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PANEL 1: Gender, Culture and Work

Moderator: **Pat Kaufert, Associate Professor, Department of Community Health Services, University of Manitoba**

Speakers: **Pat Armstrong, Head, Department of Sociology, York University**

Pat Baxter, National Coordinator, Economic Development for Canadian Aboriginal Women, Inc., Ottawa

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Introduction

Patricia Kaufert

As a moderator, I was told to introduce this panel drawing on my own "perspective and experience". Having membership in three disciplines, I was undecided whether to speak from the perspective of an epidemiologist or a medical sociologist, but opted for the voice of the anthropologist. I have four themes, each of which is derived from the title of this panel, "Gender, Culture and Work".

As a quasi-anthropologist, I read the term "culture" as a reference to values, norms, beliefs, ideological commitments, shared expectations, and material as well as intellectual artifacts. My first theme deals with the impact of the culture of the workplace on the health of women. I will explain using the hospital as my workplace examplar. Medical culture – medical ideology – demands that interns and residents prove their capacity to become physicians by their ability to work despite sleep deprivation, inadequate nutrition, and high levels of physical and psychological stress. This manner of organizing medical work may not be good for the health of patients, but it is certainly not conducive to a healthy pregnancy. US data suggests that pregnant interns and residents are at relatively high risk for prematurity and low birth-weight infants. Medical labour could be organized in more healthful ways. Commitment to the present system has more to do with ritual and ideology - the culture of medicine - than necessity. If we are to understand how work impacts on women's health, we need research which can explore the culture of the workplace and its impact on women's health. The eye of the anthropologist may be particularly important as women move into arenas in which the culture had been defined by and for men, such as the army, the lawyer's office, the building site.

My second theme starts not from the culture of work, but from the place given to women within mainstream culture and its implications for research on women and occupational health. It is a commonplace for this audience that, apart from a few very notable exceptions, researchers in occupational health have largely ignored women. (Hence lies the importance of this research round table.) One could say that this group of researchers simply could not <u>not</u> see women as research subjects. The reason is partly that they worked from cultural models in which the workplace was exclusively inhabited by men. Conversely, researchers in women's health work from models which are almost exclusively domestic. They are concerned with the impact on a woman's health of marriage, childbirth, being a mother, being a single mother, being an aging mother. They sometimes add in employment as a variable, but rarely look at the actual content of a woman's working role and its relationship to health.

I will take an example from research on osteoporosis. I have reviewed several questionnaires from studies which are trying to measure the impact of a life-time record of physical activity on post-menopausal bone loss. Questions are asked about jogging, walking, swimming, aerobics, tennis, and other forms of exercise. None include items to measure what women do with their bodies as part of their working lives. As a result, we have no idea of the implications for bone loss of standing all day (as with most women in sales and service occupations), or sitting (as with many women working in the garment industry), or lifting heavy weights (as with many women in nursing). Occupational health researchers do not see women as part of the work-force; researchers on women's health cannot see beyond the boundary of the home. In both cases, the boundaries of the researchers' vision are set by culturally-defined expectations not only about what women do, but also about what it is relevant to know about women.

My third theme is based on an interpretation of the word "culture" as a short-hand reference to those whose values, beliefs, behavior, appearance are different from whatever is accepted in mainstream society as the

norm. Whenever anthropologists are asked to talk to a medical audience about culture, the expectation is that they will speak about the cultural "other". This "other" may be those who have come recently as immigrants or refugees. It may be those who have been here for several generations, but belong to a so-called `visible minority'. It may be aboriginal peoples, those who were here first, but have been excluded always from the mainstream. The cultural "other" may even be those who are excluded on the grounds of physical or mental deviations from what is defined as "normal".

For women in any of these groups, we have only a handful of studies on the problems they face in gaining entry to the workforce. Alternatively, if women are working, we know something of the existence of job ghettos marked by low wages and very poor working conditions, but we know hardly anything about the health implications of these conditions. There is a desperate need for research on the health of women, who have to deal with a labour force structured against their full participation on terms of equality with other women.

We live in a society which discriminates on the basis of "otherness" and the culture of the workplace is not immune to the prejudices of the wider community. We need to be wary of generalizations which do not incorporate the particular experiences of the cultural "other". We need to be doubly wary that priorities are not set which do not recognize the diversity of women in the work force and the diversity of their work.

My fourth and final theme is in the form of a question which asks what are the implications of changes in the culture of women for occupational health. I am referring to those changes in values, beliefs, ideological commitments which get loosely fitted under the general label "feminism". In a way, this round table is the product of these changes. It reflects the demand by women that their experience should be acknowledged, and that their participation in the labour force should be researched, made known, and become the basis for reform.

Pat Armstrong

The title of the session, Gender, Culture and Work, reminded me of interviews done for a project I worked on with an organization called Toronto Women in Film and Television. In those interviews, a producer in a private film company said he "thinks women can do anything they want. It's just a question of how good they are". He went on to point out that:

> *very rarely is a woman gonna be grips or electronics or those traditional areas that require strength. But then again almost every script supervisor I've ever met is female, because it's more of a detail bookish discipline...I've found that the majority of people I've worked with are quite respectful of the women they are working with in the industry and treat them no more harshly than they do men, just so much as they hold up their end. I think they will find there is little time or respect for frailty, and traditionally women have been more frail than men in society and frankly there is no time for that in the film industry.*

Another male producer, interviewed for the same project, held similar views:

> *I don't think there are any barriers outside. I think there are barriers inside: women's own attitudes which have been formed by a male-dominated world...I think one of the dangers in the women's movement today tends to be that it becomes the cop-out reason, the reason for not making it because I am a woman...So that it's got to be understood if women are to make the stride, so they're going to have as much guts and perseverance and understanding, that is the nature of the beast...just somehow the chutzpah, balls and the guts to do it, but it's not a female thing in my view.*

The second thing that came to mind when I saw the title was a series of scenarios used to select employees for management training courses in a company which, like the producers described earlier, claimed there were no barriers for women in the industry. Candidates for the training courses were asked how they would respond to the situation outlined. In each case, it is clear that the manager is male. For example, in one scenario, the company changed the dress code. The men were to wear suits and the women dresses. The participant is to imagine that he has given away all his suits and that his secretary is angry about the new dress code. He would want to keep her because she is better than most. In a second case, the participant is to imagine that a transfer would mean a move but also more money. If he made more money, Suzie could quit her job and stay home with the children.

These two examples illustrate the continuing male dominance of the workplace culture and some of the barriers that keep women doing women's work at women's wages. Such dominance sets the stage for women's workplace health. Before we can examine the specific health hazards women face, it is necessary to understand what work women do and how that work is being restructured in the new global economy.

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Dorothy Wigmore

The previous presentation illustrates a classic example, not only of the differences between the health care for men and women, but also the fact that workplace causes are rarely investigated when people become ill. I suspect that neither of the people involved in your story were asked what work they did and whether there might be some parallels between their outcomes.

What I would like to talk about today is not so much specific hazards involving women, but the process by which these kinds of hazards are investigated.

I am an occupational hygienist, which means I am supposed to know about sick workplaces; that is, people's exposures, as opposed to the sick bodies that come through the door. It is not that I am not interested in the sick bodies that come through the door, but I usually ask them questions such as, "What do you work with?" and "How do you do it?" etc.

I am also speaking personally, not on behalf of my employer. I have been trained to work as an occupational hygienist who takes a fairly holistic view of occupational health. The 1963 definition of occupational health, used by the WHO and the ILO, describes people's right to prevent ill health and their right to a workplace where their good health is maintained. That definition of health includes physical and psychosocial well-being.

I am also trained to work as an occupational hygienist with an ethical point of view that says I am here for workers and my interest is workers' health. That sometimes gets me into difficulties because I am seen, therefore, to be a political, rather than a technical person. It is more of a problem that I also am a trade unionist.

What I would like to say, given that, is that the reason why people are doing occupational health research, and why I do the kind of work I do, is to identify and solve problems. It is not to bring good news or bad news to individuals, and it is not to be altruistic. What I am concerned about is identifying and solving problems that relate to the workplace, and particularly the health problems that are there. I have experience in doing that, as a government hygienist, in a multidisciplinary clinic, representing union members, and working with lawyers.

One thing that has become clear to me, and which angers me, is the fact that workers are not treated with very much respect. This has extremely serious consequences, I feel, for occupational health research.

What happens is that workers are seen as having a biased interest in these questions. They are not necessarily seen as knowing much or being people with whom one would want to discuss issues such as how research questions should be framed, what is going on, or what the solutions might be.

Unfortunately, people who work for or with workers are thrown into that same category. What gets missed is real life, what is actually happening in the workplaces. That is what some people have referred to in different ways today.

One example from real life shows the difference between what some researchers believe and what workers are experiencing. Most hygienists are

concerned with something called occupational exposure limits. The most common one of these are called Threshold Limit Values. They give standards on how much is a "safe" amount for pollutants in the air.

As a hygienist, I am expected to use these numbers to identify, evaluate, and help solve health and safety problems. For years people have used these Threshold Limit Values, which were put together by an organization in the US called the American Conference of Governmental Industrial Hygienists. For years workers have been saying that these numbers are not very good, and pointing out all the qualifications that go with the use of them.

It was not until fairly recently that some occupational hygienists and occupational health researchers looked at the primary sources used to document these numbers, and they discovered some interesting things. They discovered the workers are right; these numbers are not very good.

That is partly because in some cases they have been set by people who work for the companies that produce the substances involved. In some cases, the numbers are not very good because the primary resources were not used properly. One examination of the relationship between these standards and workers' health showed that there is absolutely no relationship between the so-called "industrial experience" behind these numbers and workers' health. However, there is a correlation between these numbers and the actual levels to which workers are being exposed. What this means is that these numbers are not set up to protect workers' health, but they do reflect what people in the workplace are being exposed to.

This kind of examination has been a credible undertaking, only because researchers have backed up workers' stories. In the past, these kinds of measurements have been used against workers in two ways. Somebody will say, "I'm getting sick. It has to be the lousy air, It's the welding. It's the work I do in some way or the other."

Then maybe, if they are lucky, a government inspector will come in. The government inspector will measure what is in the air and say, "It's not above the TLV; you can't be sick because of that." The worker might not want to believe him, and might continue fighting in the workplace to get some changes made.

Possibly, if her doctor says that she might be sick because of her work, she will want to file a workers' compensation claim. Then the Workers' Compensation Board will look at the data from the measurements done in the workplace, and will tell this person, again, that she cannot be sick with a particular symptom or disease from working with a particular material, because the numbers were not above the occupational exposure limits.

It does not matter whether people have classic symptoms. It does not matter that people get better when they leave work and get sick when they return. The government inspector and the Workers' Compensation Board have the same answer: you are not sick because of your work.

Women workers, I think, run into this problem even more so than do male workers. A classic example is the amount of time that it has taken to get the problem of indoor air quality taken seriously. Some people would argue that it is not as serious a problem as lead exposure or asbestos exposure, although we are starting to take it a little bit more seriously.

I remember first hearing about indoor air issues when I started working in this field in the mid-1970's. Across the Ottawa River here, women at the Terrasses de la Chaudière (or as they say in English, "the Terrace of the Shoddy Air"), spent years trying to convince their employer and experts that they were getting sick because of the bad design of the building in which they worked.

The same kind of frustrations has occurred with reproductive health problems and the use of VDTs or VDUs. It takes a long time for people to take some of these issues seriously and look at them.

What has happened in terms of indoor air is that measurements are often taken; as a result, workers are told that, for example, the formaldehyde levels were "nowhere near the TLV" and therefore their problems could not be due to the formaldehyde coming off the carpet, the glues, or the paints. But they are still sick and feeling discomfort.

The term "mass psychogenic illness" has been used to describe what was really going on. In one case I know of where this term was used to describe an indoor air problem, it turned out that the real problem was low-level vibration in the ventilation system.

People did not go to look at the workplace and see what was really happening. One reason that should be done, I think, is a principle that is held by trade unions and popular educators, and that is that the workers really are experts. They know a lot about their workplaces, their jobs and the problems they face; and given the right kind of forum, facilitation and interaction with people who have other kinds of knowledge related to their work, there are amazing things that can be done to sort out problems. This is true not only in this country. I have participated in

such efforts in places such as Mozambique, where we worked mostly with illiterate workers. It is quite amazing what can be done. What is also amazing is how much information it provides for researchers.

Researchers have to realize that they are not the only "experts" on occupational health work, but that the needs and interesting questions of workers are important parts of any research project. Research is not supposed to be done just to get one's name in print, but to try and identify and deal with genuine issues so that the information can be used to help solve problems.

Let me give you one example. A group of social workers, mostly women, came to the MFL Occupational Health Centre to talk to us about stress. They wanted some information. Their questions evolved into a survey about violence in their workplace. We worked with the union staff representative, some of the individuals with concerns, and worker representatives on their joint health and safety committee.

The time spent listening, learning and thinking about the issues produced significant changes in the working conditions and the collective agreement. Equally important, armed with this knowledge and their union's backing, the participants were able to force a progressive interpretation with the provincial legislation, which has set a very important precedent for other workers.

As an aside, I believe one important, but unappreciated, aspect of this case is that the union representative for these people was a woman who had done their kind of work. It was important in terms of identifying and solving the issues, because those who represent workers don't always know exactly what is going on.

I think it is important to not only work with workers' reps, but to work with individual workers who have problems. Worker participation should not be superficial. It works best when those who are most directly affected are involved.

One other example involves job descriptions. If you have ever compared your job description with what you actually do, you would know that, sometimes, they are not the same. It's very important to try and distinguish what people are really doing. A good example illustrating this is people who do cleaning work.

In my experience with people who do cleaning work, the men tend to operate the heavy equipment and the women work with all the nice sprays and chemical cleaning products. Then they are told that they're crazy when they start to have headaches or develop rashes, thyroid problems or other kinds of problems. The men do not have the same problems; but the men do not do the same kind of work.

So one consequence of not dealing with what is really going on in the workplace is that significant issues are ignored and there are delays in taking preventive action.

In terms of where we go from here, I think it is important to ask "why". Why do women have more cumula-trauma disorders? Why are they running into difficulties with the personal protective equipment they wear? Why are there different accident rates?

We have to start paying attention to the anecdotes that people tell. We have to look at research and investigation models such as the ones that have been developed in occupational health clinics, at the Université du Québec à Montréal and elsewhere. We have to look at work environment boards and funds that try to combine workers' knowledge and suspicions with those of different kinds of specialists.

Above all, I think we have to remember that we are here to try to identify and solve problems, and ask whether what we are doing does that.

Donna Mergler

The microelectronics industry, often portrayed as being clean and well-organized, employs hundreds of thousands of women worldwide, in the manufacture and assembling of printed circuit boards and their micro-components[1]. Yet the technological advances that this industry has procured for others is almost absent on their own assembly lines where the work is visually and physically demanding, sometimes performed looking continuously through a microscope while using one's hands and feet in awkward positions to carry out the operations. Most often paced by the speed of the assembly line or by a bonus system, the work is highly repetitive, requiring manual dexterity and high levels of concentration. In addition to the postural and organizational constraints, varied organic solvents, with known neurotoxic properties, are continually used in the work process, exposing workers to what can be described as "toxic cocktails"[2].

Since the early seventies, reports began appearing about women workers in this industry who complained about losing their memory; the symptoms they