s progress and advocate strenuously for him when his condition deteriorated.

"Now what I was going to tell you...of course when you get out of the hospital, they sent nurses for him. Like this [nurse’s name], I think that's what his name was, and he would come over and he would say to [husband]: How are you today? And [husband] would say to him: I'm okay, but my leg is so bad, I can't get up on it. But it wasn't in the thigh or anything, it was down there. And the nurse would write on the papers: No complaints. And he left the papers on the table one day and I read them, the whole works. For the whole week that he was home after I came home, it was: No complaints, no complaints. So one day, uh, another nurse came in, and, ah, she was a she, not a he. And she asked [husband], you know, how he was. And he told her about the leg. And I was snarky that day, perhaps I shouldn't have been. But fortunately, I guess it saved his life. And I said to her: What's the good of telling you how he is, because all the other nurse did was write No complaints, No complaints. I said: He's been telling him for the last six days that he's got a bad leg. And she, ah, she said to him: Drop your trousers and let me see that leg. And she did and she said to me: You get on the phone right away and phone your doctor—tell him that your nurse says he must be seen right away. And I did. And he had to go right up to the hospital and they admitted him right away.
He had blood clots in his leg. INT: And this is the week after you got home//
EVA: This is the week I got home.” (EVA 155-183)

Eva clearly put considerable thought and effort into coordinating care for her husband. She was the one in the anecdote above who called the doctor on the nurse’s advice and she was the one who managed his medication dosages. Yet the same attentiveness did not accompany her own self care efforts:

“And so I put the letter [from cardiovascular surgeon] to the [family] doctor in my purse...and come to think of it, I haven’t given it to him yet.” (EVA 638-640)

Caregiving was difficult to put aside during recovery. Like homemaking, caregiving incorporated an invisible component which included companionship, coordination of physical care and anticipation of needs. These intangible activities did not always involve physical labour, yet responsibility for these elements diverted attention from self care.

**Relocating Self in Relationships with Others**

It was apparent from many of the narratives that the women struggled with the implications of receiving care. They understood the pressures on those who offered them help and frequently referred to this as they described the care they received on returning home from the hospital. For the women, receiving care or help was at times problematic, for it placed them in positions of need and supplication. These represented relocations of self in relationships with family, friends and neighbours which posed marked contrasts with reported biographical patterns of independence and responsibility for others. The difficulties posed depended on the manner in which care was offered, the type of care, and the biographical nature of the relationship with the caregiver.

At times the caregivers were perceived as already overloaded with responsibilities.
The concern about burdening others was foremost in the women’s minds, and thoughtful helpers would explain how a particular arrangement held advantages for the caregivers themselves. This dynamic permitted the women to accept care with the knowledge that the others’ needs were being met at the same time:

“Well, I keep saying, you know, I’m one that I’ll say, you know, ‘I feel awful that you two, because I know you’re under such stress at work’. Because they travel quite a bit too with their company. And when they come in I’ll say: ‘Oh, I’m really sorry for being like this.’ But then [daughter] goes: ‘Yeah, yeah, mom, it’s okay.’ She wouldn’t let me go home or anything, because she said she’d prefer me to be here. Because then she wouldn’t worry. Because [location of Ruth’s own apartment] is quite a bit from here. And so it’s much easier for her, then, if something happens to me. Like for instance the other Friday when I got up and had that pain on the left side and I couldn’t get a breath. And we knew there was something wrong but we just couldn’t figure out what it was. So she just run me over to [community hospital]. And she says to me: ‘See, mom, you just being here, that makes it easier for me.’” (RUTH 273-302)

In other cases, the acceptance of assistance was cast within biographical relations of reciprocity. Gracious and grateful acceptance of help was considered appropriate when one had provided assistance in the past.

“Especially with my son coming from [northern location in Ontario] the second time. After he had been here for my bypass surgery, when I came home from hospital. I felt that we had put upon him enough and that he shouldn’t come back. Because I had come out of the hospital and I was out of danger and I had friends. But...ahm, they insisted. So I didn’t say no. You know...and I was very thankful for the help. And there have been occasions when they needed help and I would help them. And I would think when I’m better, I’d do the same thing I could do it again if anything comes up. INT: So there is some reciprocation there. ANN: Oh, there is, definitely. So I would want them to count on me. My husband feels the same way, if we were able physically. Well, we did when my daughter-in-law had her baby down in [location in USA], she’d had a cesarean so she needed help. And we went down for a week and helped. That’s just something you do.” (ANN 1111-1147)

Some of the women found it ironic that, despite their precarious health and need
for help prior to the surgery, they received more assistance after the surgery. The manner in which their bodies had been marked and invaded by the surgical experience, as well as the discursive references to risk of mortality within the hospital may have had a profound impact on close others. This residual image prompted a tender protectiveness that established the women as deserving recipients of care and justified the relocations of caring positions in the structure of close relationships. Awkwardness became secondary to a perceived need to preserve the continuity of the emotional and social bond itself rather than the usual structure of its relations. In exchange for this extraordinary help, the women felt obligated to recover and avoid disrupting the lives of caregivers any further.

Surveillance was a prominent theme in the social relations of family caregiving.

"And, uh, it was rather traumatic for my husband [chuckles] you know, but I also think that it was important for him to see it. He’s so supportive of me that I think that that reinforced it. You know, he didn’t want me to do ANYthing. Not even lift this or lift that. So...I think that impacted on him. INT: So he understood the importance of// ANN: // Oh, yeah! Yes, he did, oh yeah. He was really concerned that I was getting enough rest or whatever. He’s a doll, he really is good. I feel that, ahm, I just HAVE to stay well because it’s [chuckles] it’s too hard on my family!” (ANN 882-909)

***

"I think he’s--he [husband] talks to me now like just: Now just sit down there for a minute because you’re fine. He says: Remember you’re a lot better than you were when you went in... you’re gonna be a new person. And, ah, you know, we went to the doctor and came back and he said: Okay, now you go and sit down for a little while, rest, maybe you’ve just done--overdone it a little bit today. So you know, he’s very supportive, he’s wonderful. And, you know, he’ll say: Well let’s--would you like to go out for a little drive, you know, get some nice fresh air and then come home? Fine. [laughs] Or you know, he’d say eleven o’clock at night: Don’t you think you should get up to bed? Like I’m being told what to do [laughs] INT: Does that bother you at all? TIP: No, not at all. No. Married forty... forty-six years or forty-seven? I guess forty-seven this year. Pretty good.” (TIP 830-847)

***
"It’s made us both aware. Ahm, [husband] especially because the doctors have made him aware that, you know, like if we hadn’t taken care of this, I could not be here for much longer; I might not have been here for much longer. I could have been gone before now. And me also, I’ve been lucky enough to be given a second chance, and I think we’re both pretty well aware of that and glad for that, so it’s made that much more the feelings between us. So yeah, really, you know, it hasn’t, ah, changed our relationship...Ahm, it’s nice to know that somebody’s there to baby you, or not even so much baby you, but to make sure that you do things that you’re supposed to do because they care. That’s nice." (LAVERNE 1253-1269)

Relocations within the network of family relationships were common for others as well as for the women themselves. As Luigi’s description of her daughter’s constant involvement indicated, extraordinary role reversals and altered power relations accompanied family caregiving and help. These unusual arrangements prompted recognition of new facets of her daughter’s identity. Luigi found that her daughter was a source of support who mediated information from health professionals and maintained constant surveillance. In comparison to Luigi’s son, who was portrayed as absorbed in personal conflicts, her daughter successfully emerged as a caregiver. Olga and Laverne also depended on their daughters for help of all kinds but represented their sons as self-absorbed or in need of emotional support.

“My daughter is 26 and she’s just been a rock. She’s literally taken the place of her father as far as support. The hospital personnel all talked to her and explained...[cardiovascular surgeon] and everybody would talk to her and explain to her so she took...she took the role of...you know...the support person...[pause] INT: She was your support person, yeah. LUIGI: My significant other [chuckle]. She was amazing. I didn’t realize that she had the, you know...the maturity and the...she was amazing. She is amazing. I’m really proud of her. My son who’s 23 is going through a problem with his significant other and he has a baby and you know/// INT://Oh, yeah... LUIGI: He’s 23 and going on 18, and you know, he’s there for me as much as he can be but he has, he has enough problems in his life right now. INT: Um hmm. LUIGI: But she’s been amazing...and I think that once I get back to work and they see that I’m okay, then they’ll be able to get on with their lives. Right now [daughter] comes out every weekend. She CALLS me every
day. She’s so...I laugh, tell her that she’ll be glad to get her life back.” (LUIGI 72-96)

Later, Luigi described her daughter as “the mother” and associated this discursively feminine social position as one of strength and of shouldering burdens. She was proud and satisfied that her daughter demonstrated adult feminine comportment, but also suggested that this was at the cost of Luigi’s own sense of power:

“You know, I worry...you know. Yes I think deep down inside I really have leaned on her too much. She seems to be shouldering it but...INT: Yeah, though you said she is feeling proud of herself, too. LUIGI: Yeah. No, she is the mother, and I’m the... [laughter] She’s the strength...she’s the figure of strength you know...and I’m the wussy type thing.” (LUIGI 1038-1048)

These changes in the balance of family dynamics created some disquiet, but were ultimately cast within the context of love and biographical relationships of reciprocity.

However, in some cases the surveillance and protectiveness of others became oppressive, particularly when the women felt the need for solitude or were eager to return to more active participation in their former routines. This dynamic created a tension indicative of a reversal of familiar power relations, such as those described by Emma:

“My daughter down here is not a very strong person. She has difficulty coping with things. And ah, basic problem with her is her husband. So therefore, my youngest daughter is a far more mature person, and so she has to talk to my daughter and say: Okay now, this is the way it is. [chuckles] So you know ahm, it’s hard because they want to know exactly what I’m doing just about twenty four hours a day. And as I said to my GP yesterday: I think they would be very happy if they caged me up, and that way they could watch me every...[chuckles]” (EMMA 765-800)

Submitting to the surveillance and care of her daughters was difficult for Emma, and she preferred to maintain her own regimen without their protection. The micro social relations of local health care retained the imbalances of power which originated in the
locations of medical practice. Traces of these imbalances remained in all but the most egalitarian of arrangements. Tip’s beloved and supportive spouse monitored her bedtime, for example. Gert’s sister-in-law, who faithfully remained at her side when Gert’s husband could not tolerate the hospital environment, instructed Gert on activities which were and were not acceptable.

Discussion

The disorienting displacements and dispossessions of hospitalization were followed by equally unsettling physical and social relocations within the everyday world of home, family and neighbourhood. As the women dealt with the sensory discomforts and surface alterations of their repossessed bodies, they confronted the multiple implications of these changes. During hospitalization, one condition of bodily reposssession was acceptance of responsibility for self care, which was demonstrated by progressive efforts to ambulate and learn the rudiments of heart health. Discharge from the hospital meant relocation in a site where customary self and gender reproducing activities were embodied. These activities were essential to the continued wellbeing of others, not the women themselves. Homemaking was at times strenuous to healing hearts, and it detracted from the work of learning and incorporating new self care habits. Thus the women faced the complexity of relocating themselves at an intersection between the habitual world of homemaking and the relatively unfamiliar discursively coordinated practices of self care.

Women’s standpoint is a mode of experience grounded in activities which address the mundane requirements of others (Smith, 1990a, 1999). Women are responsible for the majority of household chores, health oriented activities, and emotional support of family
members and others (Armstrong & Armstrong, 1994; Bowlby, Gregory & McKie, 1997; Conway, 1990; Delphy & Leonard, 1992; Duncombe & Marsden, 1995, 1998; Hochschild & Machung, 1989; Kahn, 1991; Luxton. 1997; Wilson, 1991). The discourse of household and social obligation is constitutive of the context of women's lives. This discourse may be enacted in countless idiosyncratic patterns across class, cultural and generational locations, however, the idiom remains one of immutable responsibility for organizing and providing a material foundation for the sustenance of oneself and others:

“So after five and a half weeks after the surgery, 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 you know, nobody else did it so, you know, what are you going to do? And, ah, like he is tired...he's even more tired now than when he worked twelve hours a day. Yeah, so now, who else is gonna do it? I think all these things are better for men because they get served anyways. You know. But women, they--things totally get screwed up if they're not--if you're not in charge, you know.” (OLGA2 1531-1549)

***

“And again I can come back to the family example where without any question my mother would wait on my father hand and foot if he had major surgery or disability and was recovering from that. When she fell and broke her hip and was home after that before Christmas, what we had to do was go in and read the riot act. And arrange over the objections of both to get Home Care, and the first couple of weeks Meals on Wheels, because she simply didn't have the mobility. We didn't want her to get up and prepare meals and do the housework. Now the adjustment actually did come around. I mean my father, moaning and groaning from time to time, nevertheless did realize that well, this was only fair, because his wife had always looked after him. And we pointed out to him that he used to love to go camping and he didn't have any trouble cooking then, so he should be able to do the same thing in the house. [laughs] And if he wanted to fortify himself with an extra scotch before he started that was okay! [laughter] (Cardiovascular Surgeon #2)

To begin from women's standpoints is to locate inquiry within their bodily, thoughtful performance of these mundane tasks within particular sites. It is a matter of exploring the
relations of ruling from women’s everyday/everynight experience.

The respondent’s accounts of early recovery in the home setting indicate attempts to balance and accomplish self care and homemaking. In attending to activities related to both initiatives, the women encountered the line of fault between the knowing which arose from their own embodied experiences and the objectified knowledge-in-common presented to them by health professionals in educational interventions and individual interactions. Although a major dimension of early recovery was reconstruction or recovery of the biographical self, the tasks and activities in which gendered identity and selfhood were invested became problematic on two counts: the absence of a replacement homemaker, and the loss of the lived or habitual body.

Although some homemaking functions were accomplished by substitute services or helpers, only in a very few cases was the homemaker position entirely replaced. Olivia, for example, was able to take a nap secure in her belief that her husband would know how to carry on with household chores in her absence. Those who received Home Care referrals could count on assistance with some, but not all, dimensions of the homemaker position. Eva and her husband had a visiting homemaker to help with cleaning and laundry, Meals-On-Wheels to prepare food, and a nurse to periodically check on them both, but Eva retained responsibility for coordinating George’s medical regimen and for attending to some aspects of his physical care. Olga, Samara, Cookie and others received offers of assistance, or were warned not to do housework, but found that no replacement homemaker existed to coordinate the household, attend to the emotional and physical needs of others and provide care for the recovering woman. Often absent were constantly
present others who possessed the experiential knowledge of homemaking - not simply from a generic perspective, but from the local perspective of that particular woman and her home.

As Olga points out in her comments above, there was no true respite from homemaking, unless one could tolerate disorder and loss of a position of control over the home. The cardiovascular surgeon's anecdote quoted above demonstrates how assistance can be marshalled so that various homemaking tasks are completed when a woman is recovering from surgery, yet this deployment of assistance is intensely problematic, requiring arrangement of community services, the reading of a "riot act" and fortification with scotch. Interestingly, there was no one service or category of paid worker available to assume responsibility for the entire repertoire of activities which constitute homemaking. An aggregate of resources were assembled to accomplish home care: visiting homemakers, visiting nurses, Meals-On-Wheels, and so on. Moreover, these services were available on an episodic basis and workers were rarely present more than a few hours in the home for a few days of the week.

It was therefore not entirely remarkable in some instances that self care was, literally, care of the self with partial or no assistance from others. Central to this problematic is the persistence of a gender-segregated base of experiential knowledge related to homemaking which fuses "doing home" (Bowlby, Gregory & McKie, 1997) and "doing gender" (Fenstermaker, West & Zimmerman, 1992; West, 1993; West & Fenstermaker, 1993). In many of the women's accounts of the early recovery period, both sets of activities were central to reconstruction of identity in the wake of the
traumatizing negation of biographical personhood during hospitalization. The claim to a unique and valuable set of embodied skills related to homemaking was reinforced when others could not successfully complete tasks. However, it is important to acknowledge that embodied homemaking activities help to constitute the world-in-common of home, family and affectionate ties. Other identities are at stake: those of husbands, children, grandchildren, friends and neighbours. We have seen that patterns of interaction between women and any of these close others are embodied and enacted.

If the absence of a substitute homemaker was coincident with push and pull forces that encouraged respondents to resume their homemaking tasks, the loss of the habitual or lived body served as a barrier to this pursuit. Material connection between the embodied person and the world is achieved through directional activity or intentionality (Diprose, 1994; Leder, 1990; Straus, 1966) and corporeal schema, tastes or mannerisms are distinctive and habitual markers of social identification (Bourdieu, 1990; Diprose, 1994; Smith, 1990b). Most of these projections of the social body into the world are accomplished in an habitual manner unencumbered by deliberation. However, in extraordinary circumstances such as illness, injury or surgery, the viscera and the surface body intrude upon consciousness with pain and impaired mobility. Loss of the habitual or lived body was marked by pain, stiffness, inexplicable sensory disturbances and inability to tolerate exertion in the women who participated in this study. The embodied routines of living, including homemaking, became subject to these physical constraints.

But although Diprose (1994) and Leder (1990, 1998) implicitly consider the interaction between the person and the social world, analysis of the dialectical relationship
between the body and society is perhaps as deficient in the phenomenological tradition as it is in the biomedical model. To return to Kreiger and Fee's contention cited in an earlier chapter, "ignored are the many ways that...social reality gets into the body and transforms our biology" (1994, p.18). At issue here is the notion that the loss of the habitual or lived body is determined simply by the experience after surgery of the incised body as the sole barrier to unconstrained, habitual activity. Surgery is a social, as well as physical, endeavour. It is based on the Cartesian discursive assumption that the body, like any machine, can be disassembled, restructured and repaired. Most importantly, the surgical act is surrounded by a discourse of cardiovascular self care which conditions and intensifies loss of the habitual body as well as the development of what Morgan (1998) refers to as "medicalized subjectivity". The women were already aware that heart disease is potentially fatal, and were warned by their physicians of the serious nature of their condition. They were convinced that the hope of survival and continued health justified the perils and disfigurements of open heart surgery. They understood that certain personal health habits would reduce the risk of recurrence. The women shared a world in common with their health care providers. That world was one of sensuous embodiment and activity, coordinated by the identification of the problem, "heart disease".

Samara's narrative abundantly illustrated the informative underpinnings of the discourse of cardiovascular self care, which suggest that certain activities and substances place the surgically repaired body at risk of further coronary occlusion. Her body assumed vulnerability as the site of dangerous toxic effects related to certain substances, personal habits or dispositional traits. The discourse of cardiovascular self care
reconfigured the moral relationship between Samara and her body. Primacy was assigned to the obligation to pursue or avoid certain activities in order to protect the surgically repaired body. Attention to these matters threatened the domino-like collapse of the sensuous, habitual order of the everyday world even as it purportedly ensured health and survival. Samara was faced with the problem of presenting her efforts to pursue homemaking within the confines of the medical discourse of self care:

"SAMARA: Oh, I did the work. Believe me, I would even vacuum the house. INT: You would even vacuum the house? SAMARA: Oh, [giggles] then lie down. I sit on the floor to do it, doing the corners, all around. It really helps to sit down. I don't really move around much. I just use the arm that doesn't hurt. It doesn't bother the other side."

In this passage, her narrative accomplishment was to present herself as a responsible homemaker who attended to the needs of her family while simultaneously caring for herself by modifying her bodily posture as she vacuumed and by resting afterwards.

The origins of the discourse of cardiovascular self care lie in the scientific understanding of risk factors which contribute to CAD. These origins provide an objectified world-in-common (Smith, 1999) that coordinates the professional activities of selecting seminar content, developing teaching pamphlets and videotapes and providing information to patients with heart disease. They support the assumption that there is a common idiom which guides communication among the health professionals who undertake health education, despite their different perspectives on such issues as activity resumption and household chores. Yet this assumption is illusory in some respects. Health professionals held different views on the possible hazards of resuming homemaking activities soon after return home following ACBS. Similarly, the women noted
contradictions and gaps in information offered by health professionals and others. They found it challenging to translate the cognitive information presented by health professionals into embodied, sensuous practices. Most did not feel physically or emotionally strong enough in the first month at home to unravel the complexities presented by the discursive foundations of self care. As Olga protested above, there was no “replacement homemaker” to fully take care of her when she returned home, although she would assume full responsibility for her husband’s care if he were ill.

The scientific knowledge which supports the discourse of cardiovascular self care excludes the material and bodily circumstances of the everyday/everynight world, thus, the actualities of the embodied experience of risk reduction are obscured. Ironically, the discourse purports to offer protection for what Leder (1990) would call the visceral body while it ignores the sensory, instrumental and social impact of risk reduction regimens. This discursive base would depict recovery as a process of physical healing and emotional stabilization in the wake of a confrontation with mortality. However the women described the enormous personal and social consequences of naming the problem as “heart disease”, followed by the multiple displacements involved in hospitalization for surgery. These distressing experiences were followed by struggles to relocate themselves as embodied persons within the locations of important activities that constituted gender, home and family, locations where the women themselves were important actors. Relocation within the home occurred contemporaneously with the women’s attempts to locate themselves within the unfamiliar, even elusive, discourse of self care. In the next chapter, I describe the issues identified by respondents in the fourth month following surgery.
CHAPTER EIGHT

SITUATING WOMEN WITH HEART DISEASE:
BETWEEN THE HOME AND THE ENDANGERED HEART

The home posed a central problematic in the second set of interviews with study participants. As the nexus of activities which construct gender identity, personal health and familial wellbeing, the home is a social node where multiple, often contradictory, discourses converge. Making oneself "at home" suggests that emotional and bodily comfort are readily achieved in a particular setting, which possesses certain material and ambient properties conducive to these ends. But homes, like bodies, are not essentially natural entities, although there are immutable and concrete constituents of both (Rose, 1990). Homes are created and maintained through activities which extend beyond the material boundaries of dwellings and include relational as well as physical dimensions (Bowlby, Gregory & McKie, 1997; Dyck, 1990; Gurney, 1997; Moss, 1997).

Homemaking, particularly when cohabitation of two or more individuals is involved, is constitutive of a world in common in which more than one self is invested and more than one biography is embedded. This world is constructed by gendered activity and it is constitutive of gender.

Homemaking is embodied work, and illness or other changes in the body can alter the capacity to accomplish this work. In an earlier chapter, I reported that the bodily crisis of loss of mobility was first indication of ill health the women described in their narratives was. There were pronounced discomfarts associated with activity: shortness of breath, fatigue, pain. Identification of, or naming the health problem responsible for these
symptoms bore profound implications within the discursively driven relations of health care. Symptoms were caused by occlusions in particular coronary arteries. The location and extent of the occlusions placed the women in particular categories of risk, and opened or closed various remedial actions. Surgical creation of bypasses was the most dangerous option available to the women, but it was justified by the debilitating effects of progressive heart disease and by the danger of mortality. The presence of coronary artery occlusions also indicated that the moral duty to observe certain principles of personal health management had been violated by the women. Each admitted to or rejected the possibility that smoking, poor dietary habits, stressful home or working lives and lack of exercise had contributed to her disease. The women were indoctrinated into a discourse of self care that promoted extensive revision of personal health habits to prevent further occlusions once surgical bypass was complete. However, learning and change associated with this discourse was intensely problematic.

The study participants were engaged in attempts to situate themselves at the intersection of the divergent idioms of self care and homemaking. Attention to the tenets of self care imposed an obligation to learn and change, which often conflicted with the imperative of selfless caring embedded within normative conceptions governing the feminine demeanor of the homemaker. These obligations also threatened to change the manner in which home was constructed and maintained as a world in common with close others. Finally, the codified and occasionally conflicting information about diet, exercise and lifestyle management offered by health professionals was not easily translated into the local, embodied knowledge required to engage in the practices of homemaking. On the
disparate worlds of the local and extralocal as sites of knowledge creation and knowing.

Traweek remarked,

"...for many of us it is our job to separate objectivity and subjectivity, our public and our private, the social and the personal, universals and particulars, the third person masculine generic and the first person singular. To be on one side of the line is to be in the right place to make knowledge and facts and methods and theories; to be on the other side is to be at home. We rarely ask ourselves what would happen if we were to theorize at home and with a different grammar.”

(1999, p.190)

Learning itself begins with the “concrete localization” of the everyday world as its point of departure (Freire, 1999, p. 85). The process of learning requires that the learner become an active subject, not an empty vessel in which information is deposited. Learning the requisites of self care requires active and dialectical practice and experimentation within the home as a complex site of the everyday. This location was the context wherein study participants engaged with, solicited, modified, elaborated on, ignored and acted upon the information that constituted the foundations of heart health.

Case Studies

The narratives provided by Olivia and Cookie demonstrate the different ways that self care may be operationalized within the problematic context of the home. Although they occupied similar occupational and educational backgrounds, Olivia was over twenty years older than Cookie. Both elaborated unique ways of articulating, working within and resisting the discursive underpinnings of homemaking. They described the discourse of homemaking - not specifically as such - but within accounts of their actual practices and the ordering of their activities. Each struggled with different material barriers as they engaged in the process of recovery and re-appropriation of the self. Most importantly,
each accomplished a home-world in common with her spouse that supported or impeded self care initiatives.

Olivia

Olivia and her husband had lived for thirty five years in a quiet, working class subdivision at the city’s suburban perimeter. Their home was a large, carefully maintained bungalow surrounded by flowering shrubs, perennials and fruit trees. Olivia seemed proud to show me around the bright main floor, which was spotless and decorated with plants, family photos and art collected in their visit's to her husband’s native West Indies.

Olivia developed chest pain at age 67, but continued working at her job in a factory until she was 68. Her activities and comfort were gradually limited by angina until surgery was necessary 3 years later. She felt that her heart disease was largely attributable to her diabetes, which controlled with an oral hypoglycemic. She noted that she had always been an active person, and that she had always maintained her weight within recommended limits for her age and height. She had taken oral antihypertensives for several years, but had no other health problems.

It was apparent to me after my second interview with Olivia that this 71 year old woman was the closest to a “negative case” that I had encountered. She apparently felt no pressure or need to immediately resume her previous level of involvement in homemaking, yet she had taken up a full range of leisure and recreational pursuits.

“I started back to some of my activities; like I was in the choir and I go, that's for two hours and a half, and I started to play snooker again. I just play one game and finish. And I've taken up Tai-Chi. INT: Oh? Did you do Tai Chi before?

OLIVIA: I started that this year. I used to do line dancing but I stopped that before my operation because I was getting pains in my chest.”

Furthermore, while many of the older women seemed to regard participation in the care of their grandchildren as an important milestone of recovery, Olivia protected herself by reducing her involvement in this activity. Although our first interview was rescheduled so she could look after a grandson who was home from school after receiving chemotherapy, Olivia had begun to limit the amount of assistance she was willing to offer.

“Well he doesn't come, if he doesn't go for chemotherapy I don't have him. And I won't look after him anymore because he don't behave very well.”

Although Olivia’s husband had obvious joint deformities associated with a chronic arthritic condition, he occupied himself energetically in the garden and kitchen during my conversations with his wife. When I asked her how he had become so proficient at homemaking, she replied that he had been raised that way:

“Well, you see, he was taught that from the time he was small, by his mother -- everything she did, she would call him to watch her. And see, I was brought up the same way, we had to help out. So he knows what he's doing, you know. And it really helps because it gives me a chance to heal better. I mean people tell me. 'Take it easy, you shouldn't do this, take it easy', but you just can't lay down all the time, you have to keep going because the doctors tell you to keep going and
exercise and everything, which I've been trying to do.”

Olivia reflected that her husband was

“...always good anyway, that way, even when he was working. We kind of always worked together even when the children were small he would bathe them and feed them and everything. So we kind of do things together.”

Olivia here pointed out that it is important to have the time and energy to heal and to exercise after surgery, and freedom to pursue these endeavours demanded liberation from homemaking. Her husband’s willingness to take over major responsibility for the home was accompanied by considerable experience. Unlike other the women I encountered, Olivia did not find fault with her husband’s housekeeping, nor did she mention a need to supervise or direct his efforts. Indeed, during our second interview, I casually commented on the beautiful colour of her plush living room carpet. Olivia responded with obvious pleasure that her husband took good care of it, because it was installed only a year ago and he wanted it to remain like new. Implicit within her comment was the notion that her husband had the knowledge and skills required to perform this care, and that it was his project as well as hers to maintain the appearance of a beautiful home.

Yet Olivia revealed some ambivalence related to her limited participation in homemaking. She enjoyed the work, and felt that it was something that any woman would miss doing after surgery. Her comments indicate that men are less likely to experience this difficulty than women, suggesting that homemaking is a woman’s bailiwick, no matter how involved her partner might be.

“That's why I say I think it's easier for a man when he has an operation than it is for a woman. Because-- and there’s lots of things I like to do but I don't do them. Before I would, but I don't do them now. Like he vacuumed all out here day-before-yesterday. We still got the bedrooms to do, and then I will dust and things like that. (Clears throat) But otherwise I don't...do anything. I give myself a year; I should be okay by then by the grace of God.”

As she indicated in the above comments, Olivia determined that she would require a full year of modified responsibilities in the home before she could consider herself fit to resume a full range of duties. She noted that she had been told alternatively to “take it easy” by lay members of her social network and to “keep going and exercise” by her physicians.

“I mean people tell me 'take it easy, you shouldn't do this, take it easy', but you just can't lay down all the time, you have to keep going because the doctors tell you to keep going and exercise and everything, which I've been trying to do.”

She did not regard these pieces of advice as contradictory. Instead, she interpreted the lay advice as referring to everyday activities associated with the home while she understood the medicalized injunction to exercise as a directive to focus on activities such as Tai Chi or social commitments. When I asked if she intended to attend cardiac rehabilitation classes, however, Olivia responded that she preferred Tai Chi and was likely to continue with it instead of enrolling in rehabilitation sessions.

As well as missing some of the tasks that she was accustomed to carrying out, Olivia had two further reservations associated with her modified regimen. The first concerned her husband’s health. His arthritis limited the comfort with which he could
perform some activities. She also missed the sense of partnership derived from working together on larger projects. The couple particularly enjoyed gardening, but Olivia did not involve herself in this work while she recovered. Moreover, her husband was affected by his arthritis while he raked leaves and tidied the garden, and this did not escape her notice.

"Yeah, I miss going outside and helping him in the garden. Because I didn't do that this summer. So hopefully next year summer I'll be okay. Like doing up the leaves and everything. Because we always do that together. And sometimes he's so bent over. But he still goes out and all day yesterday raking up the leaves and cleaning out the shed and putting everything away."

Despite these qualms, Olivia asserted that this break from heavier chores was her due:

"I've worked hard all my life. But I guess there comes a time when you... you have to draw the line a little bit, you know."

Thus, her responsibility for her own health superseded her responsibility to promote her husband's health and comfort. The medicalized discourse of self care informed her decision to avoid some homemaking tasks but her narrative accomplishment was to refer to the discursively feminine conflicts she experienced in making and adhering to this decision. She understood that she was to consider exercise and rest a priority, but found that her absence from certain aspects of homemaking increased her husband's workload and aggravated his arthritis. Olivia portrayed her dilemma as a moral one in which promotion of her own health placed her feminine comportment in question. The tasks of homemaking were also bound up with the construction of gender.

Cookie

Cookie, at 48, was a previously divorced grandmother of three who was living in a common law partnership with a man several years younger than herself. Her soft spoken, almost shy demeanor was accompanied by a lilting Maritime accent. She had no secondary school education and had a lifetime of experience as a factory worker.

Cookie was delaying her return to paid employment as long as possible because she did not feel ready to deal with the lifting and carrying associated with her job. In addition to this, many of the events surrounding her recovery seemed coordinated by her abiding concern with her partner's emotional needs. During our first meeting, Cookie revealed that they planned to move from the one bedroom apartment they had occupied for several years into a rented house. She was not eager to make this move, but her partner was convinced that a house would provide the essence of the home that he craved. She ruefully noted as we concluded our discussion that their disparity in ages meant he was anxious to establish the trappings of home and middle class prosperity at a time when she felt ready to move beyond such pursuits.

Our second meeting took place at the new home, a small two-storey row house on a street of nearly identical older homes located near a major shopping district. When I complimented the way the furniture was arranged, she shrugged the observation off. For her, the move had been exhausting, and she seemed not to take the same pleasure in her home as Olivia did in hers. The relocation to a new home represented a series of things she “couldn't” do:
“I couldn't get it all done. I couldn't, I couldn't get the energy. I couldn't pack. Because pack a box and you have to lie down for a while. But then it was only like a one-bedroom apartment so it wasn't much furniture. But the closets and cupboards - Ahh! INT: Yeah. I guess things accumulate over time. COOKIE: Yes. (Unclear). INT: So who did most of the packing then, since you were still so tired? COOKIE: I did. INT: Yeah? COOKIE: Slowly. INT: Slowly, yes... COOKIE: At night I'd pack; like in the daytime I'm sleeping late in the day and I couldn't get organized. Seemed like I couldn't get motivated. Then later on when he was sleeping I would move the... it wasn't heavy stuff, just a lot of dishes. INT: So you were packing the boxes, were you lifting them too? COOKIE: The light ones I was, yeah. There was nothing in them really.

She was also very worried about potential damage to the surgical reconstruction of her coronary circulation. Her fear was that heavy lifting might rupture the grafts.

"I was too scared to pick anything heavy up. Like I wouldn't take the risk. Still scared now, you know, of many things. INT: When you say you're scared, what are you worried about happening? COOKIE: My chest, see, the chest bones are still...feel to me... But they said in the hospital it's normal. It's like healing together, I guess. But it's tender. Then if you think of all the things that might go wrong with the things they did to your heart, that you don't understand a lot of it. You think: Oh God, stuff might have went wrong or it might come loose, you know, the sewing of the veins."

I was also aware that Cookie had returned to full responsibility for housework within three weeks of returning home after her surgery. In our first interview, she described a pattern of shielding her partner from her own pain and emotional distress throughout her illness and recovery from surgery. I cautiously reflected on this during the second interview. Cookie responded by elaborating on the issues she faced in her relationship with her partner.

"See, he's got an addictive personality. He tried to quit smoking and he only lasted four days. But he had passed the twelve step programme at AA, so that's why it's been (unclear). Because he quit smoking before and the drinking just got worse. So that's what's so bad; he's smoking, but if he ever starts drinking again I know I couldn't handle that. He's a very unhappy drunk, very unhappy. He wouldn't drink to get happy, he drinks to get drunk every day. Come home from drinking all afternoon, or he'd say he'll be home by twelve and then not show up. he could drive me up the bend with all this. So this has gone on, I couldn't stand it [if he started drinking again]."

Her efforts to pacify her partner were intended to support his efforts to remain sober. She was mindful of his tense, explosive nature and apprehensively monitored his bouts of insomnia, believing that his previous use of alcohol was a way of coping with emotional turmoil.

"He's up before six o'clock; I know he's there, I can hear him moving around downstairs. He's very anxious and there's no like 'Oh, I'll do it tomorrow' -- he's got do it now."

Caught between her fear of triggering a relapse in her partner's alcoholism and her fear of...
injuring herself by lifting heavy objects Cookie resumed household chores and packed their belongings to spare him the frustration of grappling with tasks he did not know how to do or found unpleasant. She relocated their home so that he could live in a dwelling that he defined as more home-like. Her worries about her own physical vulnerability were overshadowed by the need to protect herself from the disruptive influence of her partner’s temper and alcoholism. This was the context of her recovery.

Cookie related these circumstances with a calm taken-for-grantedness. Her vigilance over her partner structured her activities, and in some respects her impression of her bodily self was informed by his responses. She described his reaction to her incision:

“I knew by looking at his face he didn’t like it, he didn’t like the scar. INT: Did he say anything about it? COOKIE: Not really. Not really. I said to him, ‘You don’t like touching that thing’; he said ‘Well not really’ he said, ‘I don’t’. Because it’s bumpy, it isn’t smooth skin.”

Later, she reiterated this negative assessment of her changed physical appearance from the perspective of the gaze of others:

“The doctor said, ‘Oh, you make sure that the incision’s covered in the sun. don’t go in the sun.’ Well, now, I won’t go in the sun anyway. INT: How come?
COOKIE: Well it’s - it’s ugly. It’s a terrible looking thing to see.”

Her efforts to develop a new approach to diet and exercise were also limited by her overriding mandate to soothe her partner. She noted that her efforts to change their diet were rebuffed. He was unwilling to tolerate substitutions such as margarine, and preferred to adhere to certain favourites, particularly potatoes smothered with butter. She tried without success to introduce rice instead of potatoes. Cookie seemed to focus this aspect of our conversation on her partner’s difficulties with the low cholesterol diet, rather than her own. She concluded that she was not making the food palatable enough for him to enjoy and stated, “I should go to cooking classes really.”

Her cardiologist had recently referred Cookie to a cardiac rehabilitation programme. She enjoyed the opportunity to exercise under reassuring supervision and found the programme motivated her to exercise.

“I like going down there. It’s not often enough; it’s only twice a week. Wednesday night, you don’t go again till Monday again. Because I don’t walk much at home, I’m not a walker...And they monitor you every few minutes -- you come up and they take your pulse. Then you feel fine because, you know, somebody said they know how you’re doing.”

Cookie hoped to continue with the programme after she returned to work. She planned to work the evening shift at her factory so that she could attend daytime rehabilitation classes. She thought she would be too tired to exercise after work and thought that her chances of remaining in the programme would be better with this arrangement. She had been told that she would likely be fit to return to her job within two months, following another stress test. Cookie looked forward to this with some trepidation because it meant balancing homemaking, her job and her new exercise regimen.

Initially, my conviction that Olivia represented a “negative case” was based on the
observation that she was able to delegate responsibility for homemaking to her husband for an extended period of time. After some time, it became apparent that, even in a small group of women such as this, the concept of a negative case might be somewhat simplistic. It soon became clear that Olivia was not experiencing conflict with her husband over her decision, but she was engaged in a confrontation with her own understanding of the discourses which undergirded her occupation of the subject position “homemaker”. She had a “good” husband, who fully participated with her in the project of creating and maintaining a home, even though he experienced some physical discomfort while doing the work. Olivia’s comments highlight the moral beliefs which accompanied her position of homemaker: an ethic of spousal caring troubled her as she watched her husband labouring with stooped posture to tidy the garden. She was able to resist the pressures accompanying this form of consciousness by citing a competing discourse - that of self care - and by recalling that she had worked hard all her life.

Cookie, on the other hand, assigned self care a secondary status in comparison to the emotional and physical labour of homemaking. Her commitment to operationalizing her partner’s definition of “home” superseded her own need to rest and heal. She monitored his mood and behaviour with apprehension, concerned that he might resume his previous disruptive pattern of alcohol abuse. Despite her anxieties about rupturing her incision and healing heart, she packed their belongings with minimal assistance and coordinated their move. She endeavoured to alter their diet in the prescribed manner, but was discouraged by the responses of her partner, not by her own appraisal of the food.

To describe Olivia’s pangs of guilt and Cookie’s attempts to pacify her partner as
conflicts of personal meaning would confuse the consciousness accompanying the subject position of homemaker with the individuated consciousness known as subjectivity. Included in Smith’s ontology of the social are events and activities that constitute and are constituted by concepts, knowledge, discourses, and ideas – the practices and components of consciousness. She impresses upon us that “society is emphatically, from this viewpoint, not an ensemble of meaning” (Smith, 1999, p. 75). The subject position of the homemaker is accompanied by a set of responsibilities, expectations, and obligations that are interpenetrated by the discourse of femininity. These attributes are not clarified in any textual contract, but they are conveyed incidentally through media portrayals, familial example, expert knowledge about the family and educational institutions. They form the assumptive foundation of home care policy, for example, and are reflected in the work that is assigned to occupations which are recognized as feminine. They are not formed independently as meanings by individual women within the location of the home, but are interpreted and acted upon within the context of home and family. They are a part of the relations of ruling that “coordinate the activities of people in the local sites of their bodily being into the relations operating independently of person, place, and time” (Smith, 1999, p. 75).

Thus Cookie responded to her partner’s disquiet with obligatory self sacrifice. It was his prerogative to disrupt the peace of her home and routine with his tensions and outbursts, and it was her duty to soothe him. In exploring the discursive foundations of spousal abuse, Jack (1999) argues that the social contract between spouses includes women’s obligation to de-escalate or defuse their partners’ aggression. Women become
the targets of frustration and anger when they are unable to neutralize these emotions. and they may be blamed for instigating abusive attacks because they failed in their duty to pacify. Rose (1999) notes that women’s responsibility for the tranquillity of the domestic space, as well as the threat of violence in the public sphere, means that they are not free in either space to comport themselves as they see fit. She describes women as the “repressed Other” (Rose, 1999, p.364), subject to violence inside and outside the home: “inside, it is no-one else’s concern; outside, she deserved it.” (ibid., p. 363). These social relations are invisible or known primarily as the micropolitics of individual partnerships. Thus, Olivia considered herself fortunate to have a “good” husband, while Cookie struggled to account for her partner’s behaviour as a product of an “addictive personality”. The world in common each held with her spouse constructed particular versions of masculinity and femininity, which were informed by and compared to discursive notions of gender.

Olivia’s narrative offered glimpses of the consciousness associated with the subject position of the homemaker: she missed some of the tasks that she was being “relieved of” by her husband, and she expressed concern about the impact of the additional workload on his health. While the discourses that inform this consciousness might ordinarily serve to coordinate activities so that her work and approach to homemaking might resemble those of another woman, it is also apparent that Olivia and other women in her family acted upon this discourse to develop space within this subject position for men. It is also apparent that Olivia resisted some obligations of homemaking by citing and adhering to the contravening directives of the discourse of self care.

In the next section, I examine the ways that the participants situated themselves
with reference to the discursive influences identified in the above cases. Their hearts and homes were the sites of conflicting demands and predicaments. The narratives highlighted the contrasts between embodied consciousness and a medicalized consciousness of the body.

**Situating the Self**

Situating the self between the heart and the home was accomplished with reference to the reconstructed body and the biographically determined purposes served by the embodied self. There were encounters with changes in appearance and capacity to function in customary activities. Gradually, many realized that they could not return to some previous relationship with the body as a medium of intentionality. Their hearts were forever at risk and in danger of recurrent occlusion. Instead, the women developed new understandings of their physical selves which were informed to varying degrees by the language and discourse of medicine. One challenge was to accommodate this revised consciousness of the body within the consciousness associated with the subject position of the homemaker.

**Situating Hearts Within Women’s Active Bodies**

Renegotiating identity was contingent upon recasting everyday/everynight activities within the limitations of the healing physical self. For many of the participants, there was a paradoxical tension between a perceptible renewed vigour and energy, and a concern with the body as a vulnerable, perhaps unreliable, medium of intentionality. As more of the occupations of daily life were attempted, the respondents developed expertise in deciphering the sensual language of fatigue, pain and exertion. The call to mundane
activity remained as the concrete reality that compelled physical response. Strategies were developed to accommodate the inevitability of physical labour. Negotiating the pace and order of tasks was embedded within negotiation of a recovered self.

Like Sonia, many contrasted their previous tendency to ignore fatigue with a more self-nurturing approach which focussed on the regenerative needs of their bodies. Ann, for example, explained that she was learning to "be good to" herself so that her former stamina would return. Some, like Cookie, worried about the durability of surgical repair, envisioning the unravelling of stitches. Others, with careful attunement to their bodily sensations, learned through trial and error to respect and abide by their physical limitations.

"It feels—its not for me. I used to be very active and if I started something to do whether in the kitchen, whatever I can make, I could not rest - maybe that was wrong. I had to finish it then. Now, when I start to feel so tired I can hardly move, then I just have to put it aside and lie down, even for ten, fifteen minutes, twenty minutes. Then I feel again like renewed, like I can continue and I have to start whatever I am doing.” (SONIA2 39-46)

***

"You know, be good to yourself and don’t overdo lifting, stretching and things like that and it will come back.” (ANN2 782-785)

***

"My—like when I first came home from the hospital, my incision. you could feel the tightness in here, and it sort of tends to make you bend over when you get up out of a chair or when you’re walking. That was when I first came home. And from last weekend, for this week [after return to full time hours at paid employment], it’s been doing that again all week, so I know I’m tired. It’s really funny how your body tells you.” (LAVERNE2 104-110)

***

"But if I start something by little bit and everyday by little bit. you know. Because
I have something to do and I do myself (laughs). Little by little, I learn now different. And I'm doing alright. INT: So now, what would keep you from doing a job like that? AGATA: If I do this it would like maybe heavy lifting, I find out, you know. I would feel it around my heart, a little bit like pain, not—yeah, a little pain, I would say, if I make myself real tired.” (AGATA 2 45-57)

This solicitous approach to healing hearts and bodies seemed, by the fourth month after surgery, to be a question of balancing activity and rest, exertion and regeneration, so that valued and essential activities could be resumed. Underlying this approach was an awareness of continuing risk to the heart which could be posed by strenuous activity or improper positioning.

The perceived presence of risk required an attitude of vigilance. Respondents described their cultivation of an attunement to the sensory messages that signalled fatigue, improvement in stamina or deterioration in health. The implications of these cues were pondered and most responded actively. Some women spoke of a transformation in their approach to their own physical needs. They favourably compared their new patterns of self care with a previous tendency to ignore sensory warnings. These new patterns were situated within previous routines. Homemaking tasks or the satisfaction of others' needs were accomplished with attention to pacing, conserving and replenishing energy.

"I used to cut the grass same day, back in the house, then after the cleaning and laundry, cooking, same day! But now, only cooking. And then the dishes, you know, this is it, that's all." (SAMARA 2 627-630)

***

"But if I overdo, I feel it, see? So I have to say: That's okay to do now. That's something I do later." (AGATA 2 107-109)

This transformative body management was accompanied by a watchful interest in signs of healing. Attunement to sensory cues was an elaboration of the discourse of self care
observed in the earlier interviews.

Self care was articulated with greater sophistication in the second set of interviews and descriptions indicated continuing evolution of a language of self management. Cooperative surveillance and health monitoring involved an increasing awareness of “how to mean” (Smith, 1990b, p.105) and how to act in concert with health care providers. Consciousness of the physical self seemed in some cases to be defined in medicalized terms and in relation to medical practices. Often the physical self was expressed in quantitative terms, such as heart rate, cholesterol levels, capacity to tolerate increased treadmill speed and changes in body weight. These terms indicated by proxy the level of risk to healing hearts.

“I had to do another stress test and I didn’t do too good in that stress test. to be quite honest. And I do worry about...like I went to see my cardiologist again about three weeks ago, and he gave me another appointment for a year’s time. I think that’s too long. Shouldn’t he be watching in the meantime what’s going on, because I do have the occasional chest pain still.” (OLGA2 512-518)

***

“When I usually go on a stress test machine, I would get pain after a while. But this time I just got out of breath, because when you start going they put it up faster, you know.” (OLIVIA2 340-343)

***

“I’m so pleased with myself, because I have been able to bring myself to seven point three! INT: You mean your cholesterol is coming down? RUTH: Yes, my cholesterol in March was 7.3!” (RUTH2 641-647)

***

“Sometimes I have a little bit extra bread and I gain a little bit few pounds, and they’re always after me not to be heavy...And now I’m about 138 pounds which is a little bit, I gained a few pounds” (SONIA2 255-259)
Because I have an irregular heart beat and I have had it since the operation. And in fact I have very low blood pressure and an irregular heart beat and I just shock the nurses when they put the thing on me. ‘Oh, my heavens, are you alive?’ [laughs] When I had my operation, it was down to 54, and they were really getting kind of concerned about it, but that’s just the way I am.” (EMMA2 364-371)

These excerpts indicate that the physical self was increasingly interpreted from the perspective of its impact on health professionals, particularly those who decoded the meanings of numeric diagnostic indicators. Furthermore, some women appeared to pursue responses to sensory cues in ways that anticipated the responses and decisions of health professionals. Eva, in the following example, interpreted certain sensations as signals that immediate medical attention was warranted and proceeded to an emergency room. The symptoms were transient, however, and the aberrant EKG tracings resolved to a more normal pattern. She still believed that the signs were important and proceeded to consult her internist, who was more familiar with her physical condition and her health regimen.

“I really don’t know what happened. It’s just like palpation and a weakness and pain in the chest, you know. And I thought, ‘Oh, no, not again!’ so I thought I’d better go up there [hospital emergency room] because the doctor wasn’t in yet, so I did. And they checked me on the monitor, darn thing started to straighten out and that was all there was to it, and I came home again. I haven’t had any more of it. So I went to see [internist] and he changed the medicine. Got something to do with the hydralazine.” (EVA2 56-64)

Narrative references to influences that might prove toxic, injurious or dangerous were frequent in the second interviews. In Brownie’s case, the surgically reconstructed heart was portrayed as requiring protection and preservation, primarily through prescribed regimens of diet, medication and exercise. Samara specifically avoided stimulants like tea
and coffee after noting that they contributed to unpleasant sensations such as heart palpitations and chest tightness. Agata came to regard her previous eating habits as abuse of her body and health, and she embarked upon a radical exclusion of meat and dairy products to avoid damage to her newly repaired heart. Others, like Cookie, were concerned that certain activities might cause damage to the healing tissues, and her reconstructed heart was represented as untrustworthy. Cookie was particularly worried about not knowing what had actually been done to her heart and not being able to accurately interpret sensations.

"It’s sort of nice to be able to walk up to the top of the street without having to stop. I hope it keeps up. I wonder about that, how long it will--although I guess if I stay on a fairly good diet and do my walking and so on, the cholesterol medication, maybe they won’t get blocked up again. If they do, I’ll know what to look for, you know. I didn’t know what was happening to me!" (BROWNIE2 704-711)

***

"Okay, I’m too tight, I’m saying to myself, or pushing myself, you know. And I quit drinking coffee and tea, having not too much, you know. Even sometimes not to have anything at all. And I drink juice or water. And I drink tea once or twice a week, that’s it. Coffee, every second night [laughs]." (SAMARA2 609-614)

***

"And this is a very good book [referring to a book on strict dietary regimen to prevent and control heart disease]. And sometimes, you know, when you read you could see yourself, you know, all those years, if you abuse yourself, your body, you know, and too much eating, too much of the meat and everything. So he prescribes not to eat more meat. Even cheese he says." (AGATA2 166-170)

***

"I was too scared to pick anything heavy up. Like I wouldn’t take the risk. Still scared now, you know, of many things. INT: When you say you’re scared, what are you worried about happening? COOKIE: My chest, see, the chest bones are still...feel to me...But they said in the hospital it’s normal. It’s like healing.
together, I guess. But it's tender. Then if you think of all the things that might go
wrong with the things they did to your heart, that you don't understand a lot of it.
You think: Oh God, stuff might have went wrong or it might come loose, you
know, the sewing of the veins." (COOKIE2 42-59)

The ultimate test of confidence in the reconstructed physical self was travel to a
distant location. Placing oneself in an unfamiliar environment away from the security of
proximity to trusted medical advisors or hospitals was an act laden with risk. Some
participants openly reviewed their fears:

"You know, being home and having a problem is one thing, but that far away and
you know, often if you have a problem like that, they don't want you to fly."
(BROWNIE2 209-211)

***

"I was glad to get home though. I'm still a little bit nervous about being that far
away. We have no phone and ahm...INT: Oh, there's no phone at your cottage?
GERT: No, so I was a little nervous about that." (GERT2 10-15)

***

"So everybody settled down after the first few weeks [at the cottage], like she's
not going to die on the spot because she had surgery [laughs]" (LAVERNE2 516-
518)

With the changes in location associated with travel came discomorts and inconveniences
that aggravated the healing body. Travel brought unaccustomed levels of activity and
exertion associated with outdoor recreation.

"Also I notice that there is one beach where you have to go over a dune down to
the beach; going over it on the way down was no problem. Coming up after, God,
I was in trouble there. And that's where it shows me I still have to take it easy and
don't overdo it...it's not a hill, it's a dune and there's soft sand and you have to
always have a--carry something. I had a big pack with my stuff in it, and I came
up, huh, I was glad when I was up there." (OLGA2 548-558)

***
"So couple of nights it was okay, we were fine; I was okay, nothing wrong with staying in the tent and so on. It didn’t hurt me. But the...especially at night time, you know, and when you’re camping the weather changes quickly. In the daytime is hot, night time is chilly. So gives me a little bit on the bones, like sort of pain. Just like after shower, this pain comes, so I decided not to sleep outside anymore. Might be the nighttime coldness or wetness." (SAMARA2 159-168)

Such reminders of surgical reconstruction inhibited attempts to resume an assumptive or habitual embodiment. Vigour and comfort could not be taken for granted, particularly in locations where terrain and climatic conditions were unpredictable.

Major setbacks requiring hospitalization or further diagnostic testing were experienced by at least three of the participants in the second, third or fourth months following surgery. Complications such as these demonstrated how the perception of risk was justified and reinforced by unstable physical health. Emma sustained a stroke while on a weekend road trip with cousins. Her loss of control over sensory and motor function, however transient, was profoundly disturbing.

“So we go into the store and there are soaps and all, like umpteen dried flowers and smells in the store. And we’re walking around and looking at stuff. I turned to my cousin and I said, ‘I’ve got to get out of here, I can’t stand this smell.’ And she said, ‘What smell?’ I don’t know what it is, but there was something in there. And I started drooling and slurring my words. And my cousin being - this is the one that had the heart condition - she says, ‘Come on, we’d better get out of here.’ So - I mean I could stand incense, but this is totally different...I’m looking at her and I’m trying to talk to her and I’m saying, ‘No I’m okay, I’m okay. It’s just that smell that was in there.’ Well apparently I almost passed out. Gees, I could just see me passing out in the store because it was crystal and the whole works in there, you know.” (EMMA2 150-168)

Brownie had an episode of chest pain while visiting a cousin in Vancouver but remained well enough to return home.

“I got over there before she did and when I got in there I had this awful chest pain. I thought: Oh, good grief! And this was about, oh, about three or four days before I was slated to come home. And I thought: Oh, don’t tell me something’s going to
happen here, you know, and I said: Here I am all these miles away from home.”

(ANN2 55-60)

Ann, too, suffered further complications and was hospitalized for eight days of bed rest with thrombophlebitis in one leg. The affected limb ceased to be a recognizable part of her body, nor did it function in the usual manner. Ann and her husband reacted with fear in the context of contemporaneous media coverage of catastrophic infections:

“But oh! It was awful, it was just purple. My husband was afraid it was the flesh-eating disease and I’d lose my leg and everything. There was so much publicity, that certainly would come to mind.”

(ANN2 878-889)

These reversals brought a sense of betrayal and reinforced mistrust of their reconstructed body. Recovery could not be assured. Even the most solicitous approach to care of the physical self did not guarantee health. Ann had been “good” in response to the moral imperative of self care, but still sustained a blood clot.

“I’m stronger now, I’m not tired. But that came, I think, with the conditioning of walking and other building up. I wasn’t sitting doing nothing. That’s another reason, Jan, that I felt this blood clot and thing - how could that have happened? Because, you know, [laughs] we walked, we - I haven’t been crossing my legs and I’m trying to keep up the good work, so to speak. And that, I think, was the setback really.”

(ANN2 878-889)

The appearance of the women’s bodies was permanently altered by surgery and this changed the way they situated themselves according to discursive standards of feminine appearance. Scars and swellings remained as reminders of the surgical reconstruction and notions about personal attractiveness were confronted. Several participants made concessions in selection of clothes and accessories to conceal marks. Options narrowed depending on where scars were located.

“The doctor said, ‘Oh, you make sure that the incision’s covered in the sun. don’t go in the sun.’ Well, now. I won’t go in the sun anyway. INT: How come?"
COOKIE: Well it’s - it’s ugly. It’s a terrible looking thing to see.” (COOKIE2 427-430)

***

“Actually, though, why do I hide it? It’s there, it’s a part of me and I might as well get used to it. There’s times, though, that I wish I didn’t, you know. There’s some of the clothes I have that are just lovely, but a scar just doesn’t go with it [laughs].” (LUIGI2 756-762)

***

“And there is the one spot there but it wouldn’t close up; it had closed up but it broke back open again. INT: And it’s healed now, though? TIP: Yes, see, right down. It goes right on up on both legs, see here? But everything - first my legs go, they’re - not that they’re altogether the best to look at [chuckles]. But they don’t hurt, they don’t bother me.” (TIP2 163-176)

***

“It really hurts, you know. Up here [scar tissue on upper leg] is fine, that part. Just here is like, wow, it really hurts. And down here is fine, too; just that little piece, why is that like that? INT: Some people get this. It’s called keloid tissue. OLGA: Yes, that’s what he said, keloid - and it is growing. Looks like it’s getting bigger. And that’s another reminder every day because it is so sore.” (OLGA2 329-343)

***

“You can always wear the - most of my clothes are not very low down anyway, and if they are, I can always put a scarf or something on. But it’s just one of those things, so... I thought I couldn’t wear shorts too long this summer because it would press on my incision up here. Because they cut me up here too.” (OLIVIA2 318-323)

These reminders of the surgical experience and reconstruction of the body meant that locating one’s appearance according to discursive standards of femininity was more difficult. Achievement of a flawless skin surface was a more distant possibility than before; scars were not consistent with femininity. The artistry of fashion is concerned not only with covering the body; the manner in which certain surfaces are revealed or left
uncovered is also an integral part of fashion's sensibility. For this reason, Luigi found that she could no longer wear outfits that were former favourites. As Cookie suggests, the shame of bearing scars is located in the intersubjective interpretation of the other's gaze.

According to Foucault,

"From the idea that the self is not given to us, I think that there is only one practical consequence, we have to create ourselves as a work of art." (Foucault, 1983, p. 237)

The above analysis indicates that women's bodies are not simply their own "works of art" but were interpreted and situated according to the media offered by at least two discursive influences: the medicalized discourse of self care and the discourse of femininity. This was a process of dynamic negotiation at the intersection of several layers of bodily experience. The next section will enlarge on these issues.

Situating Self

Although heart rate, cholesterol levels and other medical markers of cardiovascular wellbeing were anxiously monitored, the achievement of embodied feats of homemaking were indicators which originated from another idiom. The women described their capacity to act according to discursive standards of homemaking and their own biographical patterns. Pride was evident in statements describing success in babysitting grandchildren, holding dinner parties, maintaining social contacts and resuming full responsibility for homemaking. Women with paid employment described their return to the workplace with satisfaction. Although these activities were contingent upon cardiovascular health, they were indicators of ability to function in the social realm as mothers, spouses, grandmothers, employees and friends. They were able to situate themselves as gendered
social participants by referring to resumption of these activities.

These accomplishments established that the women were able to resume participation in and construction of a world in common with others with whom biographical patterns had been established. Some, like Vi and Ann, spoke of the ways that homemaking activities extend into the community of friends (even distant ones) and neighbourhood children. Like Luigi, most described the need to situate themselves in families, communities and workplaces.

"But I always manage to do something for myself. And even to do some cooking. I have my family over, the children and my grandchildren. INT: Oh, you've had them over for dinner? SONIA: Especially Friday nights! INT: That's special to have family over for dinner on Friday, isn't it? SONIA: Oh, yeah. The kids too, they enjoyed, they were so happy, oh, that grandma cooked! Slowly, slowly I'm beginning to do things. I made some cookies this week. My grandson, the little one, I gave him to take to camp, oh, he was so happy. Cookies I made with some chocolate chips."

***

"I invite the family, three families, fifteen people. I cooked up. I served them, you know. Not only one dish with the salad - everything - main course and dessert and everything. I did this three months after. INT: So were you tired after? SAMARA: Yes, I was. I cleaned, I put the dishes away (laughs), you know, everything. They vacuumed the house and I tidied, you know, everything is finished and I said to myself: Now I'm tired. My feet were hurting. You know. Up and down with - first I have to do shopping and I prepare what to do for supper. Thirteen people and we are four of us, we were seventeen." (SAMARA2 643-659)

***

"And we have family and friends, you know, long-time friends up there [at vacation destination] so life is busy and that's what I thrive on, being busy and involved in other people's lives. I like that. And that has always, I think, been positive. So I'm really looking forward to that." (ANN2 225-231)

***

"And the secretaries are really a very vital cog in the operation and so that's given
me a lot of self-esteem that they wanted me involved in it because it's a close-knit little organization. So anyway, I'm working for two guys who are great, and I told them - I went for only three months. I went from temp to perm, yesterday was my first day as the actual perm. I've been working as a temp because I didn't want to make a mistake. And I didn't want them to make a mistake. And anyway, it turned out that they offered me more money than they originally had said, they were really pleased. And I'm really pleased. And we're very, very busy and I'm enjoying it very much. INT: That sounds like it has worked out well for you. LUIGI: Yeah, it's good for me. I get up every morning and it's good to have a place to go and belong to something." (LUIGI 123-141)

Vi poignantly explained how past and present were linked for her in the acts associated with protecting and grandmothering children who attended a school near her home. Her words resounded with references to discursively feminine activities of protecting and nurturing children. She found connection with her biographical self in her ability to resume vigil over the neighbourhood children as they travelled past her house on their way to and from school. No longer was she easily able to walk the distance with the children as she once had done, but she could don her coat and keep watch from her front porch. She took pleasure in her continuing recognition by these children as a grandmother.

"And it got to the stage where [grandson], he's the youngest one in the family, and he's nine, and he comes in and he said to me, 'Grandma, there's a little boy outside and he's a friend of mine and the kids up the street are picking on him. Can he come in for a while till they go home?' I said yes. bring him in. So they come in and put the TV on and they sat there till the other kids went away. ... But the kids are all going up the street to school; I watch them go up. I usually put my coat on no matter how cold it's been. I go out and stand on the verandah and watch the little ones going up the street because so many things seem to be happening to them. And they all know me now. And I would walk my own brood and later my grandchildren, all of them. I would walk them up the street to the school. then I would stand at the gate of the school yard and watch them go in. And I was in the [department] store a week or so ago, when I was down in [nearby shopping mall] and I heard a little voice hollering. 'Hello, Grandma! Hello, Grandma!' And I turned around and it was one of the kids from the school." (VI2 681-709)

As many of these anecdotes imply, situating the self with reference to discursively valued
and biographically particularized facets of feminine comportment was an indicator as crucial as having a normal blood pressure or satisfactory results from a stress test. The women sought social recognition of their capacity to achieve discursively communicated functions of the homemaker, parent, spouse and employee. These feats were often carefully paced according to the limitations of comfort and stamina. Sonia began "slowly, slowly" to cook for her family; preparing a meal for them on a Friday evening was a special social and religious marker of recovery. Luigi worked on a temporary basis until she had demonstrated for herself and her employers that she was an excellent candidate for a permanent position. These participants engaged in negotiation between the requirements of the heart (indicated by sensations like pain and fatigue) and the social world.

However, these negotiations were sometimes difficult and were by no means solitary accomplishments. Emma, whose physical health was still in question, battled to maintain her independence and self-direction against increasing opposition from her daughters. Although her preference had been to pursue an active life (evidenced by the statement "I've always been a goer"), she encountered conflict with the discourse of self care, which placed emphasis on preserving and nurturing physical health. Others took issue with her habit of maintaining an vigorous approach to life. Her stroke was interpreted by her physician as a sign that she was overtaxing her physical reserves. Emma placed narrative emphasis on the confrontation between the biographical significance she attached to activity and the preoccupation with activity restriction she encountered in contacts with health professionals and her family. For her, this emphasis on limiting exertion bespoke concern that another, possibly fatal, heart attack or stroke would follow.
"I said to him [cardiologist]: ‘What do you think caused it?’ And he said: ‘Well, you’ve been doing an awful lot’.” (EMMA2 221-224)

***

“I just said, ‘Do I have to stay in bed?’ Like that’s a no-no to me and they said, ‘Well, as long as you feel okay you can get up, but don’t go too far at first. Well the next thing I know I’m going around and around and around there. My God! And no matter where I am, it’s like, ‘We have to keep this woman down, she’s going too fast. And you might have another heart attack, which is game over, you’re finished.’ It’s like, ‘We’ve almost got to handcuff her to the bed because she wants to get up and get going.’ And I don’t know if it’s nerves that causes it or if it’s just me. You know, because I’ve always been a goer. My whole family is like that.” (EMMA2 937-950)

***

Well, I went to play ball with my grandson and my daughter’s hollering, ‘Mum, you know you can’t do that.’ And it’s accepting it that you can’t do these things. And it’s just like the [community] picnic. [daughter] apologized, ‘Mum, we’d really like you to go; but I know you can’t walk all that way.’ Like, round all that distance. And I don’t like that. It’s more concern like they’re afraid that - Oh, my God!” (EMMA2 901-907)

***

“And every time I went for a walk and I was a little bit longer than I should have been, my daughter almost was calling the police to find me. And like I’ve lived too long by myself for that.” (EMMA2 787-791)

Emma’s experiences suggest that surveillance and blame do not subside easily or completely. Although the basic tenets of the discourse of self care highlight personal agency in controlling risks to health, those who do not exercise agency in the manner approved by health professionals are admonished. Emma valued independence and vitality -- both were threatened by the discourse of self care. Underlying these anecdotes is the coordination of professional and family activities around the possibility of serious exacerbation of illness. Emma’s above exclamation, “...they’re afraid that - Oh, my God!”
indicates her awareness of their (unspeakable) fear of her possible death. Even as she seeks to avoid admitting this possibility by remaining active, others go to extreme lengths to impress on her the need to moderate demands on her fragile body.

Emma’s experiences suggest that the social relations of illness may be as difficult to exit in some cases as they are to enter in others. As we saw in an earlier chapter, the activities of obtaining a diagnosis and securing treatment required time and persistence for some of the study participants. Diagnosis involved recognizing an unmistakable pattern that was consistent with coronary artery disease. This act of recognition marked the assignment of women to a specific social category and their subsequent entry into a network of social relations which interrupted biographical continuity. For a time, others claimed the authority to prescribe and monitor activities and behaviours regardless of the particularities of habit and preference. Emma’s anecdotes imply that to exit from the social relations of illness, clear evidence of satisfactory self management is required. She apparently did not demonstrate conscientious self management of her activity levels to her family and the health professionals involved in her care. Her stroke some months after surgery was an ominous cue to others that all was not as it should be.

Ann noticed and commented on similar issues. She remarked that finally, after months of surveillance, she was moving into an attitude of reticence about sharing information regarding her health with others. She explains that, in the contemporary idiom of feminine comportment, the sharing of private thoughts among other women is helpful, but she is less inclined to confide in contacts outside of her most intimate circle.

"[Heart surgery] is very public and you become very personal with people you're not usually personal with. So that's how I consider it. I'm a people person and I
like being with people and having people around, but there’s a part of me - in everyone - that’s private. And I’ve never been one to...we have a group at the church, it’s sort of a support group for things that they - it’s mostly younger women and I think this is wonderful for them. If they have problems they discuss them and whether it be religious or emotional or physical or something in the family happened, they share, they share with each other and they all become involved. And I think that’s great because in this day and age with a lot of young couples living very distant from their own parents, being on their own with families to think of, they need that support. But that was for me very uncomfortable, because I’m not conditioned that way. And to a point I’d like to, as I say, get private again.” (ANN2 981-1008)

Similarly, Luigi remarked with pride that she felt physically strong and able to meet the challenges of her new job, but explained the difficulties in regaining a sense of control over her life and the way others perceived and responded to her. She debated telling her employers that she had undergone a bypass because this might compel them to behave according to a more conventional idiom of gendered comportment whereby “gentlemen” are required to protect women.

“...these two are real gentlemen and I wondered if, you know, the male in them would try and, ‘Oh, geez, we’d better be careful, we don’t want to overwork her’.” (LUIGI2 207-209)

Later, Luigi commented on her desire to achieve a position of feminine strength and mastery over her situation by indicating a portrait of a woman that hung in her dining room. Her interpretation of the painting indicates that a woman’s appearance situates her. Fashionable hats represent cultural competence, the rings (or the lack thereof indicate) marital status.

“I love that woman. I think I’d like to be that woman. [INT: It’s a wonderful painting. Why do you like her so much? LUIGI: I don’t know, she just looks cool, in charge of herself, you know, with that sassy hat, no rings on her fingers. I think she looks like a happening lady. [laughs]]” (LUIGI2 934-944)

Olga, too, reconsidered her life and the discursive forces which had shaped it
"This is funny you know, I’ve never been a loving housewife. And yet this is my...my destiny. That’s what I am - [amused voice] a housewife. And I wonder sometimes how did that happen to me. you know. I guess I was one of the last generation where people still said, ‘Oh, yeah, she’s a girl, she’s gonna get married and, you know, and bingo!’ You’re stuck in a house for the rest of your life.” (OLGA2 797-803)

“Common knowledge” about women was assumed in these anecdotes about the biographical or interpersonal peculiarities of womanhood. These statements indicate participants’ attempts to situate themselves in relation to other women.

Situating the self as competent and capable within particular social contexts took on various complex dimensions. Vi, who was one of the oldest and most physically debilitated of the respondents, eventually resisted the overprotection of her doting family by appealing to the emphasis on exercise and restorative rest inherent within the self care discourse:

“Well, I’ll tell you. [At family summer home] nobody would let me do much [chuckles]. They kind of provoke me, you know, anything that has to be done, they’d say, ‘Now you sit down and relax, I’ll do it.’ So I put up with it just for a while and then I said, ‘This is it. I’m going to start doing it.’ So I said, ‘I’m going to start to clear the table up’ So anyway they got used to me doing that. The girls would take and do the cooking, [husband], he would do the cleaning up and the rest of it. So gradually I’d work my way into it, and I said, ‘I’m going to do some too, I’m not going to sit here and do nothing, because I’ve got to keep moving around and get some exercise.’ I said, ‘If I don’t move around, I’ll not sleep tonight.’” (VI2 263-273)

Laverne also grew impatient with the protective vigil over her wellbeing. Like Vi, she eventually resisted the helpful overtures which placed her in the position of an invalid.

‘Like I said, when we were up at the cottage the first little bit, you know, and everybody is always saying, if you’re going to pick up something, ‘I’ll do that for you’ and - like I said - it just gets a little too much. Where, ‘Don’t tell me I can’t do something anymore.’ Now I’m getting better, I want to do for myself, and you know, I won’t do it if it’s going to hurt me. Now, some women, some people they’re really dumb, because they’ll just go ahead and do whatever they did before.
If that’s what they want to do is hurt themselves, then that’s stupid.”
(LAVERNE2 542-553)

Indeed, she suggested that the overzealous assistance of others implied that she had neither the judgement nor intelligence to determine which activities were risky and which were safe. The narrative accomplishment embedded within both Vi and Laverne’s statements was the assertion of personal competency to undertake self care. Both women depicted others as well meaning and protective, but unaware of the true competency of the narrator to self manage. In Vi’s case, resistance took the form of a gradual subversion of the agenda of protectiveness. Laverne resisted more directly, arguing that she was more knowledgeable than ‘some women’ and could be counted on to avoid harming herself. Each sought to situate herself between the divergent idioms of heart and home.

Hence, an intricate balance was sought among the competing concerns identified by participants. The heart and body were understood as healing but potentially vulnerable. They were situated as the medicalized objects of self care within a moral and substantive discourse of heart health. However, situating the self within a social and biographical world was informed by a discourse of gendered comportment and appearance. The women drew on the consciousness associated with the subject position of homemaker as they monitored others’ responses. In the next section I focus on aspects of relationships with health professionals which influenced development of a position between the two discourses.

**Learning The Situation: Consulting With Health Professionals**

Health professionals were important resources as the women sought to clarify their health status and learn the foundations of self care. The idiom and tenets of heart health
were conveyed in consultations with family doctors, cardiologists, and health educators in cardiac rehabilitation programmes. Many of the women learned to communicate with these professionals on a more sophisticated level, while others grappled with barriers which limited their access to information from these consultants.

Medical consultation about resumption of important activities such as paid employment or travel provided legitimation of respondents’ efforts to situate themselves as fully recovered or debilitated. Ruth, for example, required long term disability benefits. Frequent documentation of her progress had to be obtained from her physician to provide her insurance company with evidence of her slow recovery.

“Well, to me, it’s very important, because I need to see somebody to keep updates. because I’m on long term disability now. They want an update on a regular basis. You see, my short-term is finished now, and they don’t just want [documentation from] your GP. They want a lot more for long-term disability. I had to see my family doctor here, I had to see my cardiologist, they want to know each and every doctor you’re seeing from when you had the operation. Because, you see when you’re going on LTD, you’re supposed to be totally disabled. They’re going to pay you from the insurance company then, not your own company, and insurance companies are not going to take this lightly.” (RUTH2 1274-1285)

In order to obtain this documentation, Ruth made the rounds of her various physicians, often struggling to identify the various purposes and foci of each.

“And here I was with stuff I didn’t know where to go to get filled out. Because I’m calling the surgeon doctor, I’m phoning [cardiologist’s] office, I’m phoning my own doctor, and of course, he wouldn’t have refused me okay, but when I did go to him, he said to me, ‘Ruth, you should have gone to the cardiologist’.” (RUTH2 1291-1297)

Maintaining eligibility for disability payments was in this case a demanding occupation, coordinated by the quest for textually inscribed evidence of need.

Booking and coordinating visits to physicians or for diagnostic testing was the
object of some concern and effort for other participants. Brownie learned that, even when appointments were ostensibly made by another on her behalf, the onus remained on her to seek out the details. After her episode of chest pain while travelling, she was anxious to obtain diagnostic testing.

“So he said, ‘My secretary will be in touch with you.’ So she phoned - no, I didn’t hear from her. So then on Thursday I thought, ‘I’m gonna phone and see just what’s going on, if she’s got an appointment for me’, because that was about four days since I’d been talking with him. So she said, ‘Oh, yes, I think we’ve got an appointment; I’ll look it up and call you back.’ And she took my number. So when she called back she said ‘I’ve got a cancellation, can you go tomorrow down to [hospital]?’” (BROWNIE 147-155)

Ann found, when she first began experiencing the problems that heralded thrombophlebitis, she had to maintain pressure on her physician after initial diagnostic studies were negative.

“So I went in and she said, ‘Well, I’m booking you in for a doppler.’ And so I had that and they didn’t seem to be too concerned. I said, ‘Well what about this rash and stuff that developed?’, not rash, but redness, you know. And it’s then that she said, ‘Well, maybe you should be admitted.’ I went into the hospital Tuesday night and was admitted right away. And by Wednesday, the foot was very swollen and the, ah, discolouration had gone right down to the toes and it’s enormous.” (ANN 11-23)

These instances indicate some knowledge of the inconsistencies inherent within the workings of the health care system. Brownie and Ann had learned not to trust that all would unfold as it should in their favour. Both took responsibility for exerting an influence when they suspected that they were the actors who were most interested in coordinating their own care.

Physicians served as information brokers when self management required a more sophisticated understanding of heart disease and bypass surgery. Olga felt disadvantaged
by a relative lack of knowledge about the manner in which the vasculature of her heart had been surgically reconstructed. Just prior to our second meeting, she obtained an explanation from her cardiologist.

"I just three weeks ago asked my cardiologist when I was there what exactly did they do to me. Always I wanted to know because I totally missed this here, where it says here ‘Ask your nurse or doctor to circle the location of the bypass graft’. I missed that and I didn’t - I always wanted to know. So he just did this for me three weeks ago. And all that time I was looking at the picture and I was wondering what did they do to me? So this is one big information I missed. And I don’t know why, but it helps to know.” (OLGA2 708-716)

Later, she reflected on the difficulties she encountered in obtaining explanations from other health professionals, particularly when references to some aspects of her health or surgery were cryptic or couched in ominous terms.

“Well you still wonder, you know, how -- like when I went to see the surgeon, he only told me that I, like the vein they took out of the leg wasn’t too great. Now what does that mean, it wasn’t too great?” (OLGA2 724-727)

Ultimately, Olga shared feelings of deep dissatisfaction, not with the health professionals from whom she sought information, but tragically, with herself for lacking the competency to elicit explanation.

“Even so, they are there to really help you. But I’m the kind -- I wish sometimes I was more -- there are people, they are different, you know, they go there and they nail the doctor and they want to know everything, and they don’t let them push them out of their office for nothing, you know. But I can’t do this. I’m different. So I miss to ask my questions when I go to the people where you should ask them questions.” (OLGA2 779-785)

As an immigrant woman, Olga was marked by her heavily accented English, but as noted in her first interview, her occupational status as a housewife further compounded the hierarchical gradient between herself and her physicians. Her social position disadvantaged her in her efforts to access information.
Olga was not alone. Gert, also an immigrant, pondered questions that persisted months after the surgery. Certain events seemed mysterious and puzzling to her.

"I would have liked to have known more about it; because when I had my angioplasty, I asked if there was any information available for me, you know, to see what (pause)...And I didn't see any information - I never even talked to the doctor personally, how it was done, what to expect, nothing. So I was ignorant. It may be a good thing for some people [who don't want details] but I like to know, I'm mean I'm curious I guess. INT: Sure! You want to know. GERT: I had no idea, and what I didn't know was (pause)...What I can't understand and I don't know why I felt that way was (pause)...I was in the operating room, they brought me in, I saw the room, fine, and I was out just like that. And they didn't even give me a needle, not that I know of. What could that be? INT: Did you have an intravenous? They call it an I.V. sometimes...a tube that goes into a vein in your arm, usually. GERT: I don't really remember that...I think so. I think so. INT: They can just inject medicine into the intravenous line...you don't feel it at all, but then it quickly takes effect. GERT: Oh! Yes, because it happened so fast, I was out just like, so quick." (GERT214-243)

Gert called herself "ignorant" because she did not know details of her surgery, such as how she was rendered so abruptly into an unconscious state upon entering the operating room. Implicit within this example of self effacement is the discursive assumption that the recipient of health care bears the responsibility to gather information. Although euphemistically labelled health care "consumers", many people must rely on professionals to interpret and provide the range of therapeutic services available to them when a particular health problem initially becomes evident. The adage "Consumer Beware" cannot easily be attended if knowledge about services is only accessible through their providers. That women such as Gert and Olga readily assign themselves the label of ignorance suggests the moral implications surrounding disclosure.

Cookie struggled with similar difficulties; she was unable to find a point during an office visit where she could insert her questions or voice her fears. She would later
dismiss these as unimportant. Disadvantaged by a lack of secondary school education and her blue collar class background, she was reassured that her physician cared enough about her to phone and inquire about her after her surgery. Her comments indicate that she classified her questions as less important than the physical health issues she consulted her physician about.

"I should ask my doctor some of these things but you think of these after you leave, after you leave the doctor, eh? Well they’re really not important, you know. Like that...when you go there for something else, you know, more important. But my doctor is great to phone home just to find out how I’m doing. She phoned the hospital when I had the surgery, a day or so after.” (COOKIE2 640-645)

Eva was comfortable with her internist of many years, yet resorted to “reading” his nonverbal communication when seeking information about her physical condition and progress.

“Because I was on Adalat the first time I had the heart surgery done, and I was on it for five years. Although I don’t know where [internist] got the idea that it didn’t work, because why would I be on it five years? I don’t know. But anyway, I’m on it again and it’s working. Because when I went over, my blood pressure was down. And he’s very pleased with it, I could tell by his face. He’s the doctor, you know, you can see in his face what’s going on. And I’m able to read his face pretty well.” (EVA2 99-112)

As Eva’s words indicate, the pleasure taken in improvement represented the reassertion of control over angina pain, blood pressure, peripheral edema, and pain. The body, through careful medicalized attention to and titration of foods, exercise and medication, was a site of reduced risk and biographical continuity. Medical approval was received with relief, but reassurance was in some instances implicit. Above all was a moral imperative to be informed about the foundations of heart health and to practice self care. In the next section, I examine the process of incorporating activities of self care into daily routines
while simultaneously resuming the position of homemaker.

**Situating Self Care Within Homemaking**

Self care was learned and practised concurrently with the resumption and readjustment of a daily round of activities in the home. This occurred at the intersection between a medicalized discourse of self care and discursively entrenched, biographically particularized patterns of homemaking. The process of negotiating a position between these imperatives was ongoing for many of the respondents at the time of the second interviews. Conflicts and contradictions were frequent. It was apparent from the participants’ various approaches to activities of homemaking that the division of household labour is organized around the health of others, not that of the homemaker.

**Self Protection**

By the fourth month after surgery, there was resolution of most of the physical discomforts associated with post surgical healing. There was far less emphasis on pain management or injury, and greater preoccupation with avoidance of negative emotional states and unusual physical demands. The idiom of danger associated with the diagnosis of heart disease underscored these concerns. The problems imposed by socioeconomic context were strongly evident. Situating self care within the everyday could be intensely difficult.

Ruth worried about returning to her job, because she had an unusually long commute to her place of employment. She prolonged her sick leave as long as possible to avoid exhausting herself. Although she had enrolled in a cardiac rehabilitation program, she could not regard with anything other than apprehension the combination of her long
work day and her intensive exercise program. Although she sheepishly explained that she was sometimes overly emotional and prone to anxiety about time pressure, Ruth’s description of her weekday odyssey of buses, subway transfers and occasional lifts from a friend provides evidence that her concerns were well grounded:

“What I’ll do here, you know, is take the bus here and it takes me to [intersection]. And then I change buses there and go down to [subway station]. Then I get off there. Sometimes I get a ride from a friend. My friend and I usually meet at [fast food restaurant] and sit and have a cup of coffee and then we get there at eight o’clock. I leave the house at seven. INT: That’s a long day, then. RUTH: So you see, by the time I get home at night, it’s six-thirty. So it’ll be kind of tough to get [rehabilitation programme] in. Because it’s forty-three minutes now, but you see, as I go down the line and I’m more fit, it will be more. Because they’ll be giving me more miles, they’ll be giving me more time.” (RUTH2 706-723)

Like Ruth, Olga explained that she believed herself to be overly sensitive. She described her dread of highway driving and illustrated her point with an anecdote of an uncomfortable post vacation drive on a major highway. She had previously resolved to avoid driving on large roads, but was unable to avoid a turn at the wheel.

“Actually, I drove for the last four hours coming home from Cape Cod on Sunday. And I think that’s when I got a little bit chilled because it was cold, I had no socks on; stubborn, stubborn, I had them right there, all I had to do was stop the car for a moment, put on socks. But instead I had frozen feet coming home [laughing] driving. And I was very, very nervous to go because I knew I had to go on the 401. I hate the 401; I don’t drive on it. But I was so nervous about it. The moment I got to the 401 I even had chest pain from this, really. INT: Really? OLGA: Yes, stress, you know. Just knowing that I had to, that’s good enough for me. INT: And it was necessary for you to drive? OLGA: Well, it was a long journey. My son, his girlfriend, they each took a long turn, but they were tired. It was three-thirty at night, and me, I had rested [laughs].” (OLGA2 52-68)

She noted that it was her practice to try to avoid stressful situations such as this if possible, yet her story reveals the conditions under which protection of self is secondary to the protection of others. Tip related another highway anecdote which expanded on the
theme of the intertwining of emotional and physical aspects of the heart.

“We were going up the highway on Sunday, and [husband] saw this car coming our way, the driver must have fallen asleep. Well, it swerved and hit the shoulder, almost struck the car behind us. He tried to right himself... I swear, my heart stopped. He just barely avoided us and the car behind us. INT: When you say your heart stopped, what was that like? TIP: I was concerned. Maybe I was concerned that something might go wrong; because it just leaped, you know. Yes, that did scare me. I thought ‘Oh, I’ve done something else now.’ Actually, we should have stopped. Really we should have stopped. B. said he could see in the rearview mirror that they both were stopped, and--but I mean we should have been more concerned. But I just--wanted to get to our friends’ place and sit down [laughs].” (TIP2 411-435)

Frightening incidents abound in traffic and contain the element of the unexpected. Implicit within Tip’s narrative was the social and moral imperative to demonstrate concern for others rather than dwelling on her own wellbeing. However, her fear of damage to her healing heart was so overwhelming that she could only focus on reaching a safe place to relax and calm herself. Yet her anecdote contains an awareness of a barely excusable breach of conduct.

Olivia identified her own health as a strict priority and demonstrated forthright resistance to activities which placed her under physical or emotional pressure. Soon after her surgery, she took responsibility for day care of a grandson who had cancer and required periodic chemotherapy which kept him home from school. By our second meeting, she had continued a trend toward limiting her child care responsibilities.

“Well, he doesn’t come here anymore. If he doesn’t go for chemotherapy I won’t have him. And I won’t look after him anymore because he don’t behave very well. I don’t mind them one at a time, usually, but the three of them together -- my son has three children and it’s too much. I used to babysit them when they were small, and my daughter’s children too. Now if they want to go out they can hire a sitter. [laughs]” (OLIVIA2 190-196)

Samara also limited her involvement with children to protect herself from emotional strain.
although her own children were not the issue here. She was offered a contract with the
Board of Education to teach her first language to adolescents of the same nationality.

Samara considered the offer but deferred for another year.

"What I'm teaching is Turkish, so I don't have any problem. But the only thing, make
them understand, you know. Some of them, you know, have some already, they have
Turkish family background. I don't know, but this year, it's too much. No. Since it's only
six months, I don't wanna do it, no, no, no. But it's more or less, you know, younger
kids are okay. It's grade 8, it's fine. But with the teenagers it's hard work, you know. They
to have fun [laughs]."
(SAMARA2 723-733)

On the other hand, she cheerfully described her part time involvement with her sons' school as a lunch time monitor, reasoning that this activity was good exercise and it removed her from the isolation of her home.

All of the women tried to avoid situations where physical strain might jeopardize their reconstructed bodies. Just as they avoided toxic foods, such as those high in fat, to avert further obstruction of coronary circulation, the participants refrained from activities which placed them at risk of injury. Cookie, for example, frequently referred to her fear of repeating her harrowing experiences in hospital and her concern about the stability of surgical revisions to her coronary circulation.

"I was too scared to pick anything heavy up. Like I wouldn't take the risk. Still scared
now, you know, of many things. INT: When you say you're scared, what are you worried about happening? COOKIE: My chest, see, the chest bones are still...feel to me...But they said in the hospital it's normal. It's like healing together, I guess. But it's tender. Then if you think of all the things that might go wrong with the things they did to your heart, that you don't understand a lot of it. You think: Oh God, stuff might have went wrong or it might come loose, you know, the sewing of the veins." (COOKIE2 42-59)

***

"INT: So, at first you were a little worried about pushing yourself? COOKIE: Yes,
yeah. INT: How do you feel about that now? COOKIE: Not too bad. I don't worry about it as much. [pause] Well, yes, I'm scared to push myself. I'm scared something might happen again. And I just don't want that to happen. I don't want that.” (COOKIE2 161-171)

As stamina and comfort increased, the women gingerly continued to increase their level of exertion, paying careful attention to physical signs such as pain, muscle tension or fatigue.

Laverne described her approach to resuming employment and recreational swimming.

“And then when I started back full days, I think I only had a couple of days where I came home and had an hour's nap after work, because I was really tired. But once I had that nap and then went to bed, fairly decent time, I was fine. And I didn’t start to get tired until last weekend. And I guess from having company all weekend, and then this week, like I said, I could feel everything was tightening up, ahn, the back of my neck, and my chest, I knew I was tired. That’s why I decided to stay home today, and I slept in, and I’ll sleep in tomorrow. Sunday and Monday.” (LAVERNE2 315-324)

***

“And that was my first time swimming; my first time swimming out. I was--I appreciated [children] being there, because I had no idea what was going to happen. I love to swim and I was fine; I was sore for the next two days, not outrageously, just a little sore. And like I said, it’s mostly when--when I overdo something as far as lifting or motion, it’s right on the collar bone that gets sore.” (LAVERNE2 506-513)

Of all of the women, Emma was the most reluctant to accept an attitude of self protection, although her health was precarious. She acknowledged, for instance that hot and humid weather meant that she would have to guard against the slightest exertion, yet bitterly observed that this would not have been a consideration in the past.

“And then I’ll go out again down to the park maybe about 6:30, quarter to seven, and I don’t do much at all, I just walk. But there’s lots of days that I just...[pause] And like humidity, I know I’m not going to be able to do too much the next two or three days because I’ve got myself psyched up for this hot weather that we’re gonna get, humidity that’s gonna plunk in on us. And then that just...[pause] I think that’s accepting a lot, I do. It’s like geez, before I could do this and that and something else.” (EMMA2 890-899)
Throughout the interview, Emma unhappily compared her biographical patterns with her present limitations, and attempted to envision a future position for herself. Although self protection was at the core of the medicalized discourse of self care, the extent of protection required in Emma’s uncertain situation contrasted sharply with her biographically cherished notions of active womanhood.

Samara, too, was gradually reining in her homemaking involvement. During our second interview, I was surprised to hear she had renounced all heavy activities on the advice of her physician, who was concerned about her poor results on a stress test.

“After the heart attack I come home and there was no-o-o help until I got too sick to do it—so after the operation, I expect to clean. That’s not my job any more. I know. But I can’t help myself; I wanna do something. So, and he just said to me, ‘You did something wrong’. He talked to my husband, ‘Don’t let her’. She’s gonna have another heart attack, you know. INT: So your doctor explained to him... SAMARA: Explain to him, you know, he doesn’t have to let me. But he didn’t know that [laughs].” (SAMARA2 999-1009)

Samara struggled to recognize in her new approach to self protection the biographical self established through past patterns of activity. While she pointed out that discursively established traits of masculinity were compatible with her reliance on her husband and sons for help with heavy tasks, she rejected her own apparent lack of self reliance.

“Sometimes it upsets me, why not me, you know. I used to do that. And sometimes they get upset too, but they understand it’s okay, ‘Let me do it, I’m a man’, or you know [laughs]. But not to do it, sometimes I have to wait for them. Sometimes I only do the laundry. The laundry basket is not too big. I have to carry it down and up, you know. But what am I doing? I’m putting little bit in it, carrying it down and come back again, carry some more. Up and down! Twice I get my husband to carry it, three times. But I feel like he, you know...[mimics grumbling] ‘...go down and pick them up again.’” (SAMARA2 337-348)

Samara’s anecdote reveals the same complexities of self protection faced by Emma: should she preserve her physical health by refraining from certain activities or succumb to
the desire to sustain biographical (and discursively prescribed) selfhood by retaining independence? With her husband and sons away from the home most of the day, she was forced to interrupt tasks at a point where help was required and wait for their return. She responded by carrying several small loads rather than one heavy one. Samara noted with self-mockery the absurdity of her repeated exertions on the stairs as she multiplied her trips in this manner. Yet, with assistance occasionally rendered in a less than gracious manner, Samara was encouraged to persist in her creative solutions.

**Self Care**

Changes in personal habits of eating and exercise were particularly emphasised by participants during the second interviews. Anecdotes highlighted the difficulties of instituting these changes in the presence of pressures associated with old standards. As shown in the previous chapter, these changes were accomplished in an embodied fashion. Questions of motivation and initiative coexisted with contextual barriers and physical habit. By the second interview, many of the women were pleased with the positive changes they had made, but were dismayed to encounter unexpected barriers. Learning about self care was a continuous related activity as participants embarked on what was presumed to be a life-long effort to maintain patency of their bypasses.

**Learning**

As noted previously, learning was an enterprise which encompassed embodied as well as cognitive components. For many of the women, learning to coexist comfortably with and trust the mysterious visceral body was difficult, but rewarding. Understanding the strengths and vulnerabilities of the reconstructed body was a matter of experience and
time, and it progressed at a different pace for each woman. Access to cognitive, medicalized information enhanced development of this understanding by providing reassurance and interpretation of unusual sensory signs. Lack of pertinent information intensified fears associated with perceived risk and danger.

"It was nifedipine. She put me on it after the operation because she said I had a heart spasm. I guess I’ve got small arteries which many women have. And this [drug] would help everything go through." (BROWNIE2 433-436)

***

“My chest, see, the chest bones are still...feel to me...But they said in the hospital it’s normal. It’s like healing together, I guess. But it’s tender. Then if you think of all the things that might go wrong with the things they did to your heart, that you don’t understand a lot of it. You think: Oh God, stuff might have went wrong or it might come loose, you know, the sewing of the veins.” (COOKIE2 46-59)

***

“I didn’t know if I was doing too little, if I was doing too much, if I was walking too briskly, as far as exercising, maybe not keeping up with the walking enough; I didn’t know. It’s not easy to tell -- you don’t exactly know what your body can take. I mean you know what to do, still you need someone to tell you how much to do.” (TIP2 865-869)

Access to information and learning resources was important to support experiential learning. Some of the women noted mystification of medical knowledge related to their treatment regimens. Many contravened this tendency by continuing to rely on generally available sources, such as books and social networking; others persisted in asking questions.

“This other lady sitting in the chair beside me said, ‘What’s this beta block they’re talking about?’ I said, ‘I don’t know. But we don’t have to worry because we’re not on beta block.’ And she says, ‘No.’ [laughs] At the end, when I’d done my walk, I was talking to my--my teacher and I said to her, ‘You know what? Like I was half listening when he was explaining about the beta block and all of those things, but I’m not on the beta block, am I?’ She looked at my medication and she
said I was. But I didn’t know that! Wish somebody tells you that you’re on the beta blocker.” (RUTH2 487-498)

***

“And I really think he should have told me that my cholesterol was high. I just overheard that when he was talking to an intern. He says ‘Wow, look at the cholesterol!’ But he didn’t tell me that I should have my GP check my cholesterol....What’s the big deal? You know, why don’t they tell you what’s what? I mean, you have a right to know.” (BROWNIE2 743-754)

***

“Because it was just before I’d been up to the cottage and, ah, [spouse] called me in on a Saturday night around ten o’clock. I was sitting outside with my nieces, and he said, ‘You have to come in and watch this. I watched this before you went in for surgery, I didn’t want you to see it then.’ And we watched a man that had a triple bypass on TV. Now mind you, he died three months later, which was very unfortunate, but he had had a massive heart attack before surgery. They were hoping they could wait for two or three months, so the heart muscle could mend, and they couldn’t. And of course, that’s why he had another heart attack later on; it had nothing to do with the surgery. It was because his heart muscle wasn’t strong enough. Anyway, I watched that whole thing, and I’m glad I didn’t see it before I went in. There’s a lot of things I know now that they did that I didn’t know then.... And you know, it’s funny, because they can tell you a whole bunch of things ahead of time, but they’re not going to make any sense to you until they happen. Like when you say that you’re going to click, if you don’t know what they’re talking about, if you’ve never felt this before, you’re going to say, ‘What the hell are you talking about?’” (LAVERNE2 412-440)

One particular barrier to accessing information was the problem of language confronted by immigrant women. All of the participants for whom English was a second language were able to read English to some extent. However, as Agata pointed out, reading books on heart health could be a labourious task. She demonstrated dedicated persistence in learning and applying knowledge about risk reduction.

“I used to always like to listen when people talking about the health. And well, my daughter, she is like that, you know, too. She is -- and she bought this book and she say, ‘Oh, I gave you this book and it’s very interesting!’ So that -- and then I start to read it, even - oh, I think ‘Why?’ - if I don’t understand I read twice.
maybe three times. And I do understand some more. And I'm starting to, you know, to change my style. Completely different cooking like I was doing before.” (AGATA2 514-521)

Learning was continuous as the women tried new dietary and exercise regimens. They experimented and remained attuned to their physical responses. An iterative approach prevailed for some, as successes or failures led to more engagement with resources for interpretation and new ideas. Yet it is important to note that the cognitive and physical stamina required for this appropriation of knowledge were not fully available until several months after the surgery.

a) Doing Diet. Sonia spoke for many of the participants when she pointed out that some of the most intensely enjoyable foods are also associated with heightened cardiovascular risk. She, like others, spoke of habitual tastes for certain high cholesterol items and identified a need to control embodied cravings.

“So we went over to this place for ice cream. There were two signs in the ice cream place: yoghurt - low cholesterol frozen yoghurt and the regular ice cream. It seems somebody mixed them up, the signs, or something. So they gave us the ice cream but we asked for the low cholesterol yoghurt. Well we were all sitting around the table and eating and I started to eat, I said to my sister, ‘It’s so delicious, that’s too good, that’s not low cholesterol’. You know, when I tasted it and I say it’s too good that this--I should not be able to eat it. But she says, ‘I’m going to check it again’. I say ‘Wait!’ This time you have to wait until I finish the ice cream [laughter]. For once I wanted to enjoy it. Know what? Once it happened that we knew it was mistake, we were eating high cholesterol, I would have to stop. But I tell them I’m hundred per cent sure I shouldn’t eat this. It’s too good. It was too good, you know.” (SONIA2 801-818)

Others faced the same quandary, because even as they became more informed about the effects of certain foods on their health, they were forced to confront the difficulties associated with changing embodied preferences and tastes. Ruth applied logic to the situation, reasoning that it made no sense to court further injury to her newly
reconstructed heart. She explained that she should be the one that cared most about herself, therefore if she truly did care, she would have no difficulty eating healthier food.

“I--the whole attitude changed, because I know now I’ve got only one heart, and I’ve got to look after it, even my eating habits have changed where I used to be, I wouldn’t care. If you don’t care, who cares enough to do it for you? Because now I really watch, cut all the fat off because I’m eating a piece of meat, you know. Because now I don’t want to have another [surgery].” (RUTH2 999-1006)

Bamy limited availability of foods that she knew would tempt her. She knew that, with only herself and her spouse to feed, baking a cake would surely lead to overindulgence on her part.

“We don’t eat too much, it don’t take too much to keep us in food. I never get too hungry. In the hot weather we don’t cook too much anyway. If I cook a cake...I don’t dare bake up a cake because if I do, I eat it all, there’s no one else to eat it. That’s why I stay away from cakes.” (BAMY2 625-630)

Other strategies included allowing small deviations from strict adherence in order to maintain reasonable control over cravings. Making flavourful or imperceptible substitutions for common high cholesterol foods was also popular. Gert employed both approaches to manage her diet.

“If you cheat once in a while, just taking small amounts, it’s better than, you know, having a craving and going completely off the diet altogether.” (GERT2 324-326)

***

“No more butter you know, [margarine brand] now. And everybody likes it, so that’s it now, no more butter. And, ah, they can’t tell the difference, one per cent milk instead of two per cent milk, you know. Nobody tells the difference, so why not, you know.” (GERT2 352-356)

Similarly, Agata permitted herself small indulgences when social occasions invited celebration. At such times, the enjoyment of special foods heightened the social significance of the event, setting these times apart from the norm.
“And sometimes yeah, I have, you know, if I go like for the birthday party I might have a little cheesecake or something just occasionally. But nothing brought in the house for everyday.” (AGATA2 190-192)

***

“And like you see, I make sometimes pirogi and even my grandchildren want. I’m making pirogi and I put in it vegetable and everything, but I would eat just two, that’s it. And I will never touch another one.” (AGATA2 669-673)

As her last comment illustrates, there is a fine line between indulgence and losing control over dietary management. This line, for Agata, was maintained through strict self-management.

Changing food preparation practices was necessary in some cases. As Olivia explained, frying was no longer an option for her, particularly in preparation of meats.

Her husband still preferred fried foods, however, and two separate cooking approaches were sometimes necessary for the same meal.

“We used to use a lot of fried food and everything, but I don’t do that any more. I either steam or broil. If my husband wants something fried, then he can fry his own. The other day he had some--I like pork chops, so he fried his and boiled mine [laughs]. And, if I do fry I just use about a measuring spoonful of oil to fry. Because we like--my husband loves gravy. A meal is not a meal without his gravy. So I have to fry up the onions and tomatoes and stuff. I just take a bit on my potatoes and stuff.” (OLIVIA2 443-457)

Avoiding use of salt in meal preparation was another change for some women with hypertension. Bamy reported that her son had been so successful at eliminating all added salt that she tried this herself.

“I’m trying to do better, not eat any salt, so I don’t want my--I stop kind of eating salt--putting salt on my food, I don’t like to eat, I don’t want salt. I make carrots and peas and, I think it was yesterday, no salt. It tasted alright! And even the fish. I had the fish without salt. I know my son in New Brunswick, he hasn’t had--he said he never eats salt. He just uses pepper and that’s what I’ll use. And he hasn’t used salt for many years.” (BAMY2820-830)
Eva enthusiastically reported her experimentation with new ways of preparing meats that eliminated the need for both salt and oil. She found that the flavour of onions and celery, as well as a commercially prepared herbal salt substitute, compensated for the lack of salt.

"We haven’t had any meat for well over a week, you know, though a lot of today’s meat, if you cook them carefully, they’re lean anyway in a small portion. But we’ve been eating a lot of chicken. I have got a new way of cooking it. Take a piece of tin foil. I put two halves of chicken breast skinless and boneless on the bottom of it, dice up some green onions on the top of that, chopped celery on the top of that, and place potatoes on that. Sprinkle it all with Mrs. Dash’s and put it in the oven. Wrap it all up and you know, it comes out real good! You get the flavour of the chicken in it, and those spices, no fat, you have no fat on the chicken.” (EVA2 942-954)

However, Cookie admitted that even after two sessions with a dietician and seminars at her cardiovascular rehabilitation program, she was unsure of how to change her eating and meal preparation patterns. She felt some pressure to try new recipes but found it hard to change her meal plans.

“I’ve only done one recipe in that [cookbook]. I should try it, yeah. It’s just not that easy to change how you do things.” (COOKIE2 265-267)

Later, Cookie revealed that her partner was resistant to changes in his preferred meals. She found that he responded angrily when she substituted margarine for butter, or tried to introduce leaner meats. His fondness for high cholesterol foods worried her, but her efforts to revise their eating habits were rebuked:

“Because I’ll maybe worry about something happening to him too, and ‘don’t eat too much of that, don’t take too much of it’. But butter, he loves butter on his potatoes and stuff. And he’s like, ‘Leave me alone!’” (COOKIE2 317-322)

Negotiating dietary change was, in such cases, a social endeavour.

Agata, who in her earlier interview mused that she did not know how to “do” a
low cholesterol diet seemed to have expended considerable effort in learning this skill.

Her approach to dietary change was a transformative one, as suggested in her above quoted comments. Much of her second meeting with me was spent in discussion about food and food preparation. She took great pleasure in her new approach to eating and explained that she had learned to relish a variety of vegetables. During this commentary, she produced a colourful recipe book to show me pictures of her favourite meals, and it became clear that she worked to develop a sensory appreciation of these foods. Implicitly, she identified the sensual, embodied nature of diet, taste and culinary skill.

“I cut those tofu in the end and lots of onion and I have beans and -- yes, the dry beans or the green beans -- even potato. I cook potatoes in the beans and that, it makes your meal. And no meat, you see here, no meat. That's lots of onions, and everything. And zucchini. And sweet potatoes, you know, and maybe some tomato. That's all. And the fat would be just like you see, one tablespoon of oil. You cook it all together slow. That’s my food. INT: Well, that looks good! AGATA: I think instead of having one steak, I'm having lots of vegetables like that and this fills you up if you make it with potatoes and even some beans. You can put carrots, it's a good meal. A salad, that's lots to eat.” (AGATA2 572-592)

Yet Tip, with the same books in hand, balked at the idea of changing her tastes in cuisine, rejecting the idea of strict dietary control. Her comments, like Agata's, suggested that diet is a sensual enterprise and that motivation to change is not necessarily a cognitive issue. Her doctor's support for her stance on diet illustrates a paradoxical approach. In stating that she has to live, he is not advocating that she prolong life by restricting her diet; instead, he acknowledges that living requires sensory enjoyment of life. In this case, self-care was interpreted within the limitations of tolerance for dietary change.

“I went to [doctor] and said, 'I have this book; if I start to eat all that stuff that's in that book, I'd be throwing up every day, I'm sure. It sounds terrible.’ And he said, ‘Well, you know, you do have to live. You don’t have to go by that.’” (TIP2 810-814)
Later in our discussion, she rejected the premise that diet contributed to her development of CAD.

"So, I really haven’t changed too much. Our diet wasn’t that bad. I’m sure it’s not the only cause. I think it’s hereditary myself. Because I know all my -- most of my aunts and uncles died because they had angina. And so I said, ‘I know I’m gonna get it some time’. I think it runs in the family." (TIP2 818-823)

In both examples, it appears that taste and diet are discursively organized, but embodied. Agata gradually altered her patterns using the books and recipes made available through the activities of health professionals and the publishing industry. Tip rejected this textually mediated discourse of dietary self management, but appealed to her physician for approval. Agata enthused about the sensual joy and creativity of the same diet which Tip argued her body would reject.

"Doing" diet was thus a matter of attending to embodied tastes and cravings, accomplishing social negotiations, and returning to a set of food-related habitual practices, all with reference to discourses which emanated from several sites. Adding exercise to habitual regimens required additional attention to the body, schedules and routines, as well as demands placed by employment and other responsibilities.

b) Exercise. Special challenges were encountered in developing exercise regimens. Many involved the pressures and problems presented by time and timing: pacing exercise with reference to recommendations of health professionals, finding an appropriate time for exercise, facing limitations posed by time of year, and organizing exercise around other activities. Although these concerns involved embodied practices, they also pointed to the encroachment of competing responsibilities upon the project of self care. Establishing a
routine of exercise was far from a simple matter of choice.

By the second interview, seven of the respondents were involved in formal cardiovascular rehabilitation programs. These women approached exercise in a manner that reflected their frequent contact with health professionals. They understood that they were to exercise under certain conditions, that they were to exercise a certain number of times per week, and that there were ways to monitor bodily responses in order to determine the safety of the pace at which they exercised. Tip, for example, learned from a rehabilitation expert that pain was not always a reason to stop exercising.

"You see, that’s the reason I wanted to get into the rehab program, because I knew I had to do exercises at home, but I didn’t know whether I was doing too much, too little or the wrong way. I didn’t know, so that’s why I had to get into the program, so that I knew. And the first few times were kind of rough, because I kept getting pains under here and around where there are stitches, you know. He said, ‘Just use your nitro and take it easy for a few minutes.’" (TIP2 262-269)

***

"When one of the days is a good day and I walk down to the park down at [nearby street], it’s a bit hilly. And I find it different when I’m there. Because [at rehabilitation program] they prefer you anyway to walk on a level. They’re track is nice and level -- it’s lovely. I wish we had something around here like that.” (RUTH2 429-435)

***

"I had to continue with my walking program while I was out there. I had to fill in my sheets and amend when I came back. Half the time I was walking with an umbrella.” (BROWNIE2 66-69)

***

"But they give us all sheets to follow. They say, ‘We’re gonna expect you to do this at home.’ And they monitor you every few minutes -- you come up and they take your pulse. Then you feel fine because, you know, somebody said they know how you’re doing.” (COOKIE2 81-86)
"The people at the [rehabilitation program] are wonderful; they monitor you. And they've just gotten down here in our exercise room, they just got a treadmill, a wonderful treadmill. So I do it usually two to three times a week as well on the weekend and I swim. So I'm really trying to get my...my everything, you know, my strength back up, which I have. Side benefit is that, you know, you get a waist and you feel good about yourself." (LUIGI2 32-38)

***

"I work out every day, but I'm not supposed to. I says on my walking prescription four times, four to five times a week. I walk a lot of times six or seven times. I like walking and I think that the walking -- they tell me it's good for you. Especially in the morning when I first get up and I go for my walk, I feel fresh. I feel okay." (SONIA2 675-683)

The self discipline associated with exercise involved keeping records and persistence despite discomfort, vacation related relocation and inclement weather. Each woman found times, locations and methods that suited her situation, but each remained mindful of what approaches "they" prescribed for her.

Many of the women who did not enroll in rehabilitation programs were also aware of the need to carefully manage exercise. They also noted the importance of persistence, pacing and consistency, although definition of these elements was sometimes vague: "enough exercise to make me feel better", "they say the walking is good for me", "I was supposed to walk a lot". Their comments indicate reference to other sources such as readings, health professionals, or nameless others who represented common knowledge.

"I walk two miles a day, every, well almost everyday. But yesterday it was raining so bad, I didn't walk as much then. I want to keep that up though, because I really -- I feel better about it, you know. And no problem about the incision in my leg at all, nothing, just like it never happened." (GERT2 154-158)

***

"I've just been going by the doctor. Now the books that we got give you good stretching exercises and stuff like that. And really that's all you need as well as
your walking. As far as I’m concerned anyway. I have a bicycle downstairs. I have a rowing machine. I can’t use the rowing machine until October. INT: Ouch! I guess I can understand why. [laughter] LAVERNE: Yeah! The doctor said give it six months for the rowing machine, because that’s really exerting myself. But I have the bicycle if I don’t get out walking, so I can use that. He said that was good. Just as long as I get enough exercise to make me feel better.” (LAVERNE2 61-74)

***

“The doctor said I was supposed to walk a lot for my heart. And that’s true too. See, I never walked enough the first part of it because it was winter time. And you’re supposed to exercise your heart -- walking doesn’t hurt. And I walk around the mall. That’s what I told [spouse], I have to walk. Go around the malls, I walk around, I go quite fast too. And he -- when I go across there, he looks out sometimes, he said he waits until he sees I’m okay. Every time he gets ready to look, I’m clear over to the other building because I walk so fast. Before, I couldn’t go that fast, but now I can go a lot faster.” (BAMY2 574-583)

***

“But very early in the morning, there’s no sun, it’s very cool, you know, it’s better to walk. So this way I feel better if I’m walking. Sometime I don’t know what kind of exercise and they say the walking is good for me. So I’m doing it.” (AGATA2 330-333)

However, some of the respondents were less convinced that a program of walking or other deliberate exercise was the only answer to cardiovascular health. Eva explained that she preferred forms of exertion that produced a visible product, such as painting or cleaning.

“Oh, I get a lot of motion. I really do. And I feel good when I do it, that’s the important thing. And it’s even like when you do exercise; if you overdo it you have to sit down. Well, it’s the same. I would rather do something that shows slightly when it’s done. You know, for instance, painting or doing all those curtains.” (EVA2 899-904)

Samara commented that looking after her children was difficult enough without adding a rehabilitation program to her list of obligations. She wondered if a weight loss program
would suffice, leaving her time to do such exercises as she could manage to combine with her parenting responsibilities and saving her the cost of hiring a babysitter.

"Because I have to have somebody look after the kids, you know, after school because they’re under age. One of them is twelve, the other is six. So I can’t afford that always, you know. I’d love to go and do something. The only thing I’m going to ask the doctor is if I can just join the weight loss club. Do some exercise too, you know, the way I want it. Because I’m already doing a lot here with the kids.” (SAMARA2 415-422)

Although rehabilitation programs were appreciated for the opportunities they afforded for socialization with similar others, walking for cardiovascular health presented a unique social dilemma. While close friends or family members might seek to offer support by offering to walk with the women, the brisk pace required to incur cardiac benefit made simultaneous social visiting difficult to manage. Some discouraged offers of company, while others sought out energetic companions. At times, social obligation and responsibility for the emotional wellbeing of others made refusal of companionship difficult. Special occasions or visits might limit or halt exercise routines altogether.

“You know what? I also had a rest. I didn’t go [to rehabilitation sessions] for the week when my sister was here, so maybe I should feel guilty.” (SONIA2 672-674)

***

“It depended on how I felt. My mother-in-law can do anything. It depended on how I felt. We walked rather briskly most of the time, going there. Ahm, once we got to the top of the big hill, we had to sort of slow down a bit, but that was me, not her, she wouldn’t slow down.” (LAVERNE2 82-86)

***

“Not running, but a quick step, yeah. But I’m not even out of breath. My neighbour goes with me, because she’s overweight, way overweight, and she talks constantly. I guess that’s why I’m not out of breath when I walk with her. But she talks a lot, I think that’s why. And I just listen, because she has just recently lost her husband and I think she needs to talk, so I just let her, you know.”
"I thought, 'Oh, no use, you’re better on your own.' I find that it’s better to walk alone. Here especially, I have some friends on the street who’ve offered to come with me. But I try to avoid that and I get out really early because you tend to poke along more if you’re with somebody else." (BROWNIE2 81-86)

Ann postponed joining a cardiovascular rehabilitation program altogether because she and her husband planned a long vacation to a cottage in the northern part of the province.

"I said, 'Well there’s no point in enrolling in a program now because we’re going away. And he said, 'Well you could go up to the program in [northern city] in the summer, if they run it in the summer.' But I don’t know if they run it in the summer. A friend of ours, who lives up there, said he wasn’t going in the summer. Guess I could get—go to it up there, but [doctor] said that I could swim so, you know, I’ll swim. Also I go for walks a lot and we have the mountain bikes we can ride and things like that." (ANN2 209-220)

Employment posed a threat to exercise routines for some women. As seen above, situating exercise within everyday routines was difficult enough, but the demands of employment limited time and energy still further. Ruth, as indicated earlier, worried that her long work hours and commuting times would mean she would have to forgo attendance at her rehabilitation program. However, Cookie planned to return to the evening shift at her workplace so that she could still attend a daytime rehabilitation program, while Laverne and Luigi both had access to exercise equipment in their own homes. This was a boon, because none of the women were interested in walking alone outside after dark or travelling to hospital-based programs after a long working day. Ruth had none of these advantages, thus her concerns about lacking time for her exercise regimen were considerable.

These anecdotes indicate that situating self care practices within the patterns of
everyday life is subject to more than simple motivational barriers. It entails considerable experiential and embodied learning that is embedded in, and often conflicts with particular elements of, a social world in common with others.

**Resuming Paid Employment**

By the fourth month after surgery, Laverne, Margaret and Luigi had returned to their paid employment on a full time basis, while Cookie and Ruth were contemplating return in the near future. None of these women had children under 18 years of age, although Laverne’s son and daughter continued to live with Laverne and her husband. Emma wanted to return to full time employment but was unable to do so because of her precarious health. Samara had the option of taking a part time teaching position, but did not feel ready and declined the offer. Olga pondered the possibility of looking for a job, but feared that her inability to write in English would hinder her search.

Time management issues conflicted with self care requirements in those who had returned to work, and those who had not returned to work were concerned about this issue. Margaret explained that these problems were probably less of an issue for her than for other women, because she and her husband owned their business and therefore were free to set their own hours. She continued to carefully guard her morning hours as her own time for exercise and self renewal.

“First thing in the morning is my time. I save it for my walking, my exercise. Then I’ll maybe read or watch TV after. I really relax at this point. We don’t open the store until eleven o’clock so -- and I can do a load of washing whatever I have to do. Different things.” (MARGARET2 458-462)

Although Margaret managed to maintain her morning exercise program, it is interesting to note here how naturally homemaking tasks, such as laundry, encroached upon this time.
Balancing multiple responsibilities, or multitasking, is a feature of many women's working lives, but it is poorly acknowledged, even by the women who take up this challenge. Luigi also voiced observations about finding time for competing demands, but concluded that since her new job brought such fulfilment, she felt lucky, not burdened.

"It's different being back at work, I tell you, real different. Because you know, as you're aware, before my -- I was off work for a year before my marriage broke up, so I got used to not having to do things through the day and got to quite enjoy it. Now I'm back to having to do shopping on Friday night or Saturday and cleaning and, you know, it's back to the mad sort of...but it's okay. I feel, you know, I consider myself lucky to be able to do this. So far it's still, it's okay with me. I don't mind it." (LUIGI2 90-98)

The demands posed by paid employment were noticeable in the first weeks on the job. Self protection at work involved pacing hours so that stamina was developed, or getting extra rest. Luigi mused that her job was not physically demanding, and although she felt physically tired, she did not consider this fatigue extraordinary. Ironically, she identified the stress of starting a new job as the source of her weariness in the first weeks.

"I went back to work five weeks ago, [but this is] the first two weeks I've been full days, and I took today off because, um, this whole week I've been getting tired. I can feel it. My -- like when I first came home from the hospital, my incision, you could feel the tightness in here, and it sort of tends to make you bend over when you get up out of a chair or when you're walking. And that was when I first came home. And from last weekend, for this week, it's been doing that all week, so I know I'm tired and it's really funny how your body tells you." (LAVERNE2 100-110)

***

"Well they say to go back June the 19th, but then I'm going to take -- I have five weeks to use up before the end of the year. You've got to take them before the end of the year, so what I'm doing is I'm going to take two weeks vacation, and then I'll go back. So really I'm going to go back July first. So then I'll take -- the first week and second, I'll work three days each week. And then I talked to the Girl Friday, she said she would talk to my boss to see if I can get Monday, Wednesday and Friday, and that gives me a good break in between for the first two
weeks anyway. But then the third week, I’ll be back full time. It’s not so much. But it’s me getting — remember I told you -- getting up so early?” (RUTH2 5-11)

***

“I mean it wasn’t like I was doing any physical labour. I mean it’s all a mental thing. No physical labour. And my mental was strong and fine and, physically, I felt great, I felt good. It was, you know, I was tired at the end of the day the first couple of weeks but I think any one who hadn’t worked for two years, in the stress of a new job, I mean anybody would feel that way. I didn’t put that on as a problem with my heart, I just thought that was a normal thing.” (LUIGI2 240-247)

***

“So I went in with her and I went in maybe from twelve to five and I did it for the full week. And I was kind of tired, I was really quite tired.” (MARGARET2 416-419)

Thus, fatigue was the principal sensory experience of the first weeks in paid employment. As Luigi pointed out, homemaking activities were accomplished after hours of paid labour were over, against the backdrop of weariness.

However, some women contemplated return to other forms of employment outside of the home that did not involve formal wages, and their examples are indicative of the participation of women in an underground or shadow economy.

“Oh, I feel I can do the same things again that I did before. it’s so important to me. So I do some housework for people and I wonder when I can do that again. INT: Oh, you’ve been doing housekeeping? GERT: I have, not now, but I have done it. For my hairdresser, mostly. She does my hair and I do her housework. That’s how I can get little things like that for myself.” (GER2 398-405)

***

“Sometimes I come home tired and then I have a little bit of rest. But, ah, then of course we go to the bingo, and we go to the Centre. I was going to go back to the office to do [volunteer] work over at the Centre, but, um. I lasted half a day and then I had a bad, I don’t know what it was, I had to go to the hospital and they had me on a monitor for half a day.” (EVA2 47-52)
Women's homemaking activities in such instances extend beyond the physical boundaries of home and they represent services provided outside the cash nexus. It is unlikely that these cases would be considered in studies examining “return to employment” following bypass surgery. Nevertheless, these forms of unpaid work constitute another dimension of women's work which sustains family and community. They occupy the blurred boundary between women's paid and unpaid labour.

**Homemaking**

All of the women engaged in homemaking activities by the fourth month following surgery. Most took pride in their capacity to manage a home, and the activities they described extended beyond the repertoire of household chores mentioned in studies related to women and cardiovascular disease. Indeed, it was difficult, when listening to descriptions of the women's activities, to find linkages with the limited versions of homemaking described in the literature: sweeping, vacuuming, grocery shopping and cooking. Furthermore, the concerns and problems identified in the narratives went beyond the mere question of cardiovascular exertion. Some of the women attempted to change their approaches to household work, and they encountered barriers in so doing. Some busied themselves with home improvement efforts. Two of the women, Emma and Cookie, moved their residences in the time between the first and second interviews.

Those who changed their approach to cleaning and maintaining order described these modifications in a manner that suggested concern about adhering to other’s standards. The visibility of some parts of the home to was apparent in discussion about negotiating new standards and practices of household maintenance. Olga in particular had
many observations about the visibility of housekeeping and pressure from others, particularly other women, to adhere to certain values.

“Maybe I should, but I don’t like this stuff, you know; all this women stuff I don’t like. And yet they want you to do it, and boy, oh boy, I have an old friend, she’s eighty-four years old, she even irons the dish cloth! INT: The dish cloth?// OLGA: ...the dish cloth and her face cloths. I mean give me a break! And then when I tell her I don’t know when I did my ironing -- last time I ironed anything, she can’t understand it. You should see my friend, her daughter, she asked me the other day to stretch the sheets, you know, you need two people to do this, and I said, ‘You still do this?’ I remember my aunt doing this back when I was a kid. They take the sheet and then they stretch the sheet and then they fold it and they stretch it again and then fold it again; stretch some more, and then they put it -- and then they iron it after that. And honest to God, that’s where I draw the line.” (OLGA2 844-864)

***

“We are supposed to, or we are not good women, you know, if they don’t like that. I don’t agree with this bull. So I had my run-ins with my sister-in-law and you name it. Oh! These wonderful women. It’s true, they look at you because you don’t sit and knit for ever and ever or crochet and do this needlepoint and that, they look at you like you are not a good woman.” (OLGA2 871-878)

Her rejection of the standards of womanhood expected by those around her was
dividually and incidentally accepted the inevitability of a gendered division of labour when she commented at another point in the discussion that men were not subject to the same discipline of homemaking that women were. Others raised similar points. When Ruth relaxed her standards, she too heard comments from a close female relative.

Brownie joked about meeting public health requirements. Ann mused that the sight of an unmade bed caused her to label herself as sloppy, but this really mattered very little in the grand scheme of life.

“You know my sister said to me, ‘Oh my God, you used to be so meticulous!’ When she said that to me, well, I don’t even care anymore, it’s not even a priority. INT: Was it a priority before? RUTH: Oh, yes, yes, I was careful about this place”
(RUTH2 851-858)

***

"So I still have my lady that comes in once a month and she's very thorough when she gets here. I don't think I'll get closed by the Health Department or anything [chuckles]." (BROWNIE2 932-935)

***

"This thing I know, Jan, certain things are not as important as they used to be. Like you know, this bed has to be made by eight o'clock in the morning. By eight o'clock at night I cleaned up; this kind of thing is not as important now. I would go into the bedroom and say, 'Oh, I haven't made my bed today!' And then I'd think how sloppy it looks. Oh, so what? [laughs] And losing that attitude made a difference." (ANN2 352-361)

The work of homemaking was richly varied and it firmly embedded the household within a network of other homes and the community. Vi's favourite tasks involved childcare, as noted earlier in this chapter. She reflected on her special bond with her grandchildren and her contribution to their care.

"I got a sewing machine and when I get tired of doing one thing I go over to the sewing machine and I have kids' clothes brought in to me, like the grandchildren are, 'Grandma, fix this, my mother's going to kill me' [laughs]. She said that was exaggerated by the kids, but we just got a kick out of it. I'd run things up on the machine for them and repair things. And the youngest boy, my daughter-in-law's down the street, I used to help him with his homework and he'd read. Because I used to read to him when he was little. I still have the Bernstein Bears." (VI2 620-629)

Samara did volunteer work at her sons' school besides working as a lunchtime supervisor. She explained that this helped her to maintain links with her sons' teachers as well as providing an opportunity to leave the isolation of her house on a daily basis.

"I was volunteering before anyway; I still go for volunteer, mostly for reading class or for something else. So they know me [laughs]. They said, 'Okay, if you don't feel bad, that's okay.' Its only a few hours, it doesn't hurt. And walking on the grass with the kids and talking to them, it's nice. Because the whole day I'm at
home, okay. You get on the bicycle, but it doesn’t help because still you’re home, you know.” (SAMARA2 92-98)

Tip described with obvious pleasure her role in a grandchild’s first birthday party and her return to her former notoriety as a baker of decorated cakes for special occasions.

“Yes, we had another big barbecue at [daughter’s] place. August 19th [grandson] was born, so it was the weekend after that. His first birthday! I made his first big bird cake. INT: Oh, that’s fun! Did he know what it was? TIP: Well, I don’t think so. But the other two did. Grandma’s cakes – they know Grandma’s cakes! I’ve been doing a little bit of that too, for friends. INT: Oh, baking for your friends? TIP: Yeah. I’m back to my old routine! I’m in demand for birthdays and weddings and such.” (TIP2 453-471)

Eva prepared a layette for the birth of a great-grandchild, and her creativity bridged generations as she knitted from the same pattern book she had used to make sweaters for her own infant daughter.

“Right now I’m knitting clothes for another great-grandchild, the eighteenth on the way. She’s due in October. INT: That’s a rush order! EVA: Well, I’ve got the bonnet, the coat, one mitten and the leggings made of one outfit. And I’m on the second sweater. Remember the old Beehive patterns, knit on two needles, sleeves and everything? That’s a favourite among people. I’m knitting from books that are fifty-eight years old. You know, like for my first daughter.” (EVA2 222-234)

Bamy retained ties with friends in a former neighbourhood. She combined visits to these friends with shopping for special food items at stores she used to frequent.

“But I’ve seen some of my old friends that I used to see when I lived up there in the West End. Oh, yeah, there’s a Chinese store there – they sell good fish. Whenever I go for a visit, I do some shopping. [husband] likes their fish: that’s the only fish he likes. And that’s what I’ve always liked to do. I don’t know whether I’ll get a chance for a while though, it’s been such hot weather.” (BAMY2 354-361)

At times, household activities were identified as strenuous or “heavy” and these tasks were shared, delegated or performed carefully. These references implied recognition of persistent limits to physical capability. Ruth, for example, described her efforts to clean
and hang curtains in her living room.

"I notice if I overdo it. One weekend I ended up with a pain over here, and I thought I hadn't done anything to cause it. The I realized that day, I had my sheers in the living room and I was taking those down to put my other clean sheers up, and this step thing is not tall enough for me – because I was too short. INT: Oh yes and you would have had to have stretched. RUTH: So I think that's what it was, and then that scared me and I never went back to it. So my daughter came down to do it. My daughter had this guy come in from [department store] and he cleaned my carpet and stuff. So I did alright with the rest of it. All I really ever do is dust around and clean a bit. And you know, when you're on your own, you know... INT: Yes, you don't tend to have to tidy as much, do you?" (RUTH2 809-833)

Ann not only tried to change her expectations of herself as a homemaker; she avoided specific activities that were still deemed too heavy for her to perform. Instead, her husband took these tasks on. Here it is apparent that Ann was not solely responsible for the coordination of this arrangement. She states that her husband would not permit her to vacuum the carpets. Like Ruth, Ann points out that there was little need for these tasks to be performed frequently.

"He won't let me vacuum and he washes the floors. And of course we don't – it's just two people, it doesn't get that dirty. But he does vacuum every week and any of the lifting, I don't do the lifting." (ANN2 657-661)

Agata’s husband had suffered a stroke some years prior and was unable to consistently assist with housework, beyond occasional help with lifting. She solved this problem by dividing tasks up over time or by putting them off until she felt better able to tackle them. She periodically paid a “cleaning lady” to take care of vacuuming carpets and waxing floors.

"Well, sure, I used to be working more, you know. Like I would say wash the walls and that? No I can't do that now. Maybe later. Something like that, heavy stuff in the house, you know. INT: Were you able to do it before the surgery? With all the angina? AGATA: Yes, I could do that too – little bit by little bit, not
make myself tired. So I could do this you know. So this — I was doing in this room maybe in one day. So I would do that room maybe... in two days. And I do, yes, now just a little bit; not make myself tired.” (AGATA2 22-34)

Laverne resumed full responsibility for homemaking just before her return to paid employment. She described her efforts to pace chores so that she could find time to rest at the weekends. But she also pointed out a need to conserve energy for her daytime exertions during the week as well.

“So usually I make supper with the kids, or if there’s no kids home, then I grab something to eat. Most of the time [daughter] is here. I’ve done washing, I’ve done cleaning upstairs, do the bathroom, so on and so forth, try to do something, a little something every night. I don’t want to leave everything for the weekend, and yet I don’t want to tire myself out totally. I ask [daughter] to help me sometimes, she helps with the vacuuming and so forth. Just a matter of, ahm, doing something, and then we just sit down and watch TV to relax.” (LAVERNE2 178-187)

Gert explained that her husband was willing to help with housework when some tasks were too demanding. However, there were conditions, such as his availability or her reluctance to relinquish her independence, under which she might complete tasks on her own. She took pride in her productivity in the kitchen, as other comments indicate, yet this work was paced to avoid tiring herself:

“He could, like, wash the windows for me. I don’t like dirty windows, so he washes them for me. And he’ll — if it’s too heavy for me, the groceries, he’ll bring them in. And he brings the washing up from downstairs if I, you know, if he happens to be there. If I want him to — and I still like to do it. I’m independent like that (chuckles).” (GERT2 389-394)

***

“And then I have fruit, vegetables, I do them up too, I’ve been canning too. so...Yes, I did twenty-five quarts of tomato sauce. Not all at one time, though. And I do my beans up and freeze them. So you know, I have done some work. It helps in the winter time.” (GERT2 361-366)
Despite efforts to regulate activity to avoid exertion, some respondents undertook extraordinary projects designed to reorganize living space or make their homes more attractive. These decorative touches often involved extensive change and labour. Cookie and Emma actually moved house during the time between the first and second interview. Cookie did so because her partner did not consider an apartment a home and wanted to rent a house, while Emma found her financial situation precarious and sold her condominium to raise money. Emma also reasoned that her condominium was too spacious to clean without exhausting herself. With their comments about these events and activities, the women indicated that cleanliness was not the only visible indicator of good housekeeping skills – the attractiveness of a home was an important attribute.

"I was back to painting the wall (laughs) with a brush not too long ago. It’s alright. I felt fine; there wasn’t lifting or straining. I do love to paint. I don’t have any artistic abilities (laughs) so painting the walls is my delight. The house is my work of art! I was doing a little bit of that and up at the cottage I hope to – I have some pieces of old furniture I hope to strip and fix up and that sort of thing."
(ANN2 662671)

***

"[Condo] was just too big; it was too big for me. I knew it was too big for me when I bought it, but I was used to a bigger place and I couldn’t adjust to a smaller place. And it was just that I couldn’t keep up. I was a fanatic at house cleaning to begin with, and I just couldn’t keep up to...to doing it all. (EMMA2 468-473)

***

"The only thing is, you know, I keep thinking about this place. it just isn’t my place yet until I’ve done some decorating. And then I think, well, I’m going to get going, get some energy tomorrow. I’m going to do it. Then I can’t get up the next day. See, look, I have the frames and baseboard all taped up, the paint’s all sitting there, I bought paint for here and my bedroom. But it, you know, you have to take it day by day.” (EMMA2 766-773)
"We’re going to have all the rugs cleaned next week and all the carpeting and everything. And then I’ll be pretty well near where I want. I made all these bedroom curtains since I last saw you. INT: Wow, you’ve been busy! EVA: Yeah! They go from one to – the wall is that long as well; and all these windows. So I bought 80 panels, 60 into the processing... no, I guess it wasn’t 80, it was 120 I bought. And pleated them all across the top. Oh, they look nice! And I put white room darkening blinds up too.” (EVA2 639-651)

***

“And we just moved our computer room all downstairs, the boys moved it this morning. We just have to take [son’s] bed apart and move him upstairs, so as soon as we get the bed out then I can start getting everything together. I can’t believe I had all that stuff in the room upstairs and now it’s in the rec room and it’s totally full! But it’ll be better having that work space downstairs instead of up.” (LAVERNE2 328-335)

Decorating and reordering were for these participants an important part of the work of appropriating a living space in order to make it a home. As these quotes illustrate, a home is a dynamic space. Rooms take on new uses and appearances as colour, decorative objects, furniture and other contents are shifted. These women not only participated in the labour associated with these tasks. They also created visions that directed these changes. Eva said she was “pretty well near” a point of comfort with the appearance and cleanliness of her apartment. Emma complained that she could not recognize or identify her new apartment as “my place” until she had summoned the energy to paint it. Laverne decided that a computer room in the basement would be a better use of space in her home. Situating themselves in their homes involved transforming the appearance and function of certain spaces so that these places were aesthetically pleasing and useful.

In summary, activity in the second, third, and fourth months after surgery revealed
the transformative processes associated with situating self care within everyday routines after a catastrophic confrontation with physical vulnerability and mortality. The implementation of medical recommendations for self care formed a series of embodied and cognitive accomplishments which proceeded differently for each woman. Learning and assimilating prescriptions for activity, diet and personal health management were challenging endeavours that often conflicted with other discursively driven initiatives and values. The participants described in their narratives an appropriation of knowledge through which they ceased to be the objects of teaching and became the subjects of their own active critical use of information (Freire, 1999). As we have seen, there were barriers to this appropriation, but certain influences served to facilitate learning. In the next section, I examine closely the microsocial influences on experiential learning and everyday patterns of activity.

**Situating Self With Others**

Although it is possible to find in the participants’ accounts relations that many social scientists refer to as social support, it is also apparent that social ties are complex and contradictory. If, as many authors argue, women’s unpaid work in the home is vital to the functioning of individual family members and to the productivity of the labour force on which the formal economy is founded, this work cannot simply be neglected until a woman is well enough to resume her customary routine. Indeed, the assumption that a woman would, at some point, actually recommence responsibility for homemaking was implicit in many of the respondents’ statements. As noted in the previous chapter, some women were compelled to almost immediately take on tasks such as meal preparation.
caregiving, laundry and cleaning because there was no one available, willing or knowledgeable enough to perform the work. In some cases there was no one else who could attend to the finer details of coordinating and maintaining a home.

In the cases of the younger participants with partners and children, these issues were particularly urgent. Although family members “helped out” to a greater or lesser extent, indicating sincere concern for the health and recovery of their partner or mother, there was also a general reluctance to continue these instrumentally supportive activities beyond a certain point of discomfort. Although there were instances of intense observation wherein the women were required by family members and health professionals to demonstrate their compliance with the requisites of personal health management, the women were also compelled to provide homemaking services. Their bodies were contested ground in contradictory ways. Attention to the physical health needs of participants’ bodies was mandated by the medicalized discourse of self care and by the caring concern of their loved ones who feared losing them. However, they were called to the embodied work of homemaking by these same loved ones.

Laverne provides an example of this paradoxical struggle. During our first meeting, she was overwhelmed by her partner’s determination to protect her from the physical strain of housework. He juggled full time employment, cleaning and cooking, and often accompanied Laverne on her walks. Laverne’s extended family monitored her progress carefully, as noted in this excerpt:

“Like I said, when we were up at the cottage the first little bit, you know, and everybody is always saying, if you’re going to pick up something, ’I’ll do that for you’ and - like I said - it just gets a little too much. Where, ’Don’t tell me I can’t do something anymore.’ Now I’m getting better, I want to do for myself, and you
know, I won’t do it if it’s going to hurt me. Now, some women, some people they’re really dumb, because they’ll just go ahead and do whatever they did before. If that’s what they want to do is hurt themselves, then that’s stupid.” (LAVERNE2 542-553)

Laverne understood that self care involved careful, intelligent attention to revising previous health practices, and that her family was concerned enough about this issue to instruct her in this enterprise and anticipate her needs. When she returned part time to her paid employment, she carefully nurtured her energy reserves with naps. She faced a three quarter hour commute to the city and another on the return journey. Nevertheless, she was pleased to discover that she had developed sufficient endurance to forgo regular naps by the time she increased her working day to full time hours.

“And then when I started back full days, I think I only had a couple of days where I came home and had an hour’s nap after work, because I was really tired. But once I had that nap and then went to bed, fairly decent time, I was fine.” (LAVERNE2 315-319)

It was fascinating to discover that, by our second interview, Laverne was balancing full time employment, almost an hour and a half of commuting time per day, learning a low cholesterol diet and performing most homemaking activities. Often, on her return home, her husband was absent because of overtime or evening hours at his own job.

“So usually I make supper with the kids, or if there’s no kids home, then I grab something to eat. Most of the time [daughter] is here. I’ve done washing, I’ve done cleaning upstairs, do the bathroom, so on and so forth, try to do something, a little something every night. I don’t want to leave everything for the weekend, and yet I don’t want to tire myself out totally. I ask [daughter] to help me sometimes, she helps with the vacuuming and so forth. Just a matter of, ahm, doing something, and then we just sit down and watch TV to relax.” (LAVERNE2 178-187)

When I asked Laverne how she decided to take on more of the work of homemaking, she described three separate pivotal points. The first was continuous with her declaration of
independence from the surveillance of family members.

“I was bored stiff up at the ccliffe. I just wanted something to do.” (LAVERNE2 216-217)

But soon after making this comment, she added that a sense of partnership was missing when her husband did all of the homemaking, including “waiting on” guests at the cottage. Laverne stated that she preferred working as a team with her husband when they entertained. She noted, without irony, further comment or analysis, that her husband complained of being “sick of” homemaking at that point.

“And I said to him, I said, ‘I can’t stand this any longer.’ I mean it’s nice to have everything done for you, and it was a great help having [spouse], he did everything. But when we had my sister and my niece and a friend up, they stayed for a weekend, it was so much nicer for [spouse] not to have to wait on them hand and foot. And I do – you know, it’s normally what you do when somebody stays. But I think it was nice for him again to have us work together rather than him doing everything. Actually, he said to me, he says, ‘I didn’t think I’d ever get sick of waiting on people’! (laughs) Poor [spouse] what can I say? But anyway, everything is getting back to normal now. I do – like I said, I do the washing, I do the vacuuming, you know, and really, there’s not much I don’t...I’ve washed the floors.” (LAVERNE2 231-244)

However, at a much later point in the interview, Laverne described an outburst wherein her husband clearly indicated that he could no longer cope with his extraordinary workload. She excused his irritability by referring to the stress of caregiving and housekeeping, with which she herself was very familiar. She further reasoned that their close partnership required honesty. Yet she was tearful during the confrontation and revealed guilt feelings over her husband’s overlooked health needs.

“We were out walking one day, actually it was just before we went to the ccliffe. I was reminding him about something that needed to be done. and I – [spouse] never gets upset. And he turned around and he said to me while we were walking, he said, “You know. I just can’t do everything!” And you could tell at this point that it was...it was getting to him. Like it was now, he didn’t want to do
everything any more, and I of course, the emotional situation I was in, I just broke into tears. And he said, ‘You know, I didn’t mean...’ he said, ‘I shouldn’t have said that.’ (chuckles) He said, ‘I didn’t mean to say that.’ And I said, ‘Yeah, but if you don’t tell me how you feel, whether I cry or not, we’re never going to solve this.’ But you know, like he said, ‘I shouldn’t have said that’...[long pause] So it was just one of those, you know, you could tell that he was – he wanted me to get better quicker, do you know what I mean? INT: Yes, yes. LAVERNE: It was very difficult for him. It’s, you know, he was doing everything. I mean sure, and I was even asking – like he’s got asthma, so he doesn’t walk with me a lot. But he made the effort to walk with me all the time I was walking. We’d take the dogs for a walk and you know, we wouldn’t walk a horrendous amount because I know he can’t handle it. Like he still put the effort out, and this was after working all day, and so on and so forth. He’d take me out for a walk, so he was really pushing it, and trying to do everything.” (LAVERNE2 662-709)

Here we see the various layers of accountability. At an earlier point in the interview, Laverne was describing her increasing vigour and need to break from her family’s vigilant concern. As Luigi explained in the previous chapter these close others required reassurance. Like Luigi, Laverne demonstrated her fitness to pursue everyday routines by taking on homemaking and hostessing responsibilities. She argued that she could do this in a manner that preserved her health. In this account, resuming housework was an independent decision made by herself alone. Later, the account was amended to include a discursive reference to feminine comportment. A wife is her husband’s partner, and Laverne explained that she enjoyed the feeling of partnership that came from sharing the tasks involved in homemaking. Later in the interview, when it became clear that she was actually carrying the full weight of homemaking responsibility once she returned to her paid employment, Laverne amended the account once again. She recalled for me that her husband had been greatly stressed by the double burden of homemaking and employment. She made reference to his problem with asthma and her own feelings of guilt at having subjected him to this strain.
Poor health or exhaustion was cited in other narratives as a limitation to the involvement of a partner. Bamy's partner was unable to consistently provide assistance.

"[spouse], well he vacuumed a bit this week, but it's so hot and he has a bad back. It bothers him sometimes and he can't do heavy lifting. So sometimes we just let it go without too much cleaning." (BAMY2 721-723)

Agata explained that her husband helped her as much as he could, but was recovering from a stroke that occurred some time prior to her MI.

"He feels better. Yeah, he's not the same. he's still, like he had the stroke. you know, and he's walking very slow. But he's getting better, yeah. He's getting better and he had his medications and he's going to the doctor, but he's doing alright. Most of the day he's doing for himself, yeah. Mostly he's getting there. He can go to wash himself and he's doing well." (AGATA2 743-748)

Eva continued to be more absorbed with her husband's health than the problematic of unequal responsibility. She explained that his episode of thrombophlebitis remained embedded in her memory.

"I'm very concerned about his blood clotting, you know, especially after going through that time when he had it in the brain and we didn't know. I couldn't stand to see him go through that again." (EVA2 677-680)

Olga openly complained that her husband and son were not helpful with the household chores, and because they did not share her concern with the appearance of the home, they tended to add to her workload.

"You know I have a very lovely family and that, you know, but there are things that bother me with those people. Like there's this car seat, this thing for...almost a month standing here in the living room. INT: A car seat? OLGA: Yeah. I pushed it last night into the hall to get it out of here. And it was standing right here. Because my friend's daughter went back to [distant university] a month ago and they bought our van. So they took the seat out. And now this thing is standing here and I was saying the other day it might be standing here still left for Christmas, you know. So, but because you were coming here today. I tried to get them to get it out. So I pushed it there..." (OLGA2 240-258)
Olga raised the question of the visibility of disorder in open areas of the house when she mentioned that my impending visit prompted her to take action. She was unable to enlist the help of her son and husband and so she finally moved the seat herself. However, she later added that her husband could not be expected to be interested in housework by the time he got home from an overtime shift.

“Yes, they are very nice people but they are not very helpful. On the other hand, he works twelve hours a day, you know, and he’s tired when he comes home. He doesn’t want to make housework.” (OLGA2 377-380)

The intimacy of marriage entangles women still further in the unequal distribution of responsibility for homemaking. Affection, partnership and even the status of being a married woman were cited as influences that transcended any suggestion of unfairness. Here the notion of “accounting” took on an actuarial tone as the women delineated the social and interpersonal equations that justified the uneven distribution of household responsibility. As we saw earlier, Laverne referred to the importance of partnership in her marriage, implying that the extra burden of homemaking was the price exacted for a harmonious marital relationship. She mused that it was more comfortable for her to share the work of homemaking with her husband, particularly the highly visible work of entertaining. Eva touched on similar issues. She considered herself lucky to be married to a man who was widely liked and admired. His great popularity conferred special status upon her and this understanding was reinforced by the comments of others, who ‘witnessed’ her good fortune.

“Oh, so many people love him. You go out in the street, you want to see the way they talk to him. Now, anywhere I go they tell me how lucky I was to get a man like [spouse]. And even when we were out yesterday, my friend came up and she said, you know, ‘All the ladies like [spouse] because he is so kind, but you were
the only one that could catch his eye.' (Laughs)” (EVA2 688-695)

Olga elaborated on the importance of affection and shared humour when she described the “cute” notes that her husband left her, weighing the benefits of attachment against his persistent lack of interest in household tasks.

“He left me that note there today; he writes little stories in Spanish. Now, I don’t understand totally, but I laugh my head off when I read it. And such nonsense! (laughing) But it is a cute nonsense, you know. He is nice, but not very helpful.” (OLGA2 374-377)

Ann described the symbiotic relationship she shared with her husband. He was unable to type, but taught computer programmes at a community college. She was an expert keyboarder and felt a need for intellectual stimulation. In this equation, only one partner was employed by the college, but both laboured for the wages of that one position. Ann noted earlier in the interview that she and her husband actually shared few interests; he did not take the same pleasure she did in church activities and cultural events. She found that their mutual involvement in his career cemented their partnership.

“In the fall when he teaches computers, I help him quite a bit because he has a lot of computer marking and then he doesn’t do keyboard at all. I do all the typing for him. And it’s something that we do together that I rather enjoy, and it keeps my mind active.... So this I felt was something that we could do together and when he retires, if things work out, he hopes to be doing some computer counselling and that sort of thing. So it’s something that would carry on. And I like it, it’s a challenge. ‘Specially this new programme that we’re going to be learning this summer so that he can teach it in the fall. It will be interesting. I like to keep active in my mind.” (ANN2 280-304)

Ann’s partner in turn continued to do the vacuuming and heavy lifting. He also shared Ann’s enthusiasm for improving and decorating their home. However, this careful balance obscures the fact that Ann’s husband held the paying position in the labour force and Ann occupied an unpaid position as a homemaker.
The grounding and attachment offered by a marital partner is at no time more apparent than when that partnership is severed by death or divorce. Sonia confided in an emotional moment that she had a "double problem". She was widowed and her health was poor. Her life no longer bore the promise of the familiar and everyday.

"I look at things, but everything is so changed. I'm seeing everything now so different. (Short pause) Some widows, at least they're healthy, they can walk around, you know, it's different. But then I am missing my husband and feeling so...a double problem. Same with everything I do." (SONIA2 325-329)

Emma and Luigi, both divorced when their middle-aged husbands sought younger partners, considered material and emotional inequities that went beyond the division of household labour. Both confronted problems that revealed the vulnerability of the homemaking woman. Emma remained in poor health and was still unable to go back to paid employment at the time of our second interview. Because she was previously employed as temporary office worker, she did not have workplace benefits. Her absence from the labour force while she raised her daughters and provided care for her dying father meant that she had no savings other than the proceeds from the sale of her condominium apartment. As a single woman, she faced poverty and grappled with the complexities of application procedures at a time when she felt fatigued and unwell. She was chastised by her daughter for her lack of foresight.

"I went on sick benefits. Now I got that right up to...and then I guess because my operation and moving, and I wasn't thinking of what was going to happen to the next month, I didn't apply for disability soon enough. Well, I'm still sitting waiting for something. And then somebody said to me 'Well, why don't you apply for early CPP?' ....Then my daughter up north, she's giving me shit and saying 'Well mom, you should of thought of this and you should have thought of that and should have thought of something else. Sure I got money in the bank from my sale [of condo], but you know, here I pay for like a year and a half post-dated cheques for my rent, and the rent's not what you call cheap. It's not really, really
expensive, but it’s far from being cheap. And, ahm, but being 60, I’m at that age where you’re not...Well, in fact, I said to my daughter, I can’t wait now until I’m 65 to get this for nothing. I get that for nothing and get something else for free. I’m sitting in limbo in between that age.” (EMMA2 504-531)

Luigi revealed the emotional agony of a solitude she had never wanted or sought. She reflected on her conspicuous social situation:

“My boss – our boss, the CEO and the president of the company -- had a barbecue for the executive staff. And a list came out of who was attending and it was, you know, Sue and Larry, and Jean and Dave, and then there was me, just me. There were thirty, thirty couples. And me. Well, I just burst into tears. And I thought, I’m not going, I can’t go, I just can’t go. And, ahm...and the girls said, ‘Yes, you’re coming, we understand. But if you try, you’ll have a lovely time.’ And I in one way wanted to meet the wives and the husbands of the people that I work with, that I talk to, especially my two guys. But, ‘I just can’t go. I just can’t walk in there.’ So they...they met me, they and their husbands, and they met me around the corner and we went in together. So I didn’t have to walk in alone, there were five of us. IP: It was like Noah’s Ark, everyone in twos! LUIGI: In twos, you know! And I can’t get used to that and that’s difficult and I miss...I miss being part of couples. So that’s the one...that’s the major...that’s my next major hurdle, is to try to live with, you know, and not feel like I’m a second class citizen because I don’t have someone in my life.” (LUIGI2 301-337)

Obviously, neither woman reported conflicts with a partner over the division of household labour, but their status as divorced women gave salience to other structural inequities.

Jack (1991, 1999) notes that these inequities, among other influences, encourage women to overlook and rationalize away the oppressive aspects of the discourse of homemaking.

It was apparent that homemaking was the greatest concern to those women who had the most people living with them. The work was done for the benefit of others and expanded with the number of people who inhabited a household. Ruth and Brownie noted that because they lived alone, there was very little reason to clean on a regular basis.

Emma’s definition of home was voluntarily contracted from a large two storey condominium to a small one bedroom apartment so that she would have less homemaking
to tax her waning physical reserves. In contrast, Cookie moved to a larger home to suit the needs of her partner and Olga cleared the debris left by her husband and son. Those who appeared to have more potential helpers appeared least able to draw on the assistance of those around them.

The consciousness embedded within the subject position of homemaker is intertwined with the relations of heterosexual spousal partnerships and construction of gender. Rose (1999) contends that the persistence of an unequal division of domestic labour is indicative of the ways that homemaking activities construct and support heterosexuality and masculinity. It rests on the premise that women are innately suited to the domestic tasks of nurturance and sustenance while men are biologically more predisposed to the demands of competition in the cash nexus. Women’s domesticity is supposed to nurture children and support the labours of men; femininity is measured in terms of concern and care, for instance.

Accountability for feminine comportment within the idiom associated with the gendered discourse of homemaking requires concern with such elements as the health and energy reserves of male partners, their emotional needs and their satisfaction with the marital relationship (Jack, 1999). Attention to these issues contradicted and detracted from the central tenets of the medicalized discourse of self care. At this intersection, younger women such as Olga, Cookie, Laverne and Samara struggled to envision a means of balancing their own health needs, the focus on others embedded in the work of homemaking and, in some cases, the rigours of participation in the labour force. Cookie, at the extreme end of this problematic, often subordinated her own health needs in her
efforts to soothe her partner. Other women, like Vi and Olivia, used the discursive tenets of self care to maintain what they considered a desirable level of participation in homemaking activities.

Discussion

Building on the theories of Bakhtin (1981, 1986), Volosinov (1973) and Mead (1947), Smith develops a position which enables "language, or rather speech and writing, to be explored for how they coordinate or align individual consciousnesses, hence as organization" (1999, p.142). She draws attention to how people are discursively active - that is, how they read, write, interpret or act in concert with discourse. My focus in this chapter is on how study participants were discursively active in the everyday and local from their subject positions as homemakers and as women with heart disease learning the foundations of self care. The conflicts that arose at the intersection of these two discourses illustrate ways that people take up medicalized information within the context of the local world where consciousness is informed by many idioms. It was the task of these women to situate themselves and their activities between two worlds in common: the relatively new and unfamiliar world of the endangered heart (shared with health professionals); and the world of the home (shared with family, friends and community).

The observation that women bear the weight of responsibility for homemaking is not new, but the persistence of this social organization of domestic labour has been the object of considerable study and debate. After an extensive examination of international literature, Floro (1996) concluded that, although women’s increased participation in the paid labour force has corresponded with reductions in the amount of time spent in unpaid
domestic labour, these reductions are minimal and amount to an increased burden in combination with a paid workday. Shelton and John (1996) reported a weak or nonexistent relationship between women's hours of paid employment and their partners' share of the housework. On the other hand, men's hours of paid employment are consistently and negatively associated with participation in domestic chores. Brines (1994) made similar observations, noting that unemployed men do less housework than employed men. Jackson (1996) found that Canadian women spend 78% more time on unpaid domestic work than men do. Although the participation of Canadian women in the paid labour force nearly doubled since 1961, the time they spent on homemaking tasks decreased by 11% in the same period. In contrast, men increased the time they spent on domestic tasks by 6% since 1961 (Jackson, 1996).

Korosec-Serfaty (1985) explains that the dwelling or home is the locus of an uneasy juxtaposition between the hidden and the visible. Her analysis examines the discursive significance of the home and implicitly shows how people are socially situated in homes. A home exists as a refuge from the "outside". It affords privacy and enables certain aspects of the self to be hidden from the public gaze and knowledge. The home offers closets, cupboards, doors and private rooms which conceal the organic and untidy. The home also opens to the outside to offer hospitality, participation in neighbourhood and mutual assistance. It is "simultaneously a visage and a mask" (Korosec-Serfaty, 1985, p. 78), which sustains the link between self and the social world by providing a place of refuge and a mode of self-expression. The home becomes a manifestation of our practices, a testimony to selfhood. The management of the home space for the purposes
of physical sustenance and reproduction of a labour force is thus hooked into the appropriation of selfhood and identity. Ann’s freshly painted livingroom walls were her “work of art” although she spoke of her efforts to reconcile herself with the unmade bed concealed in the less public areas of the home. Brownie referred humourously to standards of public health, while Ruth reported that a relative commented on her new, relaxed approach to housecleaning. Laverne wanted to resume her highly visible duties as a hostess when family visited her cottage.

This discussion draws on Marx’s elaboration of the concept of appropriation, in which he argues that the positive supersession of an object is not to be construed as “direct and exclusive enjoyment, as possession and having” (McLellan, 1977, p.91). Appropriation engages all of the possible sensuous modes of human relatedness to the world in an expression of selfhood or of human reality. The individual reproduces herself in relation to an object as she acts upon or creates it in the richness of all her faculties. Appropriation is a transformation of an object, and simultaneously, of the self, often in situations where reality has already been acted upon by others. Hence, explains Korosec-Serfaty (1985), “ornamentation, maintenance, and housework (in a home that has seldom been built by the dweller) evidence this drive to appropriate it” (p.75). In her view, appropriation is not expressed through the ownership of a house, but through the visible personalization of that living space.

When the work of appropriation ceases to be imbued with personal meaning, alienation results. The activities no longer enliven or express selfhood, nor do they invite full sensuous engagement. The contrast between Olivia’s pride in her home and Cookie’s
lack of enthusiasm for her new residence illustrates this point. Cookie’s homemaking efforts were directed towards soothing her partner and supporting his efforts to remain sober. The rented house was an expression of his vision of himself and a suitable abode for the person he strove to be. Cookie inhabited the house, but did not represent herself in that space. It was her task to manage that space, but not on her own behalf.

The complexity of managing the interface between the visible and the concealed in the home is a powerful component of homemaking. As Cookie’s example indicates, this is a matter that is complicated by cohabitation. The appropriation of a home on behalf of a family entails considerably more management of the signs of conflict and disorder to render them invisible or at least minimal. An ambient living space is a visible manifestation of familial identity and thus responsibility for its creation is accompanied by a full measure of accountability. That Margaret congratulates herself on continuing to protect time for her walks and exercises implies that her time is ordinarily the reserve of others. Olivia justified her delegation of heavier tasks to her husband by making narrative reference to the discourse of self care. Samara juggled her family’s taste for meat dishes and forbidden treats with her own increasingly restricted dietary regimen to create meals that approximated the family’s preferences. The division of household responsibility perpetuates gender identity. “Good” women in Olga’s family immediately clean up after a meal. According to many anecdotes, men do not see messes or out of place objects, and they have to be told how to clean a house.

Like homemaking, self care was subject to the observation of others. As noted in the previous chapter, the very visibility of self care has been conceptualized by some
authors as facilitating a complex of social control activities. However, the activities of the women and health professionals who participated in this investigation were concerted by a common concern with endangered hearts - and lives in peril. Health professionals were charged with the responsibility of seeking and implementing solutions to the problem of heart disease. The women sought assistance, and attempted to learn strategies of risk management from these health professionals. This process was confounded by the different understandings of the heart and heart disease which were held by the two groups.

As pointed out in the first chapter, health professionals regard the heart as an organ of a particular description and with specific purposes. It was accepted that CAD is caused by "risk factors", many of which are deemed avoidable. It was understood that in the treatment of heart disease, the ideal outcome was not only to repair the heart, but to revise practices which create risk. While many of the women and their family members were aware of this discursive emphasis on risk (and danger) management, their hearts and bodies were already situated within the local, active context of the home. Enacting recommended changes to personal health practices was complicated by the situations in which they were enacted.

The discursive contrasts between the locations in which risk management recommendations were made and the locations in which they were enacted lead to conflicts which impeded change. The discursive treatment of "the diet" by health professionals, for example, suggests that a diet is a noun or an object. It exists in its most simplified form as fact sheets or pamphlets which list foods high in undesired forms of fat or other toxic ingredients. Patients are instructed to avoid these foods and to eat certain
substitutes if necessary. However, the participants in this study also described "dieting" as a verb or set of embodied, sensual activities. The anecdotes of the most devoted adherents suggested a transformative appropriation of the knowledge contained in the medicalized purview of "the diet". Engagement of the self with the work and knowledge of dieting in the everyday and local world resulted in a new expression of selfhood. Tastes were reoriented, cravings were controlled and food preparation was reconsidered and relearned. However, this reconstruction of self as active in a new way within the home had to be reconciled with the work of maintaining familial habitation, or the habitual living practices of the family. Although heart disease endangered lives and bodies, dramatic changes to the social organization of homemaking threatened an enduring system of activity which defined and sustained each member.

Thus, the women were situated at the intersection of two worlds in common, and carried the responsibility of visibly adhering to tenets of self care at the same time as they maintained a visibly suitable home. Although a few achieved impressive transformations in their approaches to activity in both spheres, most still struggled to find a balance four months after their surgery. The diagnosis, heart disease, marked them as women with endangered hearts. Although surgery was performed to correct the problem of existing coronary occlusions, the presence of danger remained implicit within the activities of risk management. As Ann explained,

"Someone said to me after - this fella, he'd had a heart attack - and he said to me: That feeling does not go away for about a year, it's sort of like having an accident, and you keep looking in the mirror every time you stop so no one hits you. You know?" (ANN 316-331)

By managing risk ('checking rear view mirrors' - or by maintaining a strict dietary or
exercise regimen) the women were engaging in a discursive pattern of activity which markedly altered their approach to their lives, their bodies and their habitual practices. Aspects of self care were sometimes deliberately rejected because in preserving life they eroded the sensual joys or familial social relations that were also part of “living”.
CHAPTER NINE:
CONCLUSIONS

As stated earlier, this ethnography was intended to examine the social relations reflected in the instance of women's recovery from aortocoronary bypass surgery. I wanted to explore the conflicts and contradictions arising for women at locations where several situations and demands intersect: women's own health needs and their everyday/everynight domestic activities; professional discourse and the female body; the local and the extralocal. At these intersections, I encountered two overarching discourses: the medicalized discourse of self care, and the discourse of homemaking. Concrete activities were coordinated or organized around the tenets of these discourses. Conflicts between the two discursive influences found expression in the women's embodied activities. Each became a predominant influence during different events and in different sites. Yet each also was taken up and acted upon in different ways by each woman.

When I began this study, I expected to find a story that had a beginning, a crisis and a resolution. I expected to learn, as Keller (1991) had, that the experience of ACBS was encapsulated in a tale of a search for "normalcy" - a destination or location which could be reached as the body healed and certain changes were made to personal care practices. I expected there to be conflict and crisis as the tale unfolded and I expected these to arise as the demands of gender and home were challenged by new demands posed by altered health. But it became increasingly apparent towards the end of this project that for these women, at least, there was no arrival at a position of comfort and "normalcy", at least not within the four month period I studied. There was a story to be found within the
women's accounts, and it was one of journeys, locations and tensions. The journey was one of disjunctures, of confusing maps which translated poorly on unfamiliar terrain, and even more poorly on better known ground. And when attention was not fixed on deciphering these bewildering maps, all eyes, like Ann's, were darting between the rear view mirror and a frighteningly uncertain future.

Discussion of Major Findings

How Women Described Their Experiences of ACBS

Prior to diagnosis, embodied changes interrupted the everyday when routine activities could not be performed in comfort and with efficiency. The problem was first noticed as an inability to engage in simple activities that once were easily completed. At some point, these changes in their sensuous embodiment were recognized as deeply disruptive to daily routines and the women engaged with the techno-medical world. There was a discourse that guided their actions. They knew that changes in their bodies such as fatigue, shortness of breath and chest pain were possibly signals of ill health. These changes were problematic because they were barriers to the conduct of everyday activities. The women were already aware that these signs could be deciphered by a distinct category of professional: the family doctor. Family doctors were engaged in activities that were discursively based in the health sciences. They had learned how to recognize the alignment of certain signs and symptoms produced by the human body as indicative of specific problems or diagnoses.

Yet the interpretation of the real terrain of the body was an imperfect and social act. Some signs were known as "subjective": they had to be described or reported by the
ones that experienced them. If the women suspected a problem other than heart disease, they might omit mention of sensory experiences they considered irrelevant to the problem they considered more likely. Similarly, some cues were observed by physicians that were not relevant to the problem of heart disease, and these led to misinterpretation of the problem. This fallible process was embedded in a scientific context which was incomplete. The literature cited in the first chapter is replete with references to the inadequacy of knowledge about the diagnosis, treatment and prevention of heart disease in women. On this unstable ground, the women whose experiences, education, age, class and ethnicity aligned well with those of the physicians were best able to facilitate the work of diagnosis. But few of these women suspected heart disease.

Once the problem was deciphered and named as “heart disease” the women were repositioned socially as women with endangered hearts. They were in peril of fatal damage to their hearts, and this predicament was widely acknowledged to have resulted from adherence to harmful practices such as smoking, lack of exercise and a diet high in fats. Discursively, the women were marked as the authors of their own misfortune - although many, like Laverne and Eva, balanced a multitude of responsibilities, had contributing health conditions like arthritis or diabetes, or had strong family histories of heart disease. The discursive foundations of self care were imbued with moral overtones which obscured lives of obligation for the care and wellbeing of others and emphasized personal accountability for catastrophic illness. Accordingly, the women occupied a social position of some discomfort: they felt too unwell to pursue the often elusive information that was needed in order to successfully engage in better care of themselves, and they still
retained some or all of the responsibility for the care of others. Prior to surgery, many struggled with this conflicting social relocation, finding no real guidance toward a healthier organization of their obligations other than permission to temporarily relinquish some activities such as employment or heavier household chores. Again, the invisibility of the social relations of gender flawed the map, although the journey was made through dangerous territory.

The idiom of mortal risk justified extreme measures: the procedure known as ACBS was the most drastic of the possible responses to the problem. The women were profoundly displaced as this response was enacted. They were removed to a hospital which was a location coordinated by techno-medical discourse. Without the refuge of home and a familiar social context, social repositioning as patients erased the embodied particularities of the women’s lives. Anaesthetized, sedated, invaded by tubes and marked by incisions, their dispossessed bodies were the problematic sites of repair and reconstruction, but they ceased to be the familiar locus of feminine comportment. The terrain of their bodies was no longer recognizable to them or close others. Even visceral functions, which were usually invisible and unimaginable, were disturbingly revealed by the technologies of repair and monitoring. This radically altered and exposed terrain was reinterpreted for the women by health professionals. The women began to learn how to speak their bodies and their health in new ways - adopting an idiom that was both disembodied and distanced. Again, those who had experiences, education and demographic characteristics that enabled them to align with the hospital’s organization of activities described their stay in less alienated terms. They were successful in orientating
hospitd staff towards them as social beings with social needs. When their bodies ceased to be recognizably feminine, they obtained affirmation of their gender identity by participating in the care of others.

Within this context, the women were further indoctrinated into a medicalized discourse of self care which promoted adherence to specific practices associated with diet, exercise, activity resumption and stress management. The notion of health teaching was deeply embedded in the organization of professional activity within the hospital. Seminars were held to instruct patients and their families in a variety of areas: preparation for surgery, important dietary changes, activity resumption and general self care after discharge home. These seminars were taught by the nurses, physical therapists and dietitians who provided physical care and support services to patients after their surgery.

Yet, however important the project of health teaching might be, the work of these professionals was primarily governed by the discursive undercurrent of physical endangerment which was linked with the diagnosis of heart disease and the peril associated with the surgical response. At the time when this investigation was underway, seminars were offered on an irregular basis that coincided with the workloads of the seminar leaders. The content of the seminars was structured in a generalized manner according to the informational needs disclosed by patients in a survey, and they were presented in a mixed group format that was structured to allow questions and limited discussion. The idiom in which the information was constructed was pervaded with a perspective of the body which obscured the sensuous, active and gendered experiences of self care and highlighted the scientific, objectified effects of therapeutic regimens on the
body. Thus the women had irregular access to an incomplete map of the terrain of self care.

After discharge from hospital, relocation to the home heightened awareness that finding care for the family caregiver was problematic in many cases. As the site of health care, the home presented extraordinary challenges. Many women encountered a vacancy within the home: the absence of someone able and willing to coordinate and execute the activities of homemaking. Less available was the caregiving support of others who could interpret for the women and assist them to implement the fundamental activities of self care. The women were responsible to learn and operationalize the principles of a diet that would promote cardiovascular health, for example, but in the early days following surgery, many did not have the physical and cognitive stamina to accomplish this complex work. Furthermore, although the idiom of endangerment and risk management pervaded the world in common they held with health professionals, the women were relocated after hospitalization to another, more enduring world held in common with families, friends and neighbours - their homes. Although the pervasive danger involved in the diagnosis and treatment of heart disease had profoundly disrupted close relationships and shaken close others, this trauma underscored the discursive importance of the home as a site of stability and comfort. The maintenance of home for themselves and their loved ones was a component of emotional work which was accomplished coincidentally with physical labour as the women resumed their customary household activities.

In addition, policies and procedures governing home care services organized assistance in a fragmented manner which penalized women who ostensibly had family
“help” and obliged the few women who did receive services to coordinate or complete the work. Services were fragmented. Housecleaning and routine personal care activities were performed by different workers than those who monitored vital signs and incisions. Meals were prepared and delivered by another group of workers. Extended teaching and coaching about the foundations of heart health was not considered a function of home care although many of the respondents identified a need for considerable assistance in this area. Therefore, access to any type of health care worker in the home was very limited. The women and their families were expected to traverse a confusing maze of possibilities when problems arose. It was difficult to know which specialist to consult, whether or not there was a problem that required consultation and how to tell if progress was indeed being made. Although information about heart health was available from a variety of sources, including attending health professionals, the media, self help literature, acquaintances who were health professionals and acquaintances who had heart disease, there were contradictions and differences in advice that made it difficult for the women to undertake a programme of change. Again the map was convoluted and difficult to apply to the real terrain of the home.

In the ensuing months, repossession of their surgically reconstructed bodies was conditional upon demonstration of accountability for self care, yet care of others and coordination of the home were concurrent demands. In the first four weeks after surgery, most of the women did not feel well enough to tackle the considerable work of interpreting the tenets of self care into embodied practice. They had few resources to assist them in this pursuit. In the ensuing three months, they engaged in this work more
consistently. It became clear that they were working to situate themselves in a position that satisfied the discourses of home and endangered hearts, attempting to effect compromises between diverging demands.

Ironically, during this period, many were finally better able to learn the nature of the surgery they had undergone. Despite considerable obstacles encountered in attempts to obtain information, the women perceived that they held moral responsibility for their own accumulation of knowledge. The intensive learning and practice involved in understanding therapeutic regimens such as diet and exercise for heart health was minutely described by respondents such as Agata and Ruth. These narratives made it clear that activating the texts which deal with self care is contingent upon considerable translation into sensuous, embodied terms. Understanding bodily cues in response to activity and treatment was another skill that required considerable time and exposure to the discursive idiom employed by health professionals. Finding a position of comfort between the discourses of home and self care was extraordinarily challenging and it was apparent that this ground shifted continuously with the changing demands of homemaking and health.

The discourses of homemaking and medicalized self care were made visible to me in the women’s accounts of their activities and the challenges they faced after surgery. The discourses were also present in health professionals’ descriptions of their work and the knowledge they had gleaned from contacts with women who had heart disease. None of these informants referred to discourse as such, and none directly described the ways in which they were discursively active. Yet their language and reflections revealed the contours of these two discourses.
The Discourse of Homemaking

It became clear from the women’s narratives that homemaking may indeed involve creation or reproduction of identity as a woman, but it also involves representation of the social identities of others and groups of others. Like the heart, the home may be described as a physical dwelling with dimensions, constituent parts and functions or it may be understood as a symbol which possesses considerable social significance. Homemaking, then, involves both the maintenance of the material properties of the home and managing symbolic facets. However, the activities of homemaking also have productive social utility. The discursive foundations of homemaking promote the organization of activities in a manner that realizes this utility.

Women represent the family as clean and orderly through careful management of visible spaces and concealment of the undesirable (Korosec-Serfaty, 1985). This work is not simply a matter of creative representation of the family’s ability to control its material surroundings. Invasion of the organic and the disorderly is a threat to health. Brownie’s joke about closure of her home by the health department exaggerates this point but reveals the links to a social structure that benefits from the health of its population in several ways. Prevention of illness limits spending on health care in a climate of cost containment. It maintains a functioning labour force and controls spending on sick benefits. Olga accepted her husband’s complete lack of participation in housework because he was tired after a long day at work. She was not employed outside of the home and believed that it was her responsibility to sustain those who were.

The sense of obligation to family and society was deeply embedded in
consciousness and was reproduced intersubjectively, as the home was known to be visible to others. It was deeply interpenetrated with the reproduction of gender, with the result that discharging obligations to others became constitutive of personal adequacy. Ann felt uneasy about leaving a bed unmade and was proud of work that made the house visibly more attractive. Ruth was teased by a female relative for letting her standards slip, while Olga was concerned that she would not be considered a good woman if she did not clean the table immediately after a meal. Men, on the other hand, were known to be oblivious to tasks that needed attention. With the exception of Olivia’s husband, men were unable to do certain tasks because they were not trained to know how much detergent to add to washing machines or how to shop for groceries in an effective way. Olga pointed out that messes were the domain of women and it was their task to draw the attention of sons and husbands to work that needed masculine participation. Samara called upon her husband and sons to do heavier tasks because these were compatible with the notion that masculinity was constituted in physical strength. Husbands and sons were constructed as men by their lack of spontaneous participation. The unequal division of domestic labour supports the identification of men as masculine and heterosexual (Rose, 1999).

The home is a location that also indicates the level of prosperity enjoyed by its owners and bears the trappings of social class. It is linked to the economic organization of social structures. In their working class neighbourhood, Olivia and her husband carefully decorated and maintained their home and displayed it with pride. They had worked hard to purchase it. Cookie’s move from an apartment to a rented house a few months after her surgery was a “move up” in the class structure. Although she and her partner did not
own the house, they were able to present the appearance of greater prosperity that was
difficult to portray in the older high rise apartment building they previously inhabited. The
occupation of a single family dwelling offered more space for recreation and diversion -
Cookie’s partner had a room in the basement to play his accordion and there was a deck at
the back entrance for summer entertaining. Cookie obliged her partner’s wish to move
because of her awareness that his ongoing sense of inadequacy might trigger a relapse
from his current state of sobriety. Her efforts to pacify him contained his rage and
suppressed its public expression. Her emotional care maintained his ability to report to his
place of employment and assisted in prevention of cost to the health care system incurred
through his alcoholism.

On the other hand, Emma “moved down” from a large two-storey condominium to
a small rented apartment. She portrayed the move as one of necessity, not of choice. As a
single woman in very poor health, she could not continue to maintain her home
singlehandedly. She believed that a smaller space would be easier to keep clean and tidy -
and the discursive importance of control over the organic and disorderly supported her
actions. However, this was also an economic strategy to realize the equity she held in her
condominium residence. Emma had no source of income because her work as a
temporary employee through an agency did not entitle her to company benefits. She was
entitled to disability benefits through government welfare payments, but this money was
slow in arriving because she had been too unwell to apply immediately after her surgery.
She also anticipated that the amount of the benefits would be insufficient to maintain her
condominium in any case. Although her move was depicted as one of necessity, it was
also apparent that it supported a system of welfare that penalizes those who pursue patterns of episodic employment to allow them to raise children and provide care for sick family members. The economy rests on the unpaid and socially productive labours of these women, but they are not protected or recognized in the same way that other categories of workers are.

The narratives offered by Emma and Cookie suggest that many aspects of homemaking are done on behalf of others rather than simply to construct personal identity. These women did not promote their own health or financial wellbeing in the conduct of their labours. In other cases, however, men offered extensive assistance and support to their spouses. Laverne’s husband stepped in as a replacement homemaker while she healed. She interpreted his efforts as evidence of his love and concern for her - yet there was no pretense that this was a permanent arrangement. Prior to returning to her place of employment, Laverne was made aware that her partner was suffering because of his unusual burdens. She saw their partnership through the eyes of others as she participated in the activities of serving weekend guests with her husband. A prosperous, harmonious marriage and home was visibly portrayed in the work of entertaining at their cottage. In sharing their home, they promoted the enjoyment and leisure of others. In finally refusing the help of guests, Laverne eschewed the opportunity to rest and she protected her husband, who was showing signs of exhaustion.

The home is a symbol of stability and shelter. It displays in its location and appearance the economic prosperity of its inhabitants, yet it is also representative of an investment of financial resources. In every family, regardless of a woman’s occupational
status, the dissolution of a marital partnership results in division of properties and financial holdings. Luigi and Emma spoke of the losses involved in divorce: the dismantling of a home and way of life, loss of identity as a satisfactory partner, diminished economic security, and concern about the emotional pain suffered by children. Olga and Ann were among the women who were financially dependent on their partners. Olga was distressed that she had poor employment prospects because of her inability to write in English, and Ann invested her efforts in supporting her husband’s career by executing some of his paid responsibilities for him. Neither spoke of their vulnerability, but Luigi and Emma’s narratives highlight the material and social implications of divorce. Awareness of these unspoken implications serve as cautionary influences - an unequal division of household labour may be more easily tolerated when the alternatives are weighed and considered. Even Laverne with her established career and good income was deeply concerned to maintain her partnership with her husband by resuming responsibility for housekeeping even as she returned to her employment responsibilities and a long daily commute.

It was apparent that any change in the participation of the women in homemaking represented a threat to the ambient properties of the home and to the emotional and physical wellbeing of other inhabitants. The women physically enacted reassuring signs of love and social locatedness in the family. These activities were entangled with the definitions of family relationships and extended beyond the actual location of the home. Tip experienced terrible distress when her grandchildren did not recognize her as a grandmother in the hospital. Her body was pierced by tubes and marked by bandages, thus it suggested injury and pain rather than continuity and wellbeing. She was later
pleased to resume baking "Grandma's cakes" as a sign of affection. Other women remarked on the pain of being unable to lift and hug their puzzled grandchildren. They described with relief the children's joy as the former activities of grandmothering - and mothering - were resumed: baking cakes and cookies, playing with and babysitting children, preparing dinners for the family. Luigi explained that her early resumption of homemaking and employment were meant to provide her worried adult children with visible proof of her renewed health. Laverne's son was devastated when his affectionate tickling was interpreted by his mother as a physical threat of pain. The centrality of these loving bonds to the home and family stability were poignantly encapsulated in the worries expressed by Samara's son:

"But the only thing, the big one worried when I had the heart attack. He says: Something's gonna happen, the family's gonna broke [break up]. (chuckles) That's what he told his friends: 'My mom's gonna die or something's gonna happen. I think I'm gonna find myself on the street', he was telling his friends." (SAMARA 343-346)

Nevertheless, homemaking, like diet, exists in the techno-medical literature as the noun "housework", a list of activities that are required to maintain the essentials of a living environment. Of interest are components which contribute to cardiovascular workload, and it is reasoned that these activities should be avoided or delegated to others. The unequal distribution of this work, per se, is not considered a problematic; instead it is regarded as part of a social "role" usually occupied by women and not by men. The physical detriments associated with particular tasks are the focus of some attention, particularly as they affect women who are healing after surgery. There is some concern that responsibility for housework may serve as a barrier to learning the foundations of
heart health. Thus homemaking is conceptualized as a particular way of occupying time and space within the material location of the home. However, there is less attention to the possibility that to be a homemaker is to occupy a subject position; it is an occupation accompanied by an awareness of responsibilities to others and to a social order. The discourse of homemaking is interpenetrated with references to gender distinctions, heterosexuality, generational responsibility and aesthetics. Such considerations are beyond the limited scope and attention of health care, and indeed, they evade the awareness of homemakers themselves.

Smith (1990a) argues that “to begin with the theoretical formulations of the discipline and to construe the actualities of people’s activities as expressions of the already given is to generate ideology, not knowledge” (p.48). In the cardiovascular literature, the predominant focus is on the heart and the conditions and activities which endanger it. Homemaking in this literature is severed from the particular local and biographical conditions in which it is enacted. Only specific elements of homemaking are of interest: the cardiac workload involved in, say, vacuuming for a certain amount of time, or the metabolic effort involved in putting away several bags of groceries. The extraction of these aspects and their association with the techno-medical project of modifying cardiovascular risk reconstructs homemaking as a series of physical tasks which place demands on the healing heart. This reconstruction disconnects women - and their sensuous, embodied experiences of homemaking - from the isolated acts which are now known as housework. These tasks are now conceptualized as separate from her and her social life. The acts themselves are known either as too strenuous for women to
undertake if they are recovering from MI or ACBS, or as acceptable and perhaps even desirable. Smith (1990a) notes that

"Such transformations excise the localizing and particularizing linkages of meaning that organize the primary narrative, suppress the presence and activity of the experiencing subject, and constitute selected utterances and actions as states or symptoms that are constituents of the schemata of the textual discourse." (p. 195)

In this manner, housework becomes locked into a schema that produces its own connections and possibilities. It becomes a set of chores which are enacted in time and material space. These chores are more easily conceptualized as discretionary. They may be delegated. The social relations of homemaking, gender, class, and heterosexuality are obscured in this schema.

Thus, health professionals create and refer to the literature on housework and recovery from MI or ACBS. They understand that there is a problem: women find it difficult to avoid resumption of household chores. They explain that it involves a concerted effort on the part of family and community services to relieve women of these responsibilities as they recover. They differ in their assessments of the hazards associated with certain activities. Some tasks may hinder sternal healing. Some may exhaust women and distract them from self care. That women persist in exposing themselves to these risks and that men remain so recalcitrant in participating in homemaking becomes a source of puzzlement and concern. Seminars and pamphlets are designed to provide information about the risks involved to patients and their families. Some design studies that investigate the magnitude of the risks involved and determine which activities pose the greatest demands so that professionals can be better informed when they give advice about
resumption of activities. Ultimately, this advice is incorporated into the discourse of self care.

The Discourse of Self Care

The foundations of self care for heart health are embedded in techno-medical discursive practices which sever the relation of health to the particular local and biographical conditions in which it is created. Furthermore, the discourse of self care is embedded in relations of displacement. These conditions, as explained above, focus attention on physiological and pathophysiological function, but exclude the actual sensuous embodiment of everyday activities. In this world view, the heart is an organ which functions ceaselessly to facilitate circulatory delivery of oxygen and vital nutrients and removal of carbon dioxide and waste products. It is a muscular structure which itself requires continuous circulation of blood. When this supply is threatened by occlusions of the coronary arteries, the heart is endangered and the person with CAD is at risk of death. A variety of practices and conditions contribute to occlusion of coronary arteries, and some of these may be altered.

In promoting self care, health professionals support the notion that people have considerable influence over their own health and are capable of changing activities which contribute to ill health. The focus on endangerment begs attention to the determinants of safety; no rational person would choose to damage their own health or risk death (Kaufert, 1996; Lupton, 1993; Morgan, 1998). In the present study, the women’s narratives reveal the moral subtext of this discourse. Samara explains that by smoking, she was “killing” herself. Olivia rhetorically asked what she had done to herself. Other
women, when faced with the implication that they may have brought this misfortune upon themselves, emphatically insisted that in their cases, heart disease was a health problem with a hereditary component and that other members of their families had suffered from it. If risk can be modified through adherence to particular practices, then people may be blamed for not taking precautions.

Self care is purportedly based on informed choices and activities. The discourse is founded on the principle that the information required to pursue self care is established through health sciences research. Health professionals are the major brokers of this knowledge, but self help literature, television shows, magazine articles and alternative therapies abound. As “consumers” of health care, people have a responsibility to obtain this information from the most reliable sources possible. This assertion assumes four conditions. First, it assumes that people are easily able to obtain the necessary information and that they know that they are supposed to be seeking it. Second, it assumes that they will be able to discriminate between reliable and unreliable sources and that they will be able to discern the applicability of the information offered. Third, it assumes that they are capable of understanding the information as it is given and that learning will result from this presentation of information. Fourth, it assumes that people can translate or interpret the information into embodied everyday practices which promote health.

The health professionals involved in this investigation were concerned about several issues that linked to these assumptions. They were aware that the first five days after surgery do not present the ideal conditions for learning. The women confirmed this when they reported feeling too sick to attend seminars or that they were unable to focus
their attention because of the effects of sedation or anaesthetic. Seminars were not always available, because they were linked to the staffing patterns and workloads of the professionals who led them. The content of the seminars was generalized and based on analysis of needs assessment surveys completed by former patients. Content was structured from the standpoints of the health professionals, reflecting the foci and theoretical expertise each group claimed as its field of expertise. Consequently, the information offered to the women, and the manner in which it was offered, were structured by the locale of the hospital.

The hospital formed a complex of relations which were organized around distinctive functions. Inpatient health education was one such function which united and coordinated the activities of many distinct groups of health professionals. Within the cardiovascular service, dieticians, nurses, physical therapists, pharmacists and occupational therapists all contributed content for seminars and printed materials. All participated in teaching patients to prepare them to practice self care. The teaching was organized to take place during the inpatient period, that is, during the period of time patients were staying at the hospital. Teaching took place within the hospital itself, because that was where the staff were located. None of the staff saw the homes of the people who attended the sessions, and few had occasion to interact with significant others on a continuous basis.

Hence, the particularities of homes, families and the relations of homemaking were not visible as teaching proceeded, unless questions were raised by participants to introduce limited aspects of these specific local and biographical conditions. Power was activated
within these relations of displacement: the perspective of the health professionals gained precedence over that of the inpatients. Within the locale of the hospital, the women were presented with universalized information which had been constructed from several specialized world views. Only their questions and their voices could insert threads of their everyday worlds into the weave of the seminars. But in the presence of sedation, pain, bodily dispossession and the overwhelming relief of having survived, the everyday receded. Dietary instructions were distributed, advice about exercise was given and suggestions were offered for suitable activities during the early weeks at home. These directives were taken up by Ruth and others as the "dos and don'ts" of self care. Their responsibility was to enact these directives in order to protect themselves and their hearts as they healed. The instructions were to be applied in the home, thus the discursively organized practices which began in the hospital were drawn into the everyday worlds of the women.

The project of situating self care activities in the everyday world of home elicited disjunctures for many of the women. Inpatient learning was rendered difficult under the conditions discussed above. Questions abounded, but with relocation to the home, the women were separated from the locale of the hospital where their teachers remained. Pamphlets were the proxy teachers that reminded and instructed, but these were not constructed from the perspective of sensuous embodiment, nor could they be asked questions. Close others who had emerged from similar experiences were valued informants because they bridged the fault between the locale of the hospital and the everyday world of the home.
Appointments with family doctors or cardiologists were primarily focused on physical healing; Olga and Cookie explained that this focus limited opportunities to insert questions or request advice. Once again, in the milieu of the office appointment, displacement ensued and the everyday world receded. Within the world of the physician’s office, the healing body was examined and markers of improvement were interpreted for the women. They learned the numerical indicators that constituted the virtual bodies found in medical records. Doctors deciphered the reconstructed terrain of the women’s bodies, reassuring them that clicking sternums were to be expected and reddened incisions did not necessarily indicate infection. “Learning how to mean” (Smith, 1990b, p. 109) in this setting involved comprehending the language of the body from the perspective of the health sciences. As I point out in an earlier chapter, learning how to mean in a specific setting is a process of acquiring an intrinsic language of social organization. In this instance the women learned to interpret their corporeal experiences using language that emanated from the medical perspective. The questions and concerns that arose from the women’s standpoints were difficult to insert into this discussion. Many aspects of the everyday were out of place in the physician’s office for they did not relate to the idiom of the follow up encounter.

Lapses of health - phlebitis, wound infections, hypertension, stroke - brought endangerment into frighteningly sharp relief once again. As he took her blood pressure to evaluate the effects of a new medication regimen, Eva carefully watched her doctor’s face and reported with relief that she saw satisfaction mirrored there. The diagnostic category, heart disease, directed attention to the tasks of monitoring endangered hearts, not the
embodied activities and conditions of the everyday. The women took this concern up in their own puzzlement over the meaning of aberrant sensations. Were the sensations of a pounding heart or dizziness to be interpreted as signs of an arrhythmia which required immediate medical attention - or a “jumpy heart” resulting from emotional upset over a family argument? Self care evidently involved some vacillation between the idiom of the doctor’s office and the idiom of the everyday. From the locale of the doctor’s office, then, other manifestations of discursively organized practices trailed into the everyday lives of the women and further defined the contours of self care.

Similarly, the women who entered cardiac rehabilitation programmes ventured again onto professional ground. In that location, there were similar others to discuss problems with and opportunities to learn directly from health professionals the recommended pace and duration of exercise. Cookie was fearful of damaging herself and found the supervision of programme leaders very reassuring. Tip learned that chest pain was not necessarily an indication to discontinue activity and was taught to use her nitroglycerine spray and continue after an interval of rest. Virtual records based on pre-programme assessments were used to determine safe levels of exercise for each participant. Health professionals reassured the women that their endangered hearts were safe within specific limits of aerobic exercise; they taught the women to monitor their own pulse rates so they could take responsibility for titrating the level of activity. This training represented embodiment of discourse. The women learned in cardiac rehabilitation classes to regulate activity and hence manage risk and endangerment.

Relocation from the hospital to the home presented another daunting task: the
tenets of specific self care activities, such as exercise, diet modification, stress management and staged resumption of daily routines, had to be translated from cognitive to embodied terms. Using the example of the diet, I explained in earlier chapters that the local and biographical were obscured in the construction of the concept, “diet”, into lists of atherogenic foods which were to be avoided and healthful foods which could be eaten freely. I explained how food and eating hold powerful social and biographical implications for women, who usually plan, prepare and serve meals for others as well as themselves. Familiar and favourite dishes form one sensuous dimension which constitutes the stability of the home. Ritual and holiday occasions are often associated with the enticing odours and tastes of special foods. Agata spoke of preparing perogies for her grandchildren on special days, and of not allowing cheesecake into the house unless it was to be served for a celebration. Situating the tenets of the “healthy heart” diet within the social location of the home involved profound changes in the practices of homemaking. These changes threatened biographical and social continuity.

The task of situating a new diet within the habitual practices of the sensuous body posed additional challenges. Tip and her doctor agreed that this amounted to a choice between what Tip argued was a revolting diet or “living”. The pleasure involved in eating certain foods is, after all, a matter of taste. Enjoyment of certain foods and not others is a matter of habit, class and biographical continuity. Food is eaten for pleasure as well as nourishment. Sonia knew immediately that the ice cream she had been served by mistake was not low fat frozen yoghurt because it “tasted too good”. She had learned to appreciate the flavour and texture of ice cream, and frozen yoghurt was merely a
substitute. Ruth battled cravings for chocolate and, like Gert, had learned to indulge these cravings with a small portion of the desired food rather than risk a later binge by denying herself. The generalized recommendations of health professionals for the management of risks to the endangered heart were translated into practices that managed particular bodies.

All women did not participate in the discourse in the same way. Class location and education conditioned the manner in which information was taken up. Cookie’s working class membership and elementary school education placed her at a disadvantage when seeking and processing information. She found it difficult to insert her concerns into visits with her doctor, and ruminated on frightening images based on tales told by relatives. She spoke her experience using terms that did not align with medical lexicon:

“Then if you think of all the things that might go wrong with the things they did to your heart, that you don’t understand a lot of it. You think: ‘Oh God, stuff might have went wrong or it might come loose, you know, the sewing of the veins.’”

Laverne on the other hand was able to interpret a television show about ACBS with evidence of a more medicalized understanding of events and outcomes which reflected her post-secondary education and career experience with health professionals:

“And we watched a man that had a triple bypass on TV. Now mind you, he died three months later, which was very unfortunate, but he had had a massive heart attack before surgery. They were hoping they could wait for two or three months, so the heart muscle could mend, and they couldn’t. And of course, that’s why he had another heart attack later on; it had nothing to do with the surgery. It was because his heart muscle wasn’t strong enough.”

Both took up the discursive subtext of endangerment differently. Cookie was overwhelmed with the absurd frailty of “sewing” - seams, after all, do unravel and tear.
She received information in concrete terms, making literal translations into the everyday. Danger was connected with the unknown and barely understandable. She had great difficulty voicing her fears to her physician, and so was unable to obtain reassurance or verification. Laverne was accustomed to a mode of reasoning that is peculiar to professionals: that of connecting everyday events with abstract knowledge to render them understandable. Danger arose from specific circumstances to which her own situation could be compared. The man on television died because his grave condition called for bypass to be performed before he had fully recovered from an MI. Laverne knew that her surgery had taken place under better conditions, therefore she need not fear the same fate.

Another influence was immigrant status. Olga and Gert remained puzzled about the surgical procedure for months after it had been performed. They both encountered barriers when attempting to insert their questions into medical consultations, for although they both spoke and understood English well, they sometimes required time to formulate their ideas before speaking. They were confused at times by the speed with which health professionals spoke and by the unfamiliar terms they used, asking me for clarification in our discussions. More than the other women, they tended to use medicalized terms as if they were questions, watching my face for confirmation that the term had been used and pronounced correctly. Agata revealed that she found it an effort to read English, although she read well enough to eventually understand the basis of a new, mostly vegetarian diet. She reported that it had taken repeated readings to absorb the messages contained within the books her daughter bought for her. Nevertheless, she persisted and took great pleasure in her accomplishments.
The women attempted to learn the discourse of self care and act accordingly under particular material conditions which either facilitated or impeded their efforts. Laverne was able to go for walks on a regular basis until she returned to work. After that, she faced a long commute to and from her office, responsibility to prepare meals in the evening and other homemaking tasks. Her walks became less frequent as other activities impinged on her time and energies. Because she lived in a small community that was distant from the hospital where her surgery was performed, she did not have access to a cardiac rehabilitation programme. Margaret and her husband owned a very successful shop which was located within a short drive of her home. Although she returned to work within two months of her surgery, she was able to limit her hours and activities by relying on employees. She acknowledged that she felt some pressure to resume work because her husband and employees carried heavier responsibilities in her absence, but pointed out that the work was not physically taxing, and she found it very pleasant. The store opened at eleven o'clock on weekdays, so she was able to reserve the early morning for her walks and cardiac rehabilitation classes. It was clear from the above examples that women who juggle employment, homemaking and self care face powerful barriers. These three pursuits are demanding, and one component must be neglected or compressed to allow time and energy for the other two. Margaret was able to limit her hours at her business, but as an employee and head of a department Laverne did not have similar discretion. After her husband confessed his exhaustion, Laverne found it difficult to delegate homemaking activities to him. In her case, participation in self care was curtailed.

The gendered relations of homemaking formed a material barrier to self care
because of an accompanying discursive emphasis on the obligation to provide care for others. This care could take the form of physical assistance for sick family members, organizing and coordinating events such as appointments or special occasions, attentiveness to emotional states and needs, and protection of others from overwork or stress. The consciousness of the homemaker was directed outwards to monitor the needs of others, while self care required a consciousness of the embodied self. Although the activities of homemaking were embodied, they tended to exploit and deplete, rather than conserve, bodily resources.

Thus, the discourse of self care is taken up in everyday life in a complex and evolving process which is fraught with barriers and difficulties. Although health professionals purport to teach and counsel, the extent to which their goals are realized is limited. Perhaps the most powerful barrier for women consists of the material and discursive properties of the home. Although the discourse of self care brings an individual’s everyday activities into alignment with the work of health professionals, it is not easily learned and adopted. For women the everyday world of the home is organized along discursive lines that interact poorly with the tenets of self care. The efforts of health professionals to create better and more comprehensive health education programmes may result in greater access to knowledge about the foundations of heart health, but the conflicts and contradictions created at the intersection between the two discourses will remain the same. Pouring more knowledge into the everyday will not improve knowledge about the everyday (Griffith, 1995). Charting the course of lifestyle change for women with heart disease needs to be based on a more accurate reading of the terrain of the
everyday. Central to this problem are the social relations of displacement which pervade the experiences described by the women.

**The Social Relations of Displacement**

As pointed out in an earlier chapter, the health care system as the institutional setting for this ethnography consists of many disparate sites. Its locations include hospitals, clinics, diagnostic laboratories, the offices of doctors and other professionals, government ministry of health offices - and homes. The latter is the only site which usually functions without the physical presence of paid health professionals, although home care services are prevalent at this sociohistorical moment. I have described how the discourse of self care is learned and taken up by women with heart disease after they undergo ACBS. It is a discourse that is developed and imparted by health professionals as health education about the foundations of heart health. Its tenets converge upon the project of cardiac risk management. This discourse, in part, organized the consciousness and activities of the women who participated in this investigation, but it did not comprise the sole coordinating influence. Indeed, as we have seen, the discourse of self care corresponded poorly with the precepts of the gendered discourse of homemaking which continued to inform everyday routines.

The women’s narratives contained descriptions of multiple displacements or disjunctures, and these formed the central problematic of their experiences with heart disease and ACBS. The social relations of displacement derived from the organization of professional health care and normative conceptions about health and illness. These relations facilitated the concentration and efficacious conduct of professional activity in
locations that were, nevertheless, isolated from the everyday worlds of the women. The
everyday world of gendered homemaking, with its biographical and local particularities
were obscured from the purview of health professionals who cared for the women.
Professional activities of diagnosis and treatment of heart disease had the additional effect
of producing profound social displacements which in turn resulted in altered
consciousness. It was the women's task to manage the effects of these displacements and
attempt to find positions of comfort to deal with the discursive conflicts they encountered.

The initial displacement described by the women was one of limitations on
sensuous physical activity. Gradually symptoms such as shortness of breath, fatigue and
chest pain supplanted intentionality. The women no longer occupied time and space in an
effortlessly habitual manner. Emma recalled that she "went from Speedy Gonzalez to
walk slow." Others reported that tasks took longer, had to be carefully paced, or could
not be contemplated at all. This usurpation of the habitual was a signal that there was a
problem that required medical consultation, but this occurred in an office setting which
was distant from the home as a material, social and metaphorical locale. Displacement
into the world of professional practice supported the differentiation of objective signs and
subjective symptoms of illness. Physicians were not present in the home to witness
activity, nor could they directly experience chest pain or fatigue. Moreover, the women
were visitors in the world of professional health care. They did not determine the
structure and conduct of diagnostic and therapeutic activity.

The processes associated with professional health care practice preceded the
women. The women could determine which symptoms to describe, but they had little
control over additional information that would be taken into consideration. Information about occupation, demographic location, social status and ethnicity could be taken up as cues which forestalled the diagnosis of heart disease. As participants in the medical consultation, women and physicians alike referred to their own experience and idioms as each interpreted information offered by the other. Eva, for example, watched her doctor’s face to obtain some indication of his assessment of her condition: she noted his facial expression of satisfaction with great relief. Her lengthy domestic history of providing physical and emotional care for two chronically ill spouses, as well as her contacts with health professionals on her own behalf prepared her for this nonverbal exchange.

Ultimately, all of the women were diagnosed as having heart disease. They officially joined a social category, “women with heart disease”, which identified them as bearers of a unique identity. They had a chronic illness, one that endangered their hearts and lives. Although the tenets of cardiac risk management permeate lay discourse about health promotion, from the moment of diagnosis, the women were linked with a social group that was obliged to pursue remedial action. In some cases medical treatment, in the form of medication or more invasive measures such as angioplasty, was the sole form of risk management during the initial period after diagnosis. However, in most cases, the women’s routine activities were altered: paid employment was suspended, homemaking responsibilities were limited (but almost never completely discontinued), and changes in self care approaches were initiated. The work of health and risk management was thus taken up in the home and in coordination with professional activities. This process was facilitated by the women’s consciousness of their social displacement, which was
encapsulated in the discursive emphasis on endangerment. However, as I have argued above, it was also impeded by the isolation of the everyday worlds of the women from the arenas of professional practice.

The radical displacement represented by hospital admission for surgery continued and intensified the conditions established in the doctor's office. The biographical and local particularities of the women's everyday lives were obscured unless the women succeeded in efforts to insert these personalizing details into their encounters with individual professionals. They were visitors on professional terrain - indeed they physically entered into a highly routinized and focussed sequence of activities and events over which they had extremely limited influence. This sequence was intended and needed to preserve their lives in the presence of extraordinary peril, and the women entered into it willingly, with respect for the expertise of their professional caregivers and with considerable apprehension. These relations generated two additional displacements: dispossessioii of the body and intensified social displacement.

The women's bodies were the hub of intensive professional interest during their hospital sojourns. With the women's cooperation, their bodies were inspected, medicated, intubated, pierced, incised, invaded, reconstructed and monitored. For some of these activities, the women were rendered unconscious. Their active participation and awareness was not required or desired. Only their bodies needed to be present during surgery. Of course, exclusion of the conscious self through anaesthesia was not construed as anything other than merciful, but as Leder (1998) points out, sedation and anaesthesia render bodies inert and separated from the enlivening influence of selfhood. The women
remarked on the bizarre experience of witnessing professional interpretation of their visceral functions as EKGs were deciphered, vital signs were assessed and chest tube drainage was inspected. They had lost the capacity to speak their own bodily experience and relied on others to be more expert in this area than they were. Professional power was activated and sustained in these relations.

The relations of bodily dispossession were also relations of intensified social displacement. Hospitalization separated the women physically from their biographical and local referents. It severed them from the everyday locus of their social milieu. The relations of bodily dispossession required that all physical trappings of their social identities be removed lest they interfere with or be damaged by therapeutic activities. Clothing was replaced by blue hospital gowns and jewellery was removed. Cosmetics were eschewed, for they interfered with accurate assessment of tissue perfusion (nail polish and lipstick mask the bluish discolouration which indicates inadequate oxygenation). The women’s bodies were eventually festooned with EKG leads, bandages and tubes of every imaginable description and purpose. They were not recognizable to their loved ones and to themselves - indeed, they were barely recognizable as alive. This extraordinary displacement reverberated deeply into relationships with close others and threatened to topple the assumptive foundations of the everyday world of home. If they could not recognize a wife, a mother or a dear friend, could these close others continue to be children, husbands or confidants? And with the loss of a homemaker, could there possibly be a home?

The disturbing displacements and perils of hospitalization conditioned the women’s
further indoctrination into the discursive foundations of heart health. However, the knowledge conveyed through educational interventions by professionals was constructed and disseminated in locations which were distant from the everyday world of the home. The knowledge was developed under conditions which deliberately stripped away the particular in relations which created and demarcated subjective and objective information. The knowledge was imparted to the women in a generalized and cognitively based format which did not specifically address their gender, class or cultural locations. The seminars took place under circumstances which attenuated the women’s voices; they struggled to find the capacity to activate the texts which conveyed the tenets of self care. The women absorbed the discursive subtext of moral responsibility which obligated them to manage risk of further endangerment, but they were offered no precise coordinates to guide its translation into the activities of the everyday.

The disruption of hospitalization marked and changed the women as deeply as the surgical wounds that slowly healed between their breasts. Relocation to the familiar surroundings of their homes underscored the embodied consequences of surgery: they no longer conformed to the contours of their everyday lives. Scars were not compatible with discursive standards of feminine appearance, and in some cases wound infections exaggerated this effect. Pain and weakness transformed stairs into a formidable challenge. Beds and favourite sleeping positions were suddenly so uncomfortable as to interrupt or thwart their efforts to obtain needed rest. Grandchildren could not be lifted. Hugs and affectionate tickling from spouses and children threatened pain, hence the embodied bonds of affection were fractured. The repercussions of the grave scenarios viewed by close
others in hospital were protectiveness and, in many cases, expressions of emotional anguish.

The configuration of home, too, seemed altered. In some cases, others pursued homemaking activities on their behalf, to varying degrees of success and comfort. In other cases, no one was able, available or willing to do this work, and their homes took on an unfamiliar character. Dust appeared, the wrong foods were purchased, laundry was white with too much detergent and kitchens were not cleaned according to preference. Some, like Cookie, Olga, and Samara, found the situation unbearable. To reassure themselves and others that they and their homes would endure, they resumed their usual homemaking activities soon after discharge from hospital. They were aware of the discursive directive to regulate activity resumption, and they acknowledged it by describing their activities as careful and slow. They pointed out the absence in the home of another person with a homemaker’s consciousness and the inescapable reproach of disorder. Homemaking was discursively constructed for these women as a compulsory component of heterosexual femininity. But it was also a way to be “at home”.

The women remained socially displaced by their location as members of the category, “women with heart disease”. As a response to the problem, surgery did not completely protect their hearts from endangerment. They were aware of a discursive moral injunction to manage cardiac risk factors through dietary changes, exercise, smoking cessation and stress relief, and close others reminded them of this expectation. In the early weeks following surgery, however, few were able to begin the work of organizing new routines around these alterations to embodied practices. As Olga pointed
out, unlike a male neighbour who had undergone ACBS, she had no wife whose everyday responsibility it was to prepare her meals and interpret the appropriate dietary restrictions on her behalf. It would be her responsibility to undertake these changes and she was not equal to the effort in the first month after surgery. The discourse of self care was difficult to fit into the context of the everyday.

As weeks passed, and physical comfort and stamina increased, it became possible to feel more “at home” in their bodies and their houses. There was more interest and activity to transform the surroundings of the home so that they reflected the standards and nature of the inhabitants. As more of the routines of the everyday were resumed, it became apparent that it would be difficult to situate new approaches within this structure. For some, it was difficult to find time or space to insert self care. For others, selected elements were easily adopted, while others were not. For younger women, the return to paid employment coincided with the confrontation between self care and the everyday. A number of the women participated in cardiac rehabilitation programmes, which represented another dislocation to professional ground. Ironically, this created a spatiotemporal location for aerobic exercise which was difficult to create otherwise. It also placed them in proximity to health professionals who were intent on the activities of health education and provided access to others who grappled with similar concerns. For many who had struggled to gain access to information from the confines of the home, the inconveniences of distance were counterbalanced by the resources offered by cardiac rehabilitation sessions. However, the demands of paid employment threatened to displace these meetings unless commitments and schedules were carefully managed.
The women’s narratives revealed social relations of displacement which converged upon the women’s experiences but were less apparent to others. The women attempted to reconcile discrepancies between two worlds. First and foremost in their biographical experience was the everyday world of home - a world constructed in common with close others by the gendered discourse of homemaking. Second was the world of health care where the diagnostic category, “heart disease”, inextricably linked the women to a discursive subtext of endangerment and an ensuing moral obligation to self care. In their experiences of heart disease, the women traversed many material, social and discursive displacements, which unfolded as the events of diagnosis, treatment and recovery progressed.

Limitations of the Study

Before discussion turns to the implications of these findings, the limitations of the investigation will be considered. First, in the initial stages of design, and at several subsequent points throughout conduct of this inquiry, it has been pointed out to me by various others that much could be gained by comparing experiences from the standpoints of men and women. I chose to focus only on the standpoints of women, however. This decision was initially based on the argument that there was in existence an extensive foundation of knowledge about men and CAD. I was interested in understanding what it was like to be a member of a group whose experiences were not as well known by health professionals or as well accepted by close others. Furthermore, my academic interest in the domestic labour debate (described in Chapter 2) and my own experiences as a woman with a family, a career and a chronic health problem piqued my interest in the conflicts
encountered by women at the intersections of multiple demands. It seemed to me that there would be considerable difference among women and to also examine the difference between women and men would threaten coherence.

In pursuing this investigation, however, I have developed a stronger appreciation of Smith’s ideas about the intended focus of a new sociology. In studying what happens to women with heart disease, I was shifting my focus from the difference between men and women to the social relations that, for example, construct difference or render it problematic. I was trying to make sense of how things work to present barriers to self care for women, and I was trying to understand how things work to make it difficult for health professionals to help them practice self care. It is difficult for women to practice self care; indeed, the experiences of the women who participated in this study renders the notion of self care intensely problematic. Understanding whether or not self care is comparatively more problematic for women or men was not at all the issue I wanted to consider. However, one limitation of the study which stems from this focus on women’s experiences is that I have no information from the perspective of close others. A refinement to the design would have been to interview spouses, children or others who were involved in a particular local milieu.

Another issue lies within sampling access. All potential participants were approached during their hospital stay by a representative of the hospital. It is possible that this liaison selected women who were particularly positive about their experience or whose manner appeared more talkative or receptive than others. Very complex or difficult cases may have been avoided. All of the women were very forthcoming and even eager to
discuss what had happened to them. Many interviews took longer than the expected one hour. It is possible that these were peculiarities that affected the amount and type of information I was given and that other women might have had markedly different experiences. However, the main focus of the study was not on the meanings construed by the women but on the social relations which arise in the care of women with heart disease. As I have noted, different women have somewhat different experiences of these social relations, but the relations themselves remain consistent. One might expect that other women’s standpoints might provide entree to additional aspects or dimensions of these social relations.

Finally, the interviews were conducted at two points: four weeks and four months after surgery. However, the women’s narratives contain many references to events that occurred months or even years prior to the interviews. For example, the events surrounding diagnosis of heart disease were described by all of the women and, for some, this involved recollection of experiences which transpired as much as one to ten years prior to their surgery. Another approach might have been to interview women at particular chronological points in the trajectory to facilitate recall. Interviewing women soon after diagnosis or soon after the decision to have ACBS would have provided additional insights. A follow up interview at one year after the surgery might also have provided an additional dimension to the analysis.

Implications of the Findings

A number of preliminary implications can be drawn from the findings despite the limitations discussed above. I will discuss the results in terms of practice, policy, theory
and research.

**Implications for Health Care Practice**

Institutional ethnography inherently draws attention to professional practice and the ways in which professionals are discursively active (Smith, 1987, 1990a, 1990b, 1999). The development of a knowledge base for use in professional activities and the production of seminars for the health education of patients and the lay public are discursive practices which have been discussed and described in this thesis. Anderson (1998) explains that the activities associated with health education are often structured by the unequal power relations which still persist between professional and patient in institutional settings. In this investigation, power was activated in the activities of teaching and learning within the social relations of displacement. Teaching occurred on professional ground: in the hospital, in doctor's offices, at cardiac rehabilitation centres. Teaching was structured by the demands of professional practice within these settings. The objectives and content of the sessions were determined by the seminar leaders, and were based on objectified professional knowledge about the foundations of heart health and on generalized profiles of informational requirements which were constructed through needs assessments surveys of former patients. The terms of access to information were largely under the control of the teachers, and the institutional focus in the hospital and doctors offices was on management of immediate physical health and cardiac risk.

However, it is important to note that, according to the women's accounts, considerable learning occurred outside of direct contact with professionals. This learning drew on a variety of sources. Many women obtained information from television, books
and newspapers, and although much of this represented professional knowledge, it had to be interpreted by the women in terms of their corporeal and social experiences. At least two women worried needlessly that they had "flesh eating disease", for example. In addition, information was commonly filtered through personal contacts such as family, friends and acquaintances. At times, these contacts were health professionals, but often they were lay persons who had heart disease themselves or were close to someone who had undergone ACBS. Often learning and the acquisition of information were arduous endeavours which were reflective of particular needs and interests.

Anderson (1998) and Tang and Anderson (1999), building on Lather (1991), recommend a more transformative approach to teaching and learning in health care. They suggest that health education be regarded as a sharing of resources between professional and client. To be truly helpful to clients, health professionals ought to understand the everyday lives and challenges faced by those they seek to counsel or teach and modify their approaches with the input of their clients. Educational encounters would thus become an exchange of information and a discussion of possible strategies that would enable the client to make the changes they desire or see as manageable and worth the effort. This would address two problems noted in the present study. First, it would overcome the barriers established by the social relations of displacement - health professionals would learn more directly about the local and biographical particularities of their clients' everyday lives. The resultant world in common would bear a stronger resemblance to that directly inhabited by those who seek information. Second, it would support and assist people in their struggles to translate the information offered by health
professionals into embodied practice.

In presenting and discussing the findings and the above implications for health education practice, I have received insightful "response data" (Lather, 1999) from health professionals involved in hospital practice, particularly nurses and physical therapists. One common concern raised in relation to the notion of transformative teaching and learning is that it would simply take too long and would conflict with staffing practices in a climate of shortage and fiscal constraint. As I learned from the health professionals I interviewed for the study, seminars are structured by the need to teach as much as possible to as many inpatients as possible in as short a time as possible. One-to-one teaching is considered more time consuming and would involve the efforts of more staff. The intense - and very valid - concern with immediate survival and risk management draws the priorities of post surgical professional activity away from programme development and teaching.

There is a need to confront these structural influences and examine carefully how they contribute to the social relations of displacement. There is a need to question the purpose and strategies of health education in the immediate post operative period from the standpoints of clients/patients, as well as those of health professionals. In the hospital where the investigation was conducted, there was no one professional whose sole task was to promote health education for patients, although several were mandated with the responsibility of participating in the maintenance of an ongoing programme of professional practice. Consequently, health education programmes were subjected to sporadic review, evaluation and revision depending on time constraints and structural demands impinging on the cardiovascular inpatient service at any given time. Thoughtful review of the
structural constraints to inpatient health education would include attention to these issues.

A further consideration for practitioners is the nature of the information which is conveyed to people so that they can pursue self care. Health teaching activities in this investigation were predicated on the assumption that learning is a cognitive activity. Indeed, many of the theoretical models which guide health teaching for lifestyle or cardiac risk modification feature cognitive processes associated with change. The body appears in these models as an entity which demonstrates outcome "behaviour", or visible manifestations of change. One text of cardiovascular nursing notes a recent emphasis on "beliefs, intentions, and self-efficacy, and most recently, readiness to change" (Woods, Froelicher & Motzer, 2000, p. 885) in cardiovascular health education programming. Information is therefore presented as a package of text which is cognitively focussed.

People's bodies may demonstrate self care skills which evolve from learning, but there is little attention paid in these models to the actual embodiment of learning as the women presented it to me. The body as a sensuous and active part of the learning enterprise is displaced from ideas about teaching and learning. We could begin to correct this displacement by considering ways to bring the entire person's sensuous, embodied experience of learning into consideration, starting, as Freire (1999) suggests, from the particularities of that individual's everyday life.

For example, several of the women were concerned about the possibility of doing harm to themselves through physical exertion. This worry reflected a need for information about how sensuous experience could be interpreted as "safe" or "not safe". Tip suffered anxiety about and limited the amount of walking she did until she learned how to monitor
her own pulse and pace herself accordingly in rehabilitation classes several months after her surgery. Her understanding of the discursive emphasis on cardiac risk management was that exercise was a cornerstone of self care, but prior to rehabilitation classes, she had no basis for the translation of this mandate into actual practice. Others were concerned from time to time about the appearance of their incisions or the presence of unusual physical sensations. Samara interpreted the perception of a “jumpy heart” as an indication that she was dangerously overwrought by everyday emotional events such as disciplining children. Her observation demonstrated the linkage between the heart as a vulnerable physical organ and the heart as the mediator and container of emotional experience. Teaching in this instance might assist her in determining whether or not this type of stimulation was harmful. In addition, emphasis could be placed on her emotional experience of the heart rather than its physiological function.

This discussion of the sensuous experiences of emotion in the everyday leads to the emotional nature of family and other close relationships. Several women freely discussed the linkage between their cardiac health and their relationships with family members. Olga, Emma, Samara and Cookie, for example, alluded to their concerns about the expression of powerful feelings such as anger, anxiety and sorrow - whether their own or someone else’s. Nowhere was this more evident than in Cookie’s descriptions of life with her partner. There are individual counselling services available for persons who have heart disease, to help them explore the psychological and interpersonal ramifications of their health problem - and indeed, Cookie was in the process of exploring this option. Couple and family counselling services are also available for similar purposes. Yet these
alternatives may also tend to place responsibility for change on individuals and may pathologize those who are dealing as best they can with extraordinary pressures and contradictions. Women who were able to connect with similar others through cardiac rehabilitation classes or through their social networks found comfort in mutual discussion about their experiences as well as acknowledgement that the jarring disjunctures they encountered were not evidence of their own inadequacy or deviance. These contacts were highly valued, and their potential for “consciousness raising” and “debriefing” exchanges were particularly striking. Further efforts to facilitate these types of contacts among women would be helpful. These could take the form of support groups (which are already in existence, although limited in number), or even “mentoring” phone contacts between newly discharged patients and those at a later phase of the experience.

Finally, the intensely alienating experience of bodily dispossession was described by the participants as an artifact of the organization and focus of work in the hospital setting. Anaesthesia, surgery and other invasive technologies were regarded as necessary, but profoundly disturbing. The textual and ideological organization of patient care following ACBS is highly routinized and sequenced, obscuring biographical and local particularities of each person’s experience. Many health professionals are at some level aware of these relations of displacement when they describe their own sense of being alienated from patients and prevented by time pressures from providing emotional support or more personalized attention. Attention to issues like pain management, personal and environmental hygiene, emotional issues that arose from the events of ACBS or from other sources, and expressed learning needs was immensely helpful to and appreciated by
the women I interviewed. However, there were many constraints on their capacities to voice these needs and be heard. Health professionals ought to ponder the extraordinary imbalances of power that exist between themselves and the people they endeavour to help. Leaving a place for dialogue about the experience of bodily dispossession, the displacements confronted in the hospital and the biographical interruptions associated with health problems would enable us to know more about our clients.

**Implications for Health Policy**

To this point, my comments have centred on teaching and learning as they are assumed to occur on professional ground. One of the major findings of this investigation is that learning about self care and its practices actually occurs predominantly in the everyday world of the home. The interpretation of cognitively based information into embodied practices was located in the home and was coincident with the highly particularized activities of homemaking. The women experienced pressing demands as homemakers that were incompatible with the project of learning self care. The home, then, would appear to be a strategic site for transformative health education and counselling. It is also apparent that there is a need to recognize that women may have insufficient support in the weeks following discharge home after ACBS and other cardiac events. The presence of a family does not necessarily mean homemaking services are not required. Indeed, the women with families appeared more in need of homemaking assistance than did women who lived alone. When I discuss these issues with professionals during presentations, I am again supplied with response data from the world of professional practice. These informants express extreme reservations about the
possibility of obtaining homemaking support for women who have families available to help them. Eligibility screening for home care services would exclude women who had family living with them and educational support would not be considered an appropriate reason for referral under the current mandate of home care services.

This is an example of contractionist health policies which place the onus on individuals and families to maintain their health through prescribed self care activities (Bury, 1998; Lock, 1998). These policies interact with prevailing trends of medical discourse which attest to individual control over risk factors affecting physical wellness. I have explained that the moral discourse of self care in cardiovascular health reduces the causes of heart disease to identifiable practices which produce physiological changes. These changes in the physical body may be detected by medical assessment and diagnostic technology. Avoidance of cardiac risk factors is construed as virtue, although it is the individual’s responsibility to improve health, not the state’s mandate to facilitate these changes (Lock, 1998). The intense focus on personal control over health behaviour produces a neutralizing effect; the conditioning influences of gender, class, ethnoracial membership and age are obscured and erased.

The discursive foundations of home care policies increasingly emphasize family responsibility in caregiving, yet this intensifies the caregiving work of women (McKeever, 1996). It evades the problem of finding care, homemaking assistance and financial support for the family caregiver when she is ill herself. It is presumed that other family members will know how to “take over” for her and that they will be able and willing to do so (England, Keigher, Miller & Linsk, 1994). Women’s biographies of caregiving and
current demographic trends in divorce and spousal mortality may result in their reaching later years impoverished and alone, or heavily burdened with the care of a spouse or parents (Evans, 1991; McKeever, 1996). Although shorter hospital admissions result in savings, there is little indication of the ways in which these savings result in financial and personal health costs to individual women. Hospital cardiovascular programmes could articulate with home care services to develop educational and supportive follow up to patients after discharge with particular sensitivity to the needs of women regardless of their living arrangements. This follow up ought to extend over the period prior to enrollment in hospital cardiac rehabilitation programmes so that women have access to health assessment and educative counselling during the difficult early weeks after discharge home.

Implications for Theory and Research

As noted in the implications for practice and elsewhere in this thesis, health care practice is founded on discursive conventions which promote a limited and fragmented understanding of the body and embodied existence. It is based on social relations of displacement which support the provision of health education to women for use in their everyday personal routines but which limit knowledge about the everyday practices and conditions which may constrain the efforts of women to practice self care. The body is theorized as a physiological entity which is subject to risk and pathologic conditions, but the full sensuous range of active, gendered embodiment is effaced. This theoretical focus forms a component of the discursive ground which coordinates health care practice. It informs activation of the power inherent in professional knowledge - knowledge which
mediates the ways in which professionals can know the everyday world (Smith, 1990a). It is ironic that theory in the health sciences, in which the body is the major focus, has erased many aspects of embodiment through its fragmenting lens.

My own experience of considering women's everyday lives following ACBS using the analytic groundwork of Smith’s (1987, 1990a, 1990b, 1999) writings was one of searching to find “the body” - or a way of conceptualizing respondents’ bodies - that was contained within her work. The importance of the simple phrase “activity or practices are ‘sensuous’, done with or in the body” (Smith, 1987, p. 144) and others like it eluded me. As one with an extensive career history as a nurse, I was deeply imbued with a discursively organized understanding of the body as the object of a theorizing focus. In time, however, I realized that, for me, reference to “the body” operated as an “ideological code” (Smith, 1999, p.157). I was an expert reader of texts which conceptualized bodies and embodiment in very specific and specialized ways. I understood the body in a way that made it difficult for me to comprehend it as something other than a place where things get done, health problems are concentrated and treatments are accomplished. I became burdened by my own difficulty in representing the women’s descriptions of selfhood: why did the “embodied self” and the “social self” seem to continuously seep into one another?

Understanding health care and self care from the standpoints of women required me to confront my assumptive recognition of “the body” as a code which directed me to understand people’s health and informational needs in particular ways that were relevant to nursing and other health professions - but perhaps not relevant to those people themselves. I attended a multidisciplinary committee meeting to contribute to a
discussion of research directions for an institution that was preparing to apply for funding. As a conceptual framework was elaborated, I became increasingly aware that the focus was on providing evidence that therapeutic approaches were effective in treatment of certain disease states. I asked if the group had considered including people and their experiences within the framework and encouraged the group to consider what clients or patients wanted from professionals. More discussion ensued. It was agreed that we needed to consider "how the organism responds to the environment" and that "outcome measures" would necessitate some reference to the patient. Eventually, "persons" and "bodies" were conflated and reduced to several thematic categories which corresponded to specific disease states. My own sense of displacement as the discussion concluded was related to my participation in a discussion in which I saw how references to bodies and persons could be worked up in ways that were predicated by their existence in this context as conceptual terms or ideological codes.

It is difficult to recommend that health sciences theory be rewritten in complete opposition to these discursive practices. Technical excellence in health therapeutics is necessary and socially valued. The professionals who attended the meeting I describe above were expert practitioners and educators. They knew how to help people in very specific ways and did so with great regularity. However, it is important to understand that there is a tension within professional practice which places health professionals at an intersection between the textually mediated basis of their activities and the lived embodiment of the people they serve. Attention to theory and research in the latter area has the potential to enrich and elaborate understanding of the former, thus maintaining this
tension in balance. Consideration of the discursive basis of professional practice may further inform us about the nature of this tension and how it is played out in multiple settings by multiple individuals.

Smith explains that “there are indeed matters to be spoken of that discourse does not yet encompass” (1993, p. 183). This point bears particular relevance as I consider the ways in which participants referred to their bodies in our discussions, and the ways in which I took these references up in my analysis. Smith consistently draws our attention to the materiality of the body, of its sensuous, active locatedness in a particular time and place, although she does not elaborate the body as fully as she does text. Nevertheless, one of the great strengths of Smith’s work is the manner in which it begins inquiry at the site of the everyday and corporeal, acknowledging the predicament of embodied materiality. The participants in this study spoke about the materiality of suffering, disease and disability, and their words resonated with my years of witnessing, as a nurse, all of the often unspeakable misfortunes that can befall human bodies. Pain, palpitations, anxiety, fear and frustration were among the sensuous experiences described by the women - these emerged as the vicissitudes of their knowledge of heart disease and its treatment. Emotion and sensory perception thus entered into the process of inquiry along with activity. and in this manner, the women’s narratives “filled out, stretched and changed progressively” (Smith, 1998, p. 226) my understanding of what is meant by sensuous, active embodiment.

Importantly, Smith’s (1998) project begins with, but is not confined to, exploration of embodied experience. She is concerned with “the ways in which we are active in producing and reproducing the social relations of discourse or large-scale organization.
and, inversely the ways in which those social relations overpower our lives” (Smith, 1998, p. 227). My analysis was directed to the relations which enabled certain aspects of the women’s bodily sensations to be taken up and interpreted as part of a particular illness - heart disease - while others were obscured or dismissed as irrelevant. I was able to see how the women’s bodies became known to them according to a specialized discourse which reinterpreted the appearance of incisions from “ugly” to “infected”, or the sensation of pain from “sharp” or “crushing” to “not angina” to “angina”. I saw over time how this objectifying discourse was taken up in various ways by the women, how a consciousness of self care developed, how this consciousness found expression in activity or how it encountered constraints in the everyday world of home. With the women’s descriptions of bodily experience as a point of reference, I encountered multiple disjunctures which have relevance for professional practice in health care.

The work of health education for self care, in particular, needs further attention, beginning with a critical analysis of the notion of self care as an ideological code (Anderson, 1990). The role of learning theory in coordinating the practices of health education, the ways that health programmes are developed and delivered, and the experiences of learners within these programmes would be important foci of ethnographic inquiry. The embodied nature of learning involved in what I refer to as self care could be explored further to guide revision of educational endeavours. These investigations need to focus on the discourses and social relations that exist in the conduct of these ventures and question their impact on the everyday lives of learners and the hierarchical relationship between teaching and learning. It is important that health professionals consider the
contradictory ways that their health teaching practices relate to activities and events in other arenas of professional work and in the world of the home.

Finally, the present conceptualization of “housework” in the cardiovascular literature and research limits our ability to understand homemaking as a constraint on women’s opportunities to learn about self care in chronic illness. Penckofer and Holm (1990) called for more work in this area, but many recent studies focus on women’s activities of cooking, dishwashing, bed making, laundry, dusting and sweeping, conceptualizing these as components of women’s housekeeping “role” (Hamilton and Seidman, 1993; MacKenzie, 1993; Sharpe, Clarke, & Janz, 1991). This conceptual focus evades pressing issues such as gender inequality in distribution of homemaking responsibility and the incompatibility of homemaking activities with self care. It forecloses consideration of issues related to the discursive basis of homemaking. Studies which link resumption of homemaking with personal adequacy and gender identity (King & Jensen, 1994) move closer to touching on the gendered discourse of homemaking, but omit consideration of how homemaking constructs gender and family identity, as well as others’ embodied experiences of the home. They allude to the intricacy of homemaking activities and the social milieu in which they are embedded, but analysis does not extend to the profound investment others hold in a woman’s work in the home.

Conclusion

In analysing women’s experiences surrounding ACBS, I began my analysis from the standpoints of the narratives of eighteen women. I investigated the issues and problems which arise for women at the intersection between their unpaid work as
homemakers and their efforts to learn and apply the tenets of cardiac self care. This institutional ethnography was set within the institution of health care, which operates in multiple sites of professional practice, but also in the everyday world of the home.

In chapter 4, I explained how women initially recognized particular sensory physical experiences as problem which needed to be dealt with in a particular way. They entered into a set of relations with family physicians which effected the first of a series of displacements: the diagnosis of heart disease as the assignment to a new social category which in turn hooked them into a discourse which centred on a subtext of endangerment. This culminated in admission to hospital for ACBS, which I describe in chapter 5. Here the women experienced profound physical and social displacements during a sojourn on professional ground. Bodily dispossession was accompanied by an educative indoctrination into a discourse of moral responsibility to manage cardiac risk.

The discourse of self care contained directives for personal health management which linked activities which occurred on professional ground with activities in the everyday world of home. However, in chapter 6, I examined how this discourse was taken up with great difficulty during the early weeks of relocation in the home following surgery. Despite a professional interest in imparting health information, access to the needed details was difficult to obtain. Information was imparted in a cognitive manner which belied the sensuous, embodied nature of learning required in this instance. In addition, the women dealt in different ways with the constraining effects of a separate discourse: the gendered discourse of homemaking. In chapter 7, I discuss the progress made by the women after four months had elapsed. They were in the process of situating
the discursively coordinated activities of self care within the everyday routines of homemaking. This required embodied learning for which they had been poorly prepared during their hospitalization. It was a set of practices that often conflicted with the other-oriented work of homemaking.

I elaborated the discourses of self care and homemaking as they appear in the women’s narratives and in the insights offered by health professionals. Both are linked with sensuous experiences of the body, and involve embodied activity. I discussed how the foundations of heart health are imparted in educative interventions which are imbued with the assumptions embedded in professional practice. We saw in the women’s descriptions of homemaking and self care that health sciences literature does not fully recognize the complexities and embodiment of both sets of endeavours and thus does not provide women with an adequate “cartography” of the problems and processes of implementing new personal health practices.

I argued that the social relations of displacement promote this inaccurate and incomplete version of self care. Women effect many transitions within the course of their experiences of heart disease and ACBS. Consequently, they undergo many metaphorical, social and material displacements. Most of the work of diagnosis and treatment is accomplished on professional ground, where power is realized in professional activities which exclude recognition of the everyday embodied experiences of women. Professional knowledge about the gendered activities of homemaking is constructed from discursive schemata which explain women’s lives from a predetermined framework. It is a framework that is displaced from everyday ground. This framework excludes some
aspects of gendered embodied experience while highlighting others. Hence it presents women with the bulk of the responsibility for effecting translation of the tenets of self care into embodied practice even as they grapple with the heavy responsibilities they carry as homemakers.

I have argued that it is futile to continue pouring knowledge into the everyday world of home if we do not first understand the activities of gendered homemaking. Although the home is the site of considerable informal health and self care, and the discourse of self care interlaces activities at multiple sites of health care, the main accomplishment of the discourse of self care is to devolve responsibility for health to the individual and to families. Contractionist policies which emphasize the fiscal utility of limiting the length of hospital admissions for ACBS articulate with a medicalized discourse which depicts cardiovascular disease as the culmination of the effects of risk factors on the physiological body. Individuals become morally responsible to modify these risks, yet they are also responsible to learn how to do so with little relevant assistance from the health care system.

To begin addressing this problem, I propose that the practices and locations of teaching and learning be seriously reconsidered. It is crucial that the information given to women who want to pursue cardiovascular self care be critically examined for its relevance and accuracy in relation to the everyday world of the home as it exists for women. A reflexive approach to health education is needed, and this should begin not from professional ground, but from the sensuous, embodied ground of the home. It is an approach that should maintain a critical focus on the relations that realize power in
professional activities. Finally it is an approach that should endeavour to bring in all the diverse experiences of the home and the human heart.
REFERENCES


Philadelphia: Open University Press.


Bramwell, L. (1986). Wives’ experiences in the support role after husbands’ first MI. Heart and Lung, 15(6), 578-84.


to work after coronary artery bypass surgery (pp. 169-203). Berlin: Springer-Verlag.


The caregiving experience. Unpublished report, University of Toronto, Faculty of Nursing. Funded by Health and Welfare Canada, National Health Research and Development Branch.


Routledge & Kegan Paul.


Waltz, M. (1986). Marital context and post-infarction quality of life: Is it social support or something more? *Social Science and Medicine, 22*(8), 791-805.


APPENDIX A: INFORMATION SHEET FOR CLINIC REPRESENTATIVE

(Departmental Letterhead)

WOMEN'S EXPERIENCES DURING RECOVERY FROM CABS

Information Sheet for Contact With Potential Study Participants

I would like to tell you about a study being conducted by Jan Angus, a PhD student in the Department of Community Health at the University of Toronto. Jan Angus is interested in studying the experiences of women who have had coronary artery bypass surgery, and would like to interview you.

None of the cardiovascular staff at -------- Hospital will be involved in conducting the research project. Participation in the study is voluntary and anonymous. Information that you give during the interviews will be kept confidential and you may refuse to answer any of the questions or withdraw from the study at any time. No one involved in your care here will be aware of whether or not you take part in the study. Whether or not you chose participate, your future medical care will not be affected in any way.

Are you interested in hearing more about the study?

(IF YES)

May I give your name and telephone number to Jan Angus? She will contact you and tell you more about the study.

(IF HESITANT OR UNSURE)

If you would like more information about the study before deciding whether you will participate, please call Jan Angus at 763-6118. If she does not answer, you can leave her a confidential message on the answering machine and she will contact you promptly.

(IF NO)

Thank you for considering this request.
APPENDIX B: INFORMATION SHEET FOR PARTICIPANTS

(Departmental Letterhead)

WOMEN'S EXPERIENCES DURING RECOVERY FROM CABS

Information Sheet for Participants

Purpose of the Research

The purpose of this study is to understand what it is like for women to recover from coronary artery bypass surgery. The focus on women's experiences, because many of the past studies on recovery from this surgery have centred on men. It is possible that women do not recover in the same manner as men, however, and more information about their experiences may assist health professionals in improving care to women like you. I am Jan Angus, and I am conducting this study as part of my PhD program in Behavioural Science, at the Graduate Department of Community Health, University of Toronto. I am under the supervision of David Coburn, PhD, a faculty member in Behavioural Science at the University of Toronto.

Procedures

Your participation in the study will involve two interviews; one interview will take place approximately one month following your return home after the surgery, and one interview will occur in the fourth month after your surgery. Each time, you will be interviewed in your home, or any other location that is suitable for you, at a date and time that you prefer. The interviews will take approximately two hours. The first part of each interview will be an open discussion of your experiences while you recover from your bypass surgery and will be tape recorded so I won't forget your comments or have to write while you talk. The second part of each interview will consist of your responses to a questionnaire about your health, relationships with family and others, and your demographic characteristics.

The first interview will focus on the early stages of recovery at home, and the adjustments and challenges encountered during that period. The second interview will centre on your activities as you continue to recover from the surgery.

Everything that you say will be kept confidential. Your name will not appear on the interview forms; an identification number will be used in place of your name. If you mention during the interviews the names of family members or health professionals involved in your care, these will be removed from the interview materials and will not be identifiable in any report written about the study. The tapes of the interviews will be erased at the end of the study. The typed transcripts will be retained for further analysis.
Benefits

Participation in the study may not be directly beneficial to you unless you find it helpful to discuss experiences like this with another person. Your participation in the study may also help other women who have had coronary artery bypass, because learning about experiences like yours will help provide health professionals with a basis for better care.

Risks/discomforts

Some people feel uncomfortable with answering questions and talking about their experiences. You are free to refuse to answer any of the questions or to end the interviews at any time, and you may withdraw from the study at any point. You are under no obligation to participate, and should you choose not to participate, your care at Hospital will not be affected in any way.

Further contact

If you want to contact someone about the study at a later time, or if you think of additional comments or questions, please phone me, Jan Angus, at 763-6118. Professor David Coburn may also be contacted at 978-7513.
APPENDIX C: CONSENT FORM FOR PARTICIPANTS

(Women's Experiences with Recovery from CABG)

Consent Form for Participants

I have received an explanation of the study, as described on the Information Sheet for Participants, and any questions that I have asked have been answered to my satisfaction. I know that I am free to ask any question about the study at any time. I have been given a copy of the information sheet and consent form.

I understand that no risks or discomfort are likely to occur during this interview. Although there may not be direct benefits of this research to me, it is anticipated that the findings from this research will result in knowledge about women's recovery from coronary artery bypass surgery that may serve as the basis for future improvements in the care of such women.

I understand that I will be participating in two interviews that will be audiotaped. An identification number will appear on interview materials instead of my name, and anything I say will be kept in strictest confidence. The master list of names and identification numbers will be kept in locked storage that only Jan Angus may access. My name will never be used in any publications or presentations about the findings of this study. At the end of the study, the audiotapes of the interviews will be erased. The typed transcripts will be retained for further analysis.

I may refuse to answer any question or withdraw from the study at any time.

I hereby consent to participate in the above study.

________________________________________
Participant's Name

________________________________________
Participant's Signature Date

________________________________________
Researcher's Signature Date

I agree to have the interviews tape recorded:

Yes _____ No _____
APPENDIX D: SCHEDULE OF QUESTIONS AND PROMPTS FOR WOMEN RECOVERING FROM CABS

FIRST INTERVIEW

(NOTE: The intent of the interviews is to gain an understanding of each informant's experiences from her own perspective. In order to have the narrative proceed in a manner with which the respondent is comfortable, and to obtain a representation of issues of primary importance to the informant, the interview will begin with a very general lead question. Interviews will follow the shape of the narrative presented by the respondent, returning to the schedule of questions and prompts at appropriate points in the interview, or when the respondent seems to be at a loss for words, to deal with areas not addressed by the respondent in the earlier parts of the discussion.)

Lead Question

In this study, I am interested in getting a detailed picture of what it is like for women to recover from bypass surgery. Please begin with any aspects of your experience that you'd like to talk about and tell me anything you'd like to say.

Probes

Subjective health status:
- Tell me about how you felt before your surgery.
- How did you decide to have bypass surgery?
- How have you been feeling since the surgery? Is this how you expected to feel?

Activities:
- What kinds of things did you do around the house on a typical day before you had the bypass surgery?
- What kinds of things did you do around the house yesterday? Did yesterday differ in any way from a typical day?
- How have your activities changed since you first came home from the hospital?
- What do you presently do for enjoyment and relaxation?
- Is there anything that you would like to do that you are unable to do?
- If you had paid employment outside your home prior to the surgery, what are your plans for returning to this work?

**Personal care activities and information:**

- What things do you do or not do in order to help yourself recover from the bypass surgery?

- What teaching or information have you received to help you take care of yourself after the surgery? How did you obtain this information?

- Have you been able to follow this advice?

- Is there any other information or advice that you felt you needed upon returning home?

**Relationships with others:**

- Tell me about the people who have been most helpful to you since you’ve been at home?

- What have these helpful people done?

- Has there been anyone who has made your recovery seem more difficult in some way? What has this person done?

- Tell me about the health professionals you have been in contact with before and after your bypass surgery.

**Resources:**

- What has made it easier for you to get along after the bypass surgery? What has made it difficult?

- What else would make it easier for you manage following the surgery?

**THANK YOU FOR SHARING YOUR EXPERIENCES IN THIS INTERVIEW.**
APPENDIX E: SCHEDULE OF QUESTIONS AND PROBES FOR WOMEN RECOVERING FROM CABS

SECOND INTERVIEW

Lead Question

In this interview, I am interested in hearing about how things have been for you since your early days of recovery from CABS when I interviewed you last. Please begin with any aspects of your experience that you’d like to talk about and tell me anything you’d like to say.

Probes

Subjective health status:

- How have you been feeling since we last talked?
- How does this compare with how you expected to feel?

Activities:

- What kinds of things did you do yesterday? Was this different in any way from a typical day?
- How have your activities changed since we last talked?
- Have you resumed any other activities? If yes, please tell me what they are.
- What do you presently do for enjoyment and relaxation? How has this changed over the time since the first interview?
- Is there anything that you would like to do that you are presently unable to do?

Personal care activities and information:

- What do you do now to help yourself continue to recover from the bypass surgery?
- What additional information or advice have you needed to help you manage in the past few months? How did you obtain this information? Why was this information needed?
- What advice do you wish you could have had to help you through the past few months?
Relationships with others:

- Tell me about the people who have been most helpful to you in the past few months?
- What have these helpful people done?
- Has there been anyone who has made your recovery seem more difficult in the past few months? What has this person done?
- Tell me about the health professionals you have been in contact with since our first interview.

Resources:

- What has made it easier for you to get along in the past few months?
- Has anything made it more difficult to manage?
- What would have made it easier for you manage following the surgery?

Participation in the study:

- What has participating in these interviews been like for you?

THANK YOU FOR SHARING YOUR EXPERIENCES IN THIS INTERVIEW.
APPENDIX F: INFORMATION SHEET FOR KEY INFORMANTS

(Departmental Letterhead)

WOMEN'S EXPERIENCES WITH RECOVERY FROM CABS

Information Sheet for Key Informants

The purpose of this study is to understand how women recover from coronary artery bypass surgery after discharge home from hospital. The focus of this study is on women's experiences because many of the past studies on recovery from this surgery have centred on men. Women are being interviewed for the study at two points in their recovery from CABS: the first interview takes place one month after discharge from hospital, and the second in the fourth month following discharge. The interviews focus on the women's subjective health status, resumption of activities, relationships with others who have helped them, need for and sources of information, and use of resources during the recovery period. Additionally, some health professionals are being interviewed to gather their perspectives on the care of women who have undergone CABS. I am Jan Angus, and I am conducting this study as part of my PhD program in Behavioural Science, at the Graduate Department of Community Health, University of Toronto. I am under the supervision of David Coburn, PhD, a faculty member in Behavioural Science at the University of Toronto.

Your participation in the study will involve one interview of approximately thirty minutes to one hour in length. No individual patients or their treatment programs will be discussed during this interview, as the focus will be on your general impressions of the health needs of women who are recovering from CABS, as well as existing approaches to their care. This interview will be tape recorded with your permission.

All information will be kept in confidence, with all references to your identity being coded with an identification number instead of your name. A master listing of identification numbers and names will be kept in locked storage that can only be accessed by Jan Angus. Your name will not be used in any publications or presentations about the findings of the study, nor will your place of work be identified; any reference to your comments will be attributed to a "key informant". Tape recordings of the interviews will be erased at the end of the study. Typed transcripts will be retained for further analysis.
APPENDIX G: CONSENT FORM FOR KEY INFORMANTS

(Departmental Letterhead)

WOMEN'S EXPERIENCES WITH RECOVERY FROM CABS

Consent form for Key Informants

I have received an explanation of the study, as described on the Information Sheet for Key Informants, and any questions that I have asked have been answered to my satisfaction. I know that I am free to ask questions about the study at any time. I have been given a copy of the information sheet and consent form.

I understand that I will be participating in one interview that will be audiotaped. An identification number will appear on interview materials instead of my name, and anything I say will be kept in strictest confidence. The master list of names and identification numbers will be kept in locked storage that only Jan Angus may access. My name will never be used in any publications or presentations about the findings of this study; any reference to my comments will be attributed to a "key informant". At the end of the study, the audiotapes of the interviews will be erased. Typed transcripts of the interviews will be retained for further analysis.

I may refuse to answer any question or withdraw from the study at any time.

I hereby consent to participate in the above study.

__________________________
Key Informant's Name

__________________________    ______________________
Key Informant's Signature    Date

__________________________    ______________________
Researcher's Signature    Date

I agree to have the interviews tape recorded:

Yes ______

No ______
APPENDIX H: SCHEDULE OF QUESTIONS AND PROBES
FOR KEY INFORMANTS

(NOTE: As in the interviews with the women who are recovering from CABS, the intent of these interviews is to gain an understanding of key informants' experiences from their own perspective. The interviews will begin with a general lead question, but it is anticipated that some informants may prefer a more structured approach to questioning owing to time constraints. The schedule of questions will be followed closely for those interviews where time allotments are brief).

Lead Question

In this study, I am interested in getting a detailed picture of what it is like for women to recover from bypass surgery. I'd like to begin by asking you what issues you have encountered related to women who have CABS.

Probes

Information and advice:

- What do you think women need to know about recovery from CABS? How do they get this information?

- What concerns do women mention to you most frequently? How do you deal with these concerns?

Resources and problems:

- What resources do you or others use in helping women who have CABS? What additional resources would be useful that are not already in place?

- On what do you base your advice to women who have CABS? (eg. experience, others' shared experiences, literature)

Gender differences in recovery from CABS:

- In what ways does recovery from CABS seem different for women than for men? What similarities have you noted?

- There has recently been some debate as to whether the approaches of health professionals to women differ from those seen in the treatment of men. What do you think about this?
Are there any changes that you would like to see in the current approaches to care of women who are recovering from CABS?

Questions for informants involved in educational interventions:

- How did you decide what information to include in the sessions that you lead?
- How did you decide what teaching approaches to use during these sessions?
- What would you like to do differently for the women attending these sessions? What do you think should remain the same?
APPENDIX I: QUESTIONNAIRE FOR FIRST INTERVIEW

SECTION A: HEALTH STATUS

A1. How would you describe your state of health? Compared to other persons your age, would you say it is...

Excellent?............................ 1 (C)
Very good?............................ 2 (C)
Good?................................. 3 (C)
Fair?................................. 4 (C)
Poor?................................. 5 (C)

A2. Do you have:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis, rheumatism, or bunions?</td>
<td>01 (C)</td>
<td>02 (C)</td>
<td>03 (C)</td>
</tr>
<tr>
<td>Asthma?</td>
<td>04 (C)</td>
<td>05 (C)</td>
<td>06 (C)</td>
</tr>
<tr>
<td>Emphysema, chronic bronchitis, persistent cough, or shortness of breath?</td>
<td>07 (C)</td>
<td>08 (C)</td>
<td>09 (C)</td>
</tr>
<tr>
<td>Hay fever?</td>
<td>10 (C)</td>
<td>11 (C)</td>
<td>12 (C)</td>
</tr>
<tr>
<td>Skin or other allergies?</td>
<td>13 (C)</td>
<td>14 (C)</td>
<td>15 (C)</td>
</tr>
<tr>
<td>Stomach ulcer?</td>
<td>16 (C)</td>
<td>17 (C)</td>
<td>18 (C)</td>
</tr>
<tr>
<td>Other digestive problems?</td>
<td>19 (C)</td>
<td>20 (C)</td>
<td>21 (C)</td>
</tr>
<tr>
<td>Recurring migraine headaches?</td>
<td>22 (C)</td>
<td>23 (C)</td>
<td>24 (C)</td>
</tr>
<tr>
<td>High blood cholesterol?</td>
<td>25 (C)</td>
<td>26 (C)</td>
<td>27 (C)</td>
</tr>
<tr>
<td>Any emotional disorders?</td>
<td>28 (C)</td>
<td>29 (C)</td>
<td>30 (C)</td>
</tr>
<tr>
<td>Diabetes?</td>
<td>31 (C)</td>
<td>32 (C)</td>
<td>33 (C)</td>
</tr>
</tbody>
</table>

SECTION B: HEALTH STATUS INDICATORS

B1. Would you describe yourself as...

Happy and interested in life........ 1 (C)
Somewhat happy....................... 2 (C)
Somewhat unhappy..................... 3 (C)
Very unhappy......................... 4 (C)
No opinion............................ 5 (C)

B2. How would you describe your usual ability to remember things?

Able to remember most things........ 1 (C)
Somewhat forgetful................... 2 (C)
Very forgetful....................... 3 (C)
Unable to remember anything at all... 4 (C)
B3. How would you describe your usual ability to think and solve day to day problems?

Able to think clearly and solve problems........ 1 ☑
Having a little difficulty...................... 2 ☑
Having some difficulty..................... 3 ☑
Having a great deal of difficulty.......... 4 ☑
Unable to think or solve problems......... 5 ☑

B4. In general, do you have any trouble with pain or discomfort?

Yes........................................ 1 ☑
(specify)..................................
No........................................ 2 ☑  Go to Section C

B5. How would you describe your usual intensity of pain or discomfort?

Mild......................................... 1 ☑
Moderate.................................... 2 ☑
Severe....................................... 3 ☑

B6. How many activities does your pain and discomfort prevent you from doing?

None....................................... 1 ☑
A few........................................ 2 ☑
Some......................................... 3 ☑
Most.......................................... 4 ☑

SECTION C: EVERYDAY ACTIVITIES

The next group of questions deal with how you manage everyday activities.

C1. Who usually prepares your meals?

Yourself alone................................ 1 ☑  Go to C5
Yourself and someone else.............. 2 ☑
Someone else.............................. 3 ☑

C2. Is this because of your condition or health problem?

Yes........................................ 1 ☑
No........................................ 2 ☑

C3. Who helps prepare your meals?

<table>
<thead>
<tr>
<th>Help Provided</th>
<th>No</th>
<th>Yes</th>
<th>Everyday</th>
<th>At least once a week</th>
<th>Less than once a week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband or partner</td>
<td>i)</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>04</td>
</tr>
<tr>
<td>Son</td>
<td>ii)</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
</tr>
<tr>
<td>Daughter</td>
<td>iii)</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Parent</td>
<td>iv)</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>Brother or sister</td>
<td>v)</td>
<td>21</td>
<td>22</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>Other relative</td>
<td>vi)</td>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>Friend or neighbour</td>
<td>vii)</td>
<td>31</td>
<td>32</td>
<td>33</td>
<td>34</td>
</tr>
<tr>
<td>Voluntary organization or agency</td>
<td>viii)</td>
<td>36</td>
<td>37</td>
<td>38</td>
<td>39</td>
</tr>
<tr>
<td>Private organization or agency</td>
<td>ix)</td>
<td>41</td>
<td>42</td>
<td>43</td>
<td>44</td>
</tr>
</tbody>
</table>
C4. Do you have to pay for this service out-of-pocket, that is, you are not reimbursed by any source?

Yes........................................1 ☐

No........................................2 ☐

C5. Because of your condition, do you need help or ADDITIONAL help in preparing your meals?

Yes........................................1 ☐

No........................................2 ☐

C6. Who usually does your shopping for groceries or other necessities?

Yourself alone..........................1 ☐ Go to C10

Yourself and someone else..........2 ☐

Someone else................................3 ☐

C7. Is this because of your condition or health problems?

Yes........................................1 ☐

No........................................2 ☐

C8. Who does your shopping for groceries or other necessities?

How often do they provide this help?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>Everyday</th>
<th>At least once a week</th>
<th>Less than once a week</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Husband or partner</td>
<td>01</td>
<td>☐</td>
<td>02 ☐</td>
<td>03 (    )</td>
<td>05 (    )</td>
</tr>
<tr>
<td>ii) Son..............</td>
<td>06</td>
<td>☐</td>
<td>07 ☐</td>
<td>08 (    )</td>
<td>09 (    )</td>
</tr>
<tr>
<td>iii) Daughter........</td>
<td>11</td>
<td>☐</td>
<td>12 ☐</td>
<td>13 (    )</td>
<td>14 (    )</td>
</tr>
<tr>
<td>iv) Parent...........</td>
<td>16</td>
<td>☐</td>
<td>17 ☐</td>
<td>18 (    )</td>
<td>19 (    )</td>
</tr>
<tr>
<td>v) Brother or sister.</td>
<td>21</td>
<td>☐</td>
<td>22 ☐</td>
<td>23 (    )</td>
<td>24 (    )</td>
</tr>
<tr>
<td>vi) Other relative...</td>
<td>26</td>
<td>☐</td>
<td>27 ☐</td>
<td>28 (    )</td>
<td>29 (    )</td>
</tr>
<tr>
<td>vii) Friend or neighbour.</td>
<td>31</td>
<td>☐</td>
<td>32 ☐</td>
<td>33 (    )</td>
<td>34 (    )</td>
</tr>
<tr>
<td>viii) Voluntary organization or agency............</td>
<td>36</td>
<td>☐</td>
<td>37 ☐</td>
<td>38 (    )</td>
<td>39 (    )</td>
</tr>
<tr>
<td>ix) Private organization or agency..................</td>
<td>41</td>
<td>☐</td>
<td>42 ☐</td>
<td>43 (    )</td>
<td>44 (    )</td>
</tr>
</tbody>
</table>

C9. Do you have to pay for this service out-of-pocket, that is, you are not reimbursed by any source?

Yes........................................1 ☐

No........................................2 ☐

C10. Because of your condition, do you need help or ADDITIONAL help shopping for groceries or other necessities?

Yes........................................1 ☐

No........................................2 ☐

C11. Who usually does your normal everyday housework such as dusting, tidying up, laundry?

Yourself alone..........................1 ☐ Go to C15

Yourself and someone else..........2 ☐

Someone else................................3 ☐

C12. Is this because of your condition or health problems?

Yes........................................1 ☐

No........................................2 ☐
C13. Who helps you with your normal everyday housework such as dusting, tidying up?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>Everyday</th>
<th>At least once a week</th>
<th>Less than once a week</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Husband or partner</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>04</td>
<td>05</td>
</tr>
<tr>
<td>ii) Son</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
</tr>
<tr>
<td>iii) Daughter</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>iv) Parent</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>v) Brother or sister</td>
<td>21</td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>vi) Other relative</td>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>vii) Friend or neighbour</td>
<td>31</td>
<td>32</td>
<td>33</td>
<td>34</td>
<td>35</td>
</tr>
<tr>
<td>viii) Voluntary organization or agency</td>
<td>36</td>
<td>37</td>
<td>38</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td>ix) Private organization or agency</td>
<td>41</td>
<td>42</td>
<td>43</td>
<td>44</td>
<td>45</td>
</tr>
</tbody>
</table>

C14. Do you have to pay for this service out-of-pocket, that is, you are not reimbursed by any source?

Yes...........................................1  
No...........................................2  

C15. Because of your condition, do you need help or ADDITIONAL help doing your normal everyday housework?

Yes...........................................1  
No...........................................2  

C16. Who usually does your heavy household chores such as washing walls, yard work or snow removal?

Yourself alone................................1  
Go to C20

Yourself and someone else...........2  

Someone else................................3  

No one.....................................4  

Not applicable..........................5  

C17. Is this because of your condition or health problem?

Yes...........................................1  

No...........................................2  

C18. Who helps you with your heavy household chores?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>Everyday</th>
<th>At least once a week</th>
<th>Less than once a week</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Husband or partner</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>04</td>
<td>05</td>
</tr>
<tr>
<td>ii) Son</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
</tr>
<tr>
<td>iii) Daughter</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>iv) Parent</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>v) Brother or sister</td>
<td>21</td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>vi) Other relative</td>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>vii) Friend or neighbour</td>
<td>31</td>
<td>32</td>
<td>33</td>
<td>34</td>
<td>35</td>
</tr>
<tr>
<td>viii) Voluntary organization or agency</td>
<td>36</td>
<td>37</td>
<td>38</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td>ix) Private organization or agency</td>
<td>41</td>
<td>42</td>
<td>43</td>
<td>44</td>
<td>45</td>
</tr>
</tbody>
</table>

C19. Do you have to pay for this service out-of-pocket, that is, you are not reimbursed by any source?

Yes...........................................1  
No...........................................2  

487
C 20. Because of your condition, do you need help or ADDITIONAL help doing your heavy household chores?

Yes................................1 <
No..................................2 <

C21. Who usually looks after your personal finances, such as banking or paying bills?

Yourself alone..........................1 < Go to C25
Yourself and someone else.............2 <
Someone else............................3 <

C22. Is this because of your condition or health problem?

Yes........................................1 <
No.........................................2 <

C23. Who helps you with your personal finances such as banking or paying bills?

How often do they provide this help?

\[
\begin{array}{|c|c|c|c|}
\hline
\text{No} & \text{Yes} & \text{Everyday} & \text{At least once a week} & \text{Less than once a week} \\
\hline
\text{i) Husband or partner} & 01 & 02 & 03 & 04 & 05 \\
\text{ii) Son} & 06 & 07 & 08 & 09 & 10 \\
\text{iii) Daughter} & 11 & 12 & 13 & 14 & 15 \\
\text{iv) Parent} & 16 & 17 & 18 & 19 & 20 \\
\text{v) Brother or sister} & 21 & 22 & 23 & 24 & 25 \\
\text{vi) Other relative} & 26 & 27 & 28 & 29 & 30 \\
\text{vii) Friend or neighbour} & 31 & 32 & 33 & 34 & 35 \\
\text{viii) Voluntary organization} & 36 & 37 & 38 & 39 & 40 \\
\text{ix) Private organization} & 41 & 42 & 43 & 44 \\
\hline
\end{array}
\]

C24. Do you have to pay for this service out-of-pocket, that is, you are not reimbursed by any source?

Yes........................................1 <
No.........................................2 <

C25. Because of your condition, do you need help or ADDITIONAL help looking after your personal finances?

Yes........................................1 <
No.........................................2 <

C26. Because of your condition, do you receive assistance with personal care, such as washing, grooming, dressing, or feeding yourself?

Yes........................................1 <
No.........................................2 < Go to C29

C27. Who helps you with your personal care?

How often do they provide this help?

\[
\begin{array}{|c|c|c|c|c|c|}
\hline
\text{how many} & \text{AND} & \text{how many} & \text{How many times a week?} & \text{On average} & \text{On average hours a day?} \\
\hline
\text{i) Husband or partner} & 01 & 02 & 03 & 04 & 05 \\
\text{ii) Son} & 06 & 07 & 08 & 09 & 10 \\
\text{iii) Daughter} & 11 & 12 & 13 & 14 & 15 \\
\text{iv) Parent} & 16 & 17 & 18 & 19 & 20 \\
\text{v) Brother or sister} & 21 & 22 & 23 & 24 & 25 \\
\text{vi) Other relative} & 26 & 27 & 28 & 29 & 30 \\
\hline
\end{array}
\]
C28. Do you have to pay for this service out-of-pocket, that is, you are not reimbursed by any source?

Yes..............................................1 ()
No..............................................2 ()

C29. Because of your condition, do you need help or ADDITIONAL help with your personal care?

Yes..............................................1 ()
No..............................................2 ()

C30. How much control do you feel you have in making decisions that affect your everyday activities?

None............................................1 ()
Not very much..............................2 ()
You make most of the decisions........3 ()
You make all the decisions..............4 ()

SECTION D: PHYSICAL CONDITION AND ACTIVITY

D1. How often do you...

<table>
<thead>
<tr>
<th>Activity</th>
<th>Never</th>
<th>a day</th>
<th>a week</th>
<th>a month</th>
<th>Occasionally</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) watch TV, listen to radio, records, or tapes...........................</td>
<td>01 ()</td>
<td>02 ()</td>
<td>03 ()</td>
<td>04 ()</td>
<td>05 ()</td>
</tr>
<tr>
<td>How many hours per day? ____ hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii) read.................................</td>
<td>06 ()</td>
<td>07 ()</td>
<td>08 ()</td>
<td>09 ()</td>
<td>10 ()</td>
</tr>
<tr>
<td>How many hours per day? ____ hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii) talk on the telephone.....</td>
<td>11 ()</td>
<td>12 ()</td>
<td>13 ()</td>
<td>14 ()</td>
<td>15 ()</td>
</tr>
<tr>
<td>How many hours per day? ____ hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv) do arts, crafts or other hobbies...</td>
<td>16 ()</td>
<td>17 ()</td>
<td>18 ()</td>
<td>19 ()</td>
<td>20 ()</td>
</tr>
<tr>
<td>v) attend social activities, visit with family or friends..............</td>
<td>21 ()</td>
<td>22 ()</td>
<td>23 ()</td>
<td>24 ()</td>
<td>25 ()</td>
</tr>
<tr>
<td>vi) shop..................................</td>
<td>26 ()</td>
<td>27 ()</td>
<td>28 ()</td>
<td>29 ()</td>
<td>30 ()</td>
</tr>
<tr>
<td>vii) attend religious services or related activities....................</td>
<td>31 ()</td>
<td>32 ()</td>
<td>33 ()</td>
<td>34 ()</td>
<td>35 ()</td>
</tr>
<tr>
<td>viii) attend or participate in activities such as going to bingos or clubs, or playing cards......</td>
<td>36 ()</td>
<td>37 ()</td>
<td>38 ()</td>
<td>39 ()</td>
<td>40 ()</td>
</tr>
<tr>
<td>ix) do volunteer work..........</td>
<td>41 ()</td>
<td>42 ()</td>
<td>43 ()</td>
<td>44 ()</td>
<td>45 ()</td>
</tr>
<tr>
<td>x) attend sporting events, concerts, plays, or movies...................</td>
<td>46 ()</td>
<td>47 ()</td>
<td>48 ()</td>
<td>49 ()</td>
<td>50 ()</td>
</tr>
<tr>
<td>xi) go to museums, historic sites, libraries, or art galleries......</td>
<td>51 ()</td>
<td>52 ()</td>
<td>53 ()</td>
<td>54 ()</td>
<td>55 ()</td>
</tr>
<tr>
<td>xii) visit parks.................</td>
<td>56 ()</td>
<td>57 ()</td>
<td>58 ()</td>
<td>59 ()</td>
<td>60 ()</td>
</tr>
<tr>
<td>xiii) take courses or seminars..........................</td>
<td>61 ()</td>
<td>62 ()</td>
<td>63 ()</td>
<td>64 ()</td>
<td>65 ()</td>
</tr>
</tbody>
</table>

D2. Would you like to do more activities during your spare time?
D3. What prevents you from doing more of these activities?

Now I would like to ask you some questions about physical activity. For example, walking, gardening, swimming, or bicycling.

D4. Do you take part in any physical activity?

Yes............................... 1 

No..................................... 2  Go to D6

D5. How often do you...

<table>
<thead>
<tr>
<th>Activity</th>
<th>Never</th>
<th>At least once a day</th>
<th>At least once a week</th>
<th>At least once a month</th>
<th>Occasionally</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) walk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii) garden</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii) exercise, either at home or in class</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv) swim or participate in aquatics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>v) dance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vi) cycle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vii) other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D6. Would you like to be more physically active than you are now?

Yes............................... 1

No..................................... 2  Go to Section E

D7. What prevents you from being more physically active than you are now?

SECTION E: SLEEP

E1. How long do you usually spend sleeping each night? (Do not include time spent resting)

__ __ hours __ __ minutes

E2. Do you regularly have trouble going to sleep or staying asleep?

Yes............................... 1

No..................................... 2

E3. How often do you find your sleep refreshing?

Most of the time?................. 1

Sometimes?.......................... 2

Never!................................ 3

E4. How often do you find it difficult to stay awake when you want to?

Most of the time?................. 1

Sometimes?.......................... 2
SECTION F: SUPPORTS

Suppose you feel just a bit down or depressed, and you wanted to talk about it.

a) Whom would you turn to first for help? (mark as "A")

b) Whom would you turn to second for help? (mark as "B")

- Whom would you turn to first for help? (mark as "A")
  - Spouse/ partner
  - Parent
  - Daughter
  - Son
  - Sister/brother
  - Other relative, including in-laws
  - Friend
  - Neighbour
  - Someone you work with
  - Church/clergy/priest
  - God
  - Family doctor/GP
  - Psychologist/psychiatrist/counsellor
  - Other
  - (specify)
  - No one
  - Don't know

SECTION G: SATISFACTION

G1. Are you satisfied or dissatisfied with...

a) Your relationship with your spouse/partner or your single status?

   - Very satisfied
   - Satisfied
   - Dissatisfied
   - Very dissatisfied
   - No opinion

b) Your relationship with your immediate family?

   - Very satisfied
   - Satisfied
   - Dissatisfied
   - Very dissatisfied
c) The way housework is shared in your home?
   Very satisfied...................... 1 ( )
   Satisfied......................... 2 ( )
   Dissatisfied...................... 3 ( )
   Very dissatisfied................... 4 ( )
   No opinion............................ 5 ( )

d) Your relationship with your friends?
   Very satisfied...................... 1 ( )
   Satisfied......................... 2 ( )
   Dissatisfied...................... 3 ( )
   Very dissatisfied................... 4 ( )
   No opinion............................ 5 ( )

e) Your health?
   Very satisfied...................... 1 ( )
   Satisfied......................... 2 ( )
   Dissatisfied...................... 3 ( )
   Very dissatisfied................... 4 ( )
   No opinion............................ 5 ( )

f) Your life in general?
   Very satisfied...................... 1 ( )
   Satisfied......................... 2 ( )
   Dissatisfied...................... 3 ( )
   Very dissatisfied................... 4 ( )
   No opinion............................ 5 ( )

SECTION II: DEMOGRAPHIC INFORMATION

H1. What is your marital status?
   Married common-law................... 1 ( )
   Widowed.............................. 2 ( )
   Separated/ divorced.................. 3 ( )
   Single................................. 4 ( ) Go to HJ

H2. For how many years have you been (married/widowed/separated/divorced)?
   __ __ years
H3. Excluding kindergarten, how many years of elementary and high school education have you successfully completed?

- No schooling........................................... 01 ( )
- One to five years................................. 02 ( )
- Six...................................................... 03 ( )
- Seven................................................... 04 ( )
- Eight.................................................... 05 ( )
- Nine..................................................... 06 ( )
- Ten...................................................... 07 ( )
- Eleven............................................... 08 ( )
- Twelve............................................... 09 ( )
- Thirteen........................................... 10 ( )

H4. Have you graduated from high school?

- Yes.................................................. 1 ( )
- No..................................................... 2 ( )

H5. Have you had any further schooling beyond elementary/high school?

- Yes.................................................. 1 ( )
- No..................................................... 2 ( ) Go to 117

H6. What is the highest level of education you attained?

- Masters or earned doctorate.............. 01 ( )
- Degree in Medicine, Dentistry, Veterinary Medicine, or Optometry. 02 ( )
- Bachelor or undergraduate degree, or teacher's college........... 03 ( )
- Diploma or certificate from community college, CEGEP, or nursing school. 04 ( )
- Diploma or certificate from trade, technical or vocational school, or business college. 05 ( )
- Some university.................................. 06 ( )
- Some community college, CEGEP, or nursing school............. 07 ( )
- Some trade, technical or vocational school or business college 08 ( )
- Other.............................................. 09 ( )
- (specify)........................................... ( )

H7. The ancestors of Canadians come from many ethnoracial and cultural groups such as Inuit, French, Scottish, and Chinese. To which group(s) did your ancestors belong? (accept multiple responses)

- English........................................ 01 ( )
- French......................................... 02 ( )
H8. For the past twelve months, please give your best estimate of these extra OUT-OF-POCKET expenses. I will read you a list. Please answer yes or no for all sources. If "Yes" also specify the amount.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Please specify amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription and non-prescription drugs</td>
<td>O1</td>
<td>O2</td>
</tr>
<tr>
<td>Disposable items needed for your condition or health problem</td>
<td>O3</td>
<td>$</td>
</tr>
<tr>
<td>Purchase and maintenance of specialized aids, medical supplies, or equipment</td>
<td>O4</td>
<td>$</td>
</tr>
<tr>
<td>Health and medical services not covered by any insurance plan, for example, additional hospital or physician fees</td>
<td>O5</td>
<td>$</td>
</tr>
<tr>
<td>Out-of-pocket expenses for modifications to your residence because of your condition</td>
<td>O6</td>
<td>$</td>
</tr>
<tr>
<td>Transportation, for example, travel to and from treatment, therapy, or other medical or rehabilitation services</td>
<td>O7</td>
<td>$</td>
</tr>
<tr>
<td>Personal services, for example, home care, housekeeping</td>
<td>O8</td>
<td>$</td>
</tr>
<tr>
<td>Other</td>
<td>O9</td>
<td>O10</td>
</tr>
<tr>
<td>(specify)</td>
<td>O11</td>
<td>O12</td>
</tr>
</tbody>
</table>
H9. What is your best estimate of your own income from all sources, before deductions during the past 12 months?

Was your income...

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $5,000?</td>
<td>10</td>
</tr>
<tr>
<td>$5,000 or more?</td>
<td>11</td>
</tr>
<tr>
<td>Less than $10,000?</td>
<td>06</td>
</tr>
<tr>
<td>$10,000 or more?</td>
<td>07</td>
</tr>
<tr>
<td>Less than $15,000?</td>
<td>12</td>
</tr>
<tr>
<td>$15,000 or more?</td>
<td>13</td>
</tr>
<tr>
<td>Less than $20,000?</td>
<td>14</td>
</tr>
<tr>
<td>$20,000 or more?</td>
<td>15</td>
</tr>
<tr>
<td>$25,000 or more?</td>
<td>16</td>
</tr>
<tr>
<td>$30,000 or more?</td>
<td>17</td>
</tr>
<tr>
<td>$35,000 or more?</td>
<td>18</td>
</tr>
<tr>
<td>No income</td>
<td>03</td>
</tr>
<tr>
<td>Don't know</td>
<td>04</td>
</tr>
<tr>
<td>Refused</td>
<td>05</td>
</tr>
</tbody>
</table>
H10. What is your best estimate of the total income of all household members from all sources during the past 12 months?

Was the total household income...

- Less than $5,000? 10 ○
- Less than $10,000? 06 ○
- Less than $20,000? 01 ○
- Less than $30,000? or more? 07 ○
- Less than $15,000? or more? 12 ○
- Less than $40,000? or more? 14 ○
- Less than $30,000? or more? 15 ○
- $20,000 or more? 02 ○
- $40,000 or more? 09 ○
- $60,000 or more? 16 ○
- $60,000 to less than $80,000? 17 ○
- $80,000 or more? 18 ○
- No income 03 ○
- Don’t know 04 ○
- Refused 05 ○

H11. Who else lives in your household with you?

Name               Age               Relationship to Respondent

H12. How old were you on your last birthday?

   _ _ years

END OF QUESTIONNAIRE.
APPENDIX J: QUESTIONNAIRE FOR SECOND INTERVIEW

SECTION A: HEALTH STATUS

A1. How would you describe your state of health? Compared to other persons your age, would you say it is...

- Excellent?.......................... 1 ( )
- Very good?.............................. 2 ( )
- Good?................................. 3 ( )
- Fair?................................. 4 ( )
- Poor?.................................. 5 ( )

SECTION B: HEALTH STATUS INDICATORS

B1. Would you describe yourself as...

- Happy and interested in life......... 1 ( )
- Somewhat happy....................... 2 ( )
- Somewhat unhappy................... 3 ( )
- Very unhappy......................... 4 ( )
- No opinion................................ 5 ( )

B2. How would you describe your usual ability to remember things?

- Able to remember most things........ 1 ( )
- Somewhat forgetful.................... 2 ( )
- Very forgetful.......................... 3 ( )
- Unable to remember anything at all.... 4 ( )

B3. How would you describe your usual ability to think and solve day to day problems?

- Able to think clearly and solve problems........ 1 ( )
- Having a little difficulty.............. 2 ( )
- Having some difficulty.................. 3 ( )
- Having a great deal of difficulty........ 4 ( )
- Unable to think or solve problems...... 5 ( )

B4. In general, do you have any trouble with pain or discomfort?

- Yes......................................... 1 ( )
  (specify)__________________________
B5. How would you describe your usual intensity of pain or discomfort?
- Mild
- Moderate
- Severe

B6. How many activities does your pain and discomfort prevent you from doing?
- None
- A few
- Some
- Most

SECTION C: EVERYDAY ACTIVITIES

The next group of questions deal with how you manage everyday activities.

C1. Who usually prepares your meals?
- Yourself alone
- Yourself and someone else
- Someone else

C2. Is this because of your condition or health problem?
- Yes
- No

C3. Who helps prepare your meals?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Everyday</th>
<th>Once a week</th>
<th>At least</th>
<th>Less than</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i)</td>
<td>Husband or partner</td>
<td>01 : 02</td>
<td>03 : 04</td>
<td>05</td>
<td></td>
</tr>
<tr>
<td>ii)</td>
<td>Son</td>
<td>06 ( ) 07 ( )</td>
<td>08 : 09</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>iii)</td>
<td>Daughter</td>
<td>11 : 12</td>
<td>13 : 14</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>iv)</td>
<td>Parent</td>
<td>16 : 17</td>
<td>18 : 19</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>v)</td>
<td>Brother or sister</td>
<td>21 : 22</td>
<td>23 : 24</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>vi)</td>
<td>Other relative</td>
<td>26 : 27</td>
<td>28 : 29</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>vii)</td>
<td>Friend or neighbour</td>
<td>31 : 32</td>
<td>33 : 34</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>viii)</td>
<td>Voluntary organization</td>
<td>33 : 34</td>
<td>35 : 36</td>
<td>37 : 38</td>
<td>39 : 40</td>
</tr>
<tr>
<td></td>
<td>or agency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ix)</td>
<td>Private organization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
C4. Do you have to pay for this service out-of-pocket, that is, you are not reimbursed by any source?

Yes: ........................................... 1 ☐

No: ............................................. 2 ☐

C5. Because of your condition, do you need help or ADDITIONAL help in preparing your meals?

Yes: ........................................... 1 ☐

No: ............................................. 2 ☐

C6. Who usually does your shopping for groceries or other necessities?

Yourself alone: ......................... 1 : Go to C10

Yourself and someone else: ........... 2 ☐

Someone else: ............................ 3 ☐

C7. Is this because of your condition or health problem?

Yes: ........................................... 1 ☐

No: ............................................. 2 ☐

C8. Who does your shopping for groceries or other necessities?

How often do they provide this help?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Everyday</th>
<th>once a week</th>
<th>At least once a week</th>
<th>Less than once a week</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Husband or partner</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>04</td>
<td>05</td>
</tr>
<tr>
<td>ii) Son</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
</tr>
<tr>
<td>iii) Daughter</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>iv) Parent</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>v) Brother or sister</td>
<td>21</td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>vi) Other relative</td>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>vii) Friend or neighbour</td>
<td>31</td>
<td>32</td>
<td>33</td>
<td>34</td>
<td>35</td>
</tr>
<tr>
<td>viii) Voluntary organization or agency</td>
<td>36</td>
<td>37</td>
<td>38</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td>ix) Private organization or agency</td>
<td>41</td>
<td>42</td>
<td>43</td>
<td>44</td>
<td>45</td>
</tr>
</tbody>
</table>

C9. Do you have to pay for this service out-of-pocket, that is, you are not reimbursed by any source?

Yes: ........................................... 1 ☐

No: ............................................. 2 ☐
C10. Because of your condition, do you need help or ADDITIONAL help shopping for groceries or other necessities?

Yes..............................1 ○

No..............................2 ○

C11. Who usually does your normal everyday housework such as dusting, tidying up, laundry?

Yourself alone......................1 : Go to C15

Yourself and someone else.........2 ○

Someone else......................3 ○

C12. Is this because of your condition or health problem?

Yes..............................1 ○

No..............................2 ○

C13. Who helps you with your normal everyday housework such as dusting, tidying up?

How often do they provide this help?

At least

Less than

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Everyday</th>
<th>once a week</th>
<th>once a week</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Husband or partner......01 ○ 02 ○ 03 ○ 04 ○ 05 ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii) Son.......................06 ○ 07 ○ 08 ○ 09 ○ 10 ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii) Daughter...............11 ○ 12 ○ 13 ○ 14 ○ 15 ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv) Parent...................16 ○ 17 ○ 18 ○ 19 ○ 20 ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>v) Brother or sister.......21 ○ 22 ○ 23 ○ 24 ○ 25 ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vi) Other relative.........26 ○ 27 ○ 28 ○ 29 ○ 30 ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vii) Friend or neighbour...31 ○ 32 ○ 33 ○ 34 ○ 35 ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>viii) Voluntary organization or agency.......36 ○ 37 ○ 38 ○ 39 ○ 40 ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ix) Private organization or agency.......41 ○ 42 ○ 43 ○ 44 ○ 45 ○</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C14. Do you have to pay for this service out-of-pocket, that is, you are not reimbursed by any source?

Yes..............................1 ○

No..............................2 ○

C15. Because of your condition, do you need help or ADDITIONAL help doing your normal everyday housework?

Yes..............................1 ○

No..............................2 ○

C16. Who usually does your heavy household chores such as washing walls, yard work or snow removal?

Yourself alone......................1 ○ Go to C20

Yourself and someone else........2 ○
17. Is this because of your condition or health problem?

Yes................................1 (☐)
No.................................2 (☐)

C18. Who helps you with your heavy household chores?

How often do they provide this help?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>Everyday</th>
<th>once a week</th>
<th>At least once a week</th>
<th>Less than</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Husband or partner</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>04</td>
<td>05</td>
<td></td>
</tr>
<tr>
<td>ii) Son...............</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>iii) Daughter......</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>iv) Parent...........</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>v) Brother or sister.</td>
<td>21</td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>vi) Other relative..</td>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>vii) Friend or neighbour</td>
<td>31</td>
<td>32</td>
<td>33</td>
<td>34</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>viii) Voluntary organization</td>
<td>36</td>
<td>37</td>
<td>38</td>
<td>39</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>x) Private organization or agency.</td>
<td>41</td>
<td>42</td>
<td>43</td>
<td>44</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C19. Do you have to pay for this service out-of-pocket, that is, you are not reimbursed by any source?

Yes...............................1 (☐)
No.................................2 (☐)

C20. Because of your condition, do you need help or ADDITIONAL help doing your heavy household chores?

Yes...............................1 (☐)
No.................................2 (☐)

C21. Who usually looks after your personal finances, such as banking or paying bills?

Yourself alone..................1 (☐) Go to C25
Yourself and someone else....2 (☐)
Someone else....................3 (☐)

C22. Is this because of your condition or health problem?

Yes...............................1 (☐)
No.................................2 (☐)

C23. Who helps you with your personal finances such as banking or paying bills?

How often do they provide this help?
At last

No Yes Everyday once a week At least once a week

i) Husband or partner...01 (□) 02 (□) 03 (□) 04 (□) 05 (□)
ii) Son..................06 (□) 07 (□) 08 (□) 09 (□) 10 (□)
iii) Daughter..........11 (□) 12 (□) 13 (□) 14 (□) 15 (□)
iv) Parent..............16 (□) 17 (□) 18 (□) 19 (□) 20 (□)
v) Brother or sister...21 (□) 22 (□) 23 (□) 24 (□) 25 (□)
vi) Other relative......26 (□) 27 (□) 28 (□) 29 (□) 30 (□)
vii) Friend or neighbour...31 (□) 32 (□) 33 (□) 34 (□) 35 (□)
viii) Voluntary organization
or agency..............36 (□) 37 (□) 38 (□) 39 (□) 40 (□)
ix) Private organization
or agency..............41 (□) 42 (□) 43 (□) 44 (□)

C24. Do you have to pay for this service out-of-pocket, that is, you are not reimbursed by any source?
Yes........................1 (□)
No........................2 (□)

C25. Because of your condition, do you need help or ADDITIONAL help looking after your personal finances?
Yes........................1 (□)
No........................2 (□)

C26. Because of your condition, do you receive assistance with personal care, such as washing, grooming, dressing, or feeding yourself?
Yes........................1 (□)
No........................2 (□) Go to C29

C27. Who helps you with your personal care?
How often do they provide this help?

On average
No Yes days a week? hours a day? how many AND how many

i) Husband or partner...01 (□) 02 (□) — — — —
ii) Son..................03 (□) 04 (□) — — — —
iii) Daughter..........05 (□) 06 (□) — — — —
iv) Parent..............07 (□) 08 (□) — — — —
v) Brother or sister...09 (□) 10 (□) — — — —
vi) Other relative......11 (□) 12 (□) — — — —
vii) Friend or neighbour...13 (□) 14 (□) — — — —
viii) Voluntary organization
or agency..............15 (□) 16 (□) — — — —
ix) Private organization
or agency..............17 (□) 18 (□) — — — —

C28. Do you have to pay for this service out-of-pocket, that is, you are not reimbursed by any source?
C29. Because of your condition, do you need help or ADDITIONAL help with your personal care?

Yes........................................1  ☐

No........................................2  ☐

C30. How much control do you feel you have in making decisions that affect your everyday activities?

None........................................1  ☐

Not very much...........................2  ☐

You make most of the decisions.......3  ☐

You make all the decisions..........4  ☐

SECTION D: PHYSICAL CONDITION AND ACTIVITY

D1. How often do you...

<table>
<thead>
<tr>
<th>Activity</th>
<th>Never</th>
<th>a day</th>
<th>a week</th>
<th>a month</th>
<th>Occasionally</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) watch TV, listen to radio, records, or tapes</td>
<td>01-02</td>
<td>03-04</td>
<td>05-06</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii) read</td>
<td>06-07</td>
<td>08-09</td>
<td>10-11</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii) talk on the telephone</td>
<td>11-12</td>
<td>13-14</td>
<td>15-16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv) do arts, crafts or other hobbies...</td>
<td>16-17</td>
<td>18-19</td>
<td>20-21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>v) attend social activities, visit with family or friends</td>
<td>22-23</td>
<td>24-25</td>
<td>26-27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>vi) shop</td>
<td>28-29</td>
<td>30-31</td>
<td>32-33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>vii) attend religious services or related activities</td>
<td>34-35</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>viii) attend or participate in activities such as going to bingos or clubs, or playing cards</td>
<td>36-37</td>
<td>38-39</td>
<td>40-41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ix) do volunteer work</td>
<td>41-42</td>
<td>43-44</td>
<td>45-46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>x) attend sporting events, concerts, plays, or movies</td>
<td>47-48</td>
<td>49-50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
xi) go to museums, historic sites, libraries, or art galleries........ 51 (□) 52 (□) 53 (□) 54 (□) 55 (□)
xii) visit parks........................... 56 (□) 57 (□) 58 (□) 59 (□) 60 (□)
xiii) take courses or seminars.......... 61 (□) 62 (□) 63 (□) 64 (□) 65 (□)

D2. Would you like to do more activities during your spare time?

Yes..................................... 1 (□)

No..................................... 2 (□) Go to D4

D3. What prevents you from doing more of these activities?

Now I would like to ask you some questions about physical activity, for example, walking, gardening, swimming, or bicycling.

D4. Do you take part in any physical activity?

Yes..................................... 1 : :

No..................................... 2 : : Go to D6

D5. How often do you... One time once once

once once once

Never a day a week a month Occasionally

i) walk................................. 01 (□) 02 (□) 03 (□) 04 (□) 05 (□)

ii) garden............................ 06 (□) 07 (□) 08 (□) 09 (□) 10 (□)

iii) exercise, either at home or in class......................... 11 (□) 12 (□) 13 (□) 14 (□) 15 (□)

iv) swim or participate in aquatics..... 16 (□) 17 (□) 18 (□) 19 (□) 20 (□)

v) dance............................... 21 (□) 22 (□) 23 (□) 24 (□) 25 (□)

vi) cycle............................... 26 (□) 27 (□) 28 (□) 29 (□) 30 (□)

vii) other............................. 31 (□) 32 (□) 33 (□) 34 (□) 35 (□)

(specify)................................

D6. Would you like to be more physically active than you are now?

Yes..................................... 1 (□)

No..................................... 2 (□) Go to Section E

D7. What prevents you from being more physically active than you are now?

SECTION E: SLEEP
E1. How long do you usually spend sleeping each night? (do not include time spent resting)

    ___ hours  ___ minutes

E2. Do you regularly have trouble going to sleep or staying asleep?

    Yes........................................ 1 ☐
    No........................................ 2 ☐

E3. How often do you find your sleep refreshing?

    Most of the time?......................... 1 ☐
    Sometimes?................................ 2 ☐
    Never?..................................... 3 ☐

E4. How often do you find it difficult to stay awake when you want to?

    Most of the time?......................... 1 ☐
    Sometimes?................................ 2 ☐
    Never?..................................... 3 ☐

SECTION F: SUPPORTS

Suppose you feel just a bit down or depressed, and you wanted to talk about it.

a) Whom would you turn to first for help? (mark as "A")

b) Whom would you turn to second for help? (mark as "B")

    Spouse/ partner...................................... 01 ☐
    Parent............................................. 02 ☐
    Daughter........................................... 03 ☐
    Son.................................................. 04 ☐
    Sister/ brother................................. 05 ☐
    Other relative, including in-laws............ 06 ☐
    Friend............................................. 07 ☐
    Neighbour........................................ 08 ☐
    Someone you work with...................... 09 ☐
    Church/ clergy/ priest....................... 10 ☐
    God............................................... 11 ☐
SECTION G: SATISFACTION

G1. Are you satisfied or dissatisfied with...

a) Your relationship with your spouse/partner or your single status?

Very satisfied ........................................ 1 (7)
Satisfied ............................................ 2 (7)
Dissatisfied ......................................... 3 (7)
Very dissatisfied ...................................... 4 (7)
No opinion ............................................ 5 (7)

b) Your relationship with your immediate family?

Very satisfied ........................................ 1 (7)
Satisfied ............................................ 2 (7)
Dissatisfied ......................................... 3 (7)
Very dissatisfied ...................................... 4 (7)
No opinion ............................................ 5 (7)

c) The way housework is shared in your home?

Very satisfied ........................................ 1 (7)
Satisfied ............................................ 2 (7)
Dissatisfied ......................................... 3 (7)
Very dissatisfied ...................................... 4 (7)
No opinion ............................................ 5 (7)

d) Your relationship with your friends?
Very satisfied.......................... 1 (○)
Satisfied.................................. 2 (○)
Dissatisfied............................. 3 (○)
Very dissatisfied........................ 4 (○)
No opinion.............................. 5 (○)

e) Your health?

Very satisfied.......................... 1 (○)
Satisfied.................................. 2 (○)
Dissatisfied............................. 3 (○)
Very dissatisfied........................ 4 (○)
No opinion.............................. 5 (○)

1) Your life in general?

Very satisfied.......................... 1 (○)
Satisfied.................................. 2 (○)
Dissatisfied............................. 3 (○)
Very dissatisfied........................ 4 (○)
No opinion.............................. 5 (○)

END OF QUESTIONNAIRE