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Work Related Injury among Aging Women

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Abstract

This article reports the experiences of women age 55 to 75 with mobility impairments who attributed aspects of their limitations to workplace injuries and provides insight into worker's compensation policies. The study sample includes Mexican American and non-Hispanic White women ages 55–75 who participated in a 4-year ethnographic study of disablement. Ninety-two of the 122 participants in the study attributed aspects of their functional limitations to employment, and their experiences were analyzed using data from 354 meetings. Using Lipscomb and colleagues' conceptual model of work and health disparities, the women's experiences were grouped into three categories according to type of injury, assistance gained, and the consequences of a workplace injury; the results have broad implications for policies that influence aging outcomes. Workplace injuries causing permanent functional limitations compound the effects of age and gender on employment outcomes. Policies addressing health disparities should consider work related influences.

After a workplace injury, an injured employee may be cared for through the oldest social insurance program in the United States (U.S.)—the Worker's Compensation (WC) system. Started in 1908 to cover the injuries of federal employees (Sengupta & Reno, 2007), the modern day WC system is managed under rules specific to each state. WC is designed to prevent tort suits considered disadvantageous to employers due to potentially large monetary

settlements to injured workers, and considered disadvantageous to employees by demanding that they must legally prove an employer at fault for their injuries—a process that is costly and difficult (Clayton, 2003/2004). Overall, permanent unemployment due to injury in WC disability cases is rare; combined with fatalities, it accounted for only 12 percent of the 3 million workplace injuries reported in 2010 (U.S. Department of Labor, 2011). There were, however, 118/10,000 workers who required time-off from work due to temporary or permanent functional limitations following a workplace injury. Temporary benefits are the most common allotted benefit; the majority of workers with or without permanent functional limitation return to work after their initial injury (Clayton, 2003/2004).

The impact of workplace injury is an issue for both men and women; regardless, women experience age- and gender-specific issues in the workplace that create a need to examine the process and outcomes unique to their long-term outcomes. Women report gender-specific types of jobs and injuries, and they have greater risk than men for poverty in old age due to employment inequalities inherent in U.S. society. Aging women, and especially older minority women, experience severe consequences from work injury beyond what is reported in national labor data sets, which may be important for planning retirement and insurance policies to support working class older Americans (Murgatroyd, Cameron & Harris, 2011). The purpose of this study is to present the experiences of women age 55 to 75 years who report functional limitation attributed to their employment.

The Worker's Compensation Process

Given that states manage their own WC programs, these programs vary throughout the country. For the purposes of this paper, Texas (TX) will serve as an exemplar. In TX, the injured worker is required to use the medical treatment recommended by a WC-designated physician (WCDP) from within the worker's specified network, with any change approved by WC and the TX Department of Insurance (TDI) office. Any worker who uses treatments not recommended by the WCDP may lose benefits, including any monetary compensation for permanent impairment and lost wages; compensation is set at 80% of weekly wages with a \$537.00/week salary cap (TDI, 2012). In other words, if one injured worker was compensated at a regular wage of 671.00/week and another injured worker was compensated at a regular wage of 950.00/week, they both would not receive any more than the 537.00/week in workers compensation benefits after their injuries.. The workers yearly salary would drop to under \$26 thousand/year. The WCDP provides treatment and then determines the likelihood for improvement by designating the point of maximum medical improvement (MMI) and assigning an impairment rating (IR), which quantifies the degree of permanent damage for purposes of compensation. The assignment of an IR is based on lasting loss of movement of the body or loss of appendages. Treatments are not meant to improve function after MMI is established.

Gender Issues

Although barriers to care and return to work (RTW) have been reported after workplace injury for both men and women, researchers report more problematic circumstances for women. For example the causes of work-related fatality differ for women. The leading cause of work related fatality among women were employment-related transportation, which accounted for 43% among women and 38% among men, and violent acts in the work place, which accounted for 30% among women and 17% among men in 2009 (Bureau of Labor Statistics, 2011). Women also have a wide range of work-related injuries and a wider range of activity-related pain causing functional limitation and unemployment than do men (Treaster & Burr, 2004). In addition, women are more susceptible to depression (Adams et al., 2008), which may influence perceptions of functional limitation and pain.

Once women are injured and unemployed, RTW becomes difficult (Steenstra, Verbeek, Heymans, & Bongers, 2005; Stover, Wickizer, Zimmerman, Fulton-Kehoe, & Franklin, 2007). Women have been less likely to belong to a workforce union for support than are men, a consistent trend from 1983 to 2011 (Bureau of Labor Statistics, 2012). Studies also reveal gender inequality in the process of claiming compensation for work leave (Harrold, Savageau, Pransky, & Benjamin, 2008). It has been suggested that gender inequality does not come from state laws or policies; rather, medical and rehabilitation practitioners, as well as trade unionists, have been identified as making compensation and RTW less beneficial for women (Guthrie & Jansz, 2006). Having a workplace injury exposes women to a high risk of functional limitation and long-term unemployment. Not only do salary discrepancies put women and women of color at high risk for aging into poverty over the life course, but rates of work injuries increase and the rates of RTW decrease with age (U.S. Department of Labor, 2011) exacerbating levels of poverty at the end of life.

Theoretical Model

The theoretical perspective used to guide this study is based on the conceptual model of work and health disparities provided by Lipscomb and colleagues (2006). According to these theorists, different groups have unequal access to work and job assignments within the workplace, which leads to varying levels of income and benefits over time. Health and social policies, both formal and informal, directly influence the knowledge groups have regarding work benefits, exposures to injuries, access to care, and job related skills, which can lead to health disparities. People with greater susceptibility to injury due to pre-existing illness or injury are also at higher risk for health disparities. These factors influence the direct progression from work activity, to exposure, to occupationally created noxious stimuli, to injury/illness, and finally to health disparities in long-term health, economic and quality of life outcomes. These outcomes have an impact on both the individual and the family.

Based on this model, we describe the types of workplace injuries/illnesses reported by NHW and MA women, the experience of women gaining WC benefits after their injury, and the perceived outcome of their injuries on their aging experience in terms of health, economics and quality of life. It is the purpose of this qualitative study to explore the experiences of work related injuries perceived to impact levels of health disparity in middle to late life.

Methodology

After approval from the local institutional review board, the research team gained a certificate of confidentiality. This permitted the collection of extensive confidential data from women of Mexican and European descent residing in TX, using interpretive ethnographic methods (Spradley, 1979). Here we report data relaying the process and outcomes of work-related injury.

Setting

Data were collected individually in the participants' homes, workplaces, rehabilitation settings, seniors' centers, and other nontraditional places (e.g., a rural field). Meetings were scheduled if the place was mutually agreeable. Participant and naturalistic observations occurred in these locations over the 4 years of data collection throughout 44 different cities and 32 different counties in TX.

Recruitment

Purposeful sampling was used to recruit participants that reported mobility impairment, an age of 55 to 75, being female and Mexican American (MA) or non-Hispanic White (NHW),

speaking English or Spanish, and residing in their communities. To qualify as mobility impaired, they needed to have reported 2 of the 4 functional limitations: the inability to walk 10 steps without resting, the inability to walk a quarter of a mile, the inability to stand for 20 min, or the inability to bend down from a standing position (Maag, 2006).

The study office was contacted by a total of 205 women interested in the study. A bilingual research assistant answered all initial correspondence by phone and enrolled women who met the inclusion criteria. Thirty-two of these women were not eligible, 14 were eligible but not interested after hearing of the requirements, 19 were interested and eligible but not interviewed, and 16 made contact with the office answering machine but did not leave accurate return contact information. A total of 124 were therefore enrolled, but one NHW woman was dropped due to death and another withdrew due to her father's discomfort with the study. Ninety-two of the 122 women spoke of work-related factors as one reason for their mobility impairment; these 92 were included in the present analysis. Other reasons for disability included illnesses from birth and during other times in their lives, accidents outside of the workplace, and the compounding impact of loss and mental illness.

Data Collection

Data for this mixed-method study were collected in Spanish and English, depending on the participant's language preference. Over a series of meetings, each woman completed demographic questionnaires, provided life history calendar data, and completed topical biographical interviews. For this analysis, the demographic questions, topical biographical interviews, and fieldnotes were used, as detailed below.

Fieldnotes documenting the environmental surroundings in which the interviews were conducted and the environmental surroundings of their neighborhoods and communities including documentation on accessibility issues, appearance, accommodations, and mood were written. Fieldnotes were written after each interview and during time spent in the participants' communities. For the women who maintained employment, notes were made of their employment surroundings. Questionnaires and consent forms were mailed to participants after they agreed to participate in the study during the phone screening. They were asked to complete the booklet of questions prior to the first interview or wait if desired and complete it with the interviewer. Of the 92 women, a total of 84 chose interviews in English; 8 chose Spanish.

Topical biographical interviews were held with each participant. These were open-ended and conversational, regarding memories of experiences with functional limitation. The topical interview was focused on disablement over the life course with no time limit on what they might consider as a contributor to their current functional limitation. Work, or other contributors to their limitations, could have occurred early or later in the life. The interviews were audio taped and transcribed verbatim. Office staff listened to each interview after transcription to check it for accuracy in transcription. The Spanish interviews were transcribed into Spanish and checked for accuracy. A certified bilingual translator, native of South TX, translated the Spanish interviews into English. The 122 participants completed 464 interviews, collectively. The 92 women who spoke of work-related mobility impairment completed 354, collectively. As saturation was obtained, fewer meetings were needed per person. The average number of interviews per person was 3.84; 87% completed 4, 11% completed 3, and 2% completed 2.

Analysis

Qualitative content analysis was used to analyze the data. Participants' names were changed to pseudonyms. First, all data were read for mention of work as a potential reason for

functional limitation. The participant interviews that mentioned work were then pulled out and read again. All discussions relating to the type of injuries, process of gaining care, and aftermath of injuries were sorted into corresponding categories. Within each category, the content was coded line-by-line for details on the types, processes, and aftermaths of the injuries. Themes were created by organizing and labeling the meaning given to their experiences represented by common codes.

Sample

The sample for this analysis included a subset of 92 women with workplace injuries or work-related exacerbations purposefully sampled throughout TX, based on their experiences of mobility impairment. Sample characteristics are presented in Table 1.

Findings

The findings are presented within the following categories: the types of injuries, the process of gaining assistance for workplace injuries, and the aftermath of workplace injuries. There were four themes describing types of injuries: sudden injuries, sudden injuries with delayed response, gradual and cumulative injuries, and injury on top of existing disability. The process of gaining assistance was broken down into three themes: barriers of derision, the question “whose body is this?” and the resolution. The latter category was broken down into two themes: “the damage was done,” and “it wasn’t personal.”

Types of Injuries

Sudden injuries—The most common work injury was the sudden and unexpected physical damage that altered the ability to function as before. As the participant Lydia stated, “I made the mistake of carrying my massage table with me, and didn’t carry it right. My mechanics, I didn’t use my mechanics properly. So I pulled my shoulder.” The injuries forced women such as Lydia to immediately stop work and seek assistance. The women described sudden injuries such as falls, strains, sprains, soft tissue injuries, and fractures. The most severe was Esther’s injury. She was a nurse’s aide who was hit by a car leaving a client’s home; over a 4-year period she had multiple surgeries, and she lost her leg. In all of the sudden injury cases, the injuries were born out of an otherwise normal routine work day; in aberrant events immediately preceding the injury, the women perceived that something within the environment had caused the injury. This was of importance for understanding that the injury was work related. By inferring that aberrant circumstances led to injuries, the women identified the damage with associated reasons for the event and the injury, which qualified the event for WC benefits.

Sudden injuries with delayed response—The next type of work-related injury was a sudden damage without environmental aberrancy. This caused a gradual response to the physical damage. The events were similar to the aforementioned sudden injuries, but different in that they were not recognized as physically damaging until weeks or months later. If symptoms worsened or did not go away within a subjective time period, the women sought assistance. This was the case for Antonia, who said,

So, I went into this room and there was an elderly lady. She really wasn’t that heavy. She really wasn’t a heavy lady. But. [pause] It wasn’t that the bed was not locked. I mean it could move. And I don’t know whether it was because I had done it so many times or the way I did it that time or [pause] I don’t know. But I reached for the bed and pulled it away from the wall and I felt this horrible pull. And I didn’t think too much about it. I just sort of shook it off and I kept working.

Antonia's injury involved a routine activity in which she normally engaged without any interruption. She could not identify a factor that might have caused the event. This left her doubting the possibility and extent of the injury. By not acknowledging the injury, she delayed reporting it and seeking assistance. This compromised her ability to receive WC benefits for a severe shoulder injury that left her in chronic pain.

Gradual and cumulative injury—The most difficult type of workplace injuries to describe and gain WC benefits for was gradual and cumulative. Women with gradual and cumulative strain on their bodies described multiple singular events, each potentiating the effects of the last. Several physical and mental injuries could occur in one person, all contributing to a greater magnitude of functional limitation over time. As Candice stated, “the ankle was my first worker’s compensation. The ankle, I mean the wrist was my second, which I didn’t have surgery on it though. And then my knee was another worker’s comp. But two of these, my ankle and my wrist, were at the same place.” Further, the women perceived that a long history of work-related physical injuries combined with mental stressors to create worse functional limitation with age.

Women whose injuries were classified as gradual and cumulative also reported aches and pains from daily work routines that were not considered major acute physical damage; instead, these symptoms were perceived as normal wear and tear associated with doing the job. For instance, Gloria stated, “So I think I damaged my body by working so much and not taking care of it.” In these instances, the women perceived that their current functional limitation was due to the accumulation of multiple stressors. They described a trajectory of work-related physical hazards coupled with the contextual factors of age, working conditions, work benefits, and a risky work culture.

Age was perceived as a contextual factor that led to gradual and cumulative injuries. It was a chronological marker for specific injuries, a reason for physical decline and lost ability, a symbol for the amount of cumulative stress and strain experienced, and a source of stigma used to alienate them from employment and its benefits. Cumulative injury with increasing age often led to the decision to leave the work force.

Age could also combine with the other contextual factors to make conditions worse. For instance, age would combine with severe working conditions to intimidate women from asking for benefits.

Donna (69 year old NHW): I said, “You know, if I got hurt when I did that, it’s a worker’s comp.” He got real mad. I never filed a worker’s comp, just like I didn’t get health insurance from them because quote, “I was an old woman, and it would cost too much.”

TCH: He told you that?

Donna: Yes, he told me that.

Severe working conditions were perceived as the second contextual factor that led to gradual and cumulative injuries. Women who worked in factories and fields spoke of extreme weather, long days, and heavy lifting that led to physical damage and mental stress. Women who worked in offices also reported long days, heavy lifting that led to physical damage and mental stress. Dominique said, “So what happened was I ended up falling terribly at work, hurting myself, and several times because I was just so exhausted. Pushing myself, pushing myself! Where it got the point where in ’93 I just said, I can’t do this anymore.”

The third contextual factor leading to cumulative and gradual injuries was the availability of benefits. Benefits available at the work site influenced the women’s reactions to stressors

that could worsen with time. If WC, health insurance, or paid time off were not available, the women would often ignore their injuries and keep working. They feared losing their salary and jobs if they left to seek care.

Finally, the women perceived that a risky work site led to gradual and cumulative injuries. A risky work site was one where dangerous conditions were ignored. For instance, Joyce worked as a large machinery operator, which required her to stand on cement soaked in multiple chemicals for long periods of time. Later in life, she developed severe inexplicable leg problems with chronic pain. She wore braces to maintain mobility and prevent further falls. She stated,

The machinery that I run, because we were on cement, you have oil that you use to lubricate your steel and it, of course, falls on the floor. Drill presses run with water to keep them cool and that falls on the floor. I worked with chemicals of all kinds for different reasons. Cleaning the steel or whatever, but you just – it's kind of sloppy that stuff got to go some place, and usually, it winds up on the floor.

Injury on top of existing impairments and limitations—Finally, work injury was described by women with a preexisting functional limitation, such as those women with functional limitation due to early-onset arthritis or polio who reported a workplace injury. As Lucia stated, “I actually got injured through my disability and then an accidental injury at work in 1988, but I didn’t stop working until 1993. But I already had some disabilities that I grew up with.” This was also the case for Justine, who had rheumatoid arthritis for 15 years prior to being injured at work. She did not file a WC claim for this injury because she did not want WC to interfere with the private health care services that enabled her to maintain employment. She believed that if she had involved WC, she would have lost a voice in her care. It is also unclear whether Justine would have qualified for WC benefits because she would have to prove that her injuries were due to the job accident and not her previous condition. Injuries occurring to a person with a preexisting condition are covered by WC only if evidence proves that the workplace aggravated the condition or increased the risk (Sedo, 2007). Benefits are withheld if the employee refuses to adhere to testing and examinations.

Gaining Assistance for Workplace Injuries

Barriers of derision—The women who sought WC benefits intimated that the process of filing papers to document the problem was usually straightforward; only one participant had trouble finding the appropriate forms. The entire process ultimately involved more than completing forms, however; the women discussed barriers such as denied claims, lack of access to knowledgeable WC adjustors and/or doctors, minimal voice in the evaluation and treatment of their bodies, disrespect, and, finally, unclear guidance on RTW. Due to the multiple barriers to resolution, they perceived that the process was created to benefit the employer. The women responded by negotiating contingency-based legal assistance to overcome the barriers and gain resolution, by managing their injuries without WC assistance, or by living with minimal WC benefit beyond their initial evaluations.

The women perceived that the WC difficulties were due to cultural negativity on the part of adjusters, employers, and doctors toward their benefits; gaining profit from injury was not a fair way to gain benefit compensation. Some women also perceived a lack of understanding between their needs, as those of blue collar workers with low pay, and the staff who processed the forms and provided approval for medical treatment. For instance, many women perceived that WC system adjusters did not understand the perceived risk of job and wage loss associated with filing claims and missing days of work due to medical follow-up. Jessica described an insurance adjuster thus: “The way she would belittle me, and the way

she would make it sound like I was pretending; and I was making all this up, that was it. That was it. Just the way she spoke to me and the way I was just nothing but dirt; and you're another one of those people that want compensation when you're not really hurting that much." There was a struggle between WC adjusters who were monitoring the system for abuses and the injured women who were trying to get access to benefits while caring for self and family. As Antonia recalled, "Workmen's comp paid for the arthroscopic surgery on this one and they fought me and fought me on the other one. I just gave up on it and did not do anymore after that."

Whose body is this?—The women believed that the WC-designated physicians (WCDP) worked to benefit the employer. For instance, the women complained of long waits in WCDP offices causing them to be off work and away from their families for hours. Nora explained her experience with this situation, "So, I went and they didn't see me. They left me sitting in the lobby; they didn't see me. In fact, I couldn't even sit. You know, I had to keep walking back and forth, back and forth and all of a sudden I didn't see anybody. So, I went over there and I said, you know, I'm so and so, when are you going to see me? Oh, he's already gone. Oh we're sorry."

Filing a claim did not mean that the WCDP would diagnose a problem. Donna said, "Well I didn't go to the doctor because after I fell and they sent me to the doctor here and they x-rayed me. They said I was fine, that nothing was wrong." Linda was bemused; she responded, "Well, I'm in a lot of pain. I can't sit. I can't. The only thing I can do is either lay down or stand up. And he said, well, there's nothing that can be done." In this instance, Linda said, "So, I started taking some over the counter pain relievers and it just kept getting worse and worse and worse."

Given that some of the WCDPs did not diagnose problems, filing WC claims had a negative effect on the women's status at work and within their families and communities. Joyce said she experienced "a lot of pain" after hurting her back at work. She "kept telling the doctor that at first," but he would respond by telling her the "x-rays show that you're fine and your x-rays show that it's fine." The WCDP would use objective test results to undermine subjective complaints of dysfunction and pain. As Anna stated, "You look very good? No! Only I know how I feel." Donna said,

the bad thing is it hurt my friendships and my relationship with my daughter, and my husband couldn't understand it. And instead of being on my side, he'd say, "well, it's not believable and it is not provable." So, I didn't. I felt like he thought I was lying, too. And he could see that he was having to do things for me. [pause] But I think he was scared.

On the other hand, gaining a diagnosis from the WCDP did not mean that a woman would receive care. Any care that the women might receive after their injuries was contingent on their WC adjusters' approval. Antoinette said, "And workmen's compensation had not approved an urologist after the surgery. So, they said we can't do anything. We can't catheterize you. We can't. I said, 'well, what am I going to do?' Well, we don't care." That same day, she said, "They wouldn't approve it. So, they just sent me home like that and [pause, crying]. And they wouldn't approve an ambulance either so the ride home was horrible." In the state of TX, the WCDP cannot bill the injured worker, only the WC insurer. As an unintended consequence of legislation, these women lost control over the treatment of their bodies.

The resolution—Fewer than half of the women said that they received monetary compensation in the form of remuneration for lost wages or permanent disability compensation. For women who never worked again, the ability to pay off bills allowed by

the settlement was a way to survive on the subsequent small amount that SS/DI offered. Anna Lee said, “Yes, they gave me a settlement. And when they gave me the settlement I finished paying my house here because I still had my house here.” The compensation was always split with the women’s attorneys. Maria stated, “I only got \$41,000. Of the lawsuit but I only kept \$20,000. Because the lawyer took the rest. His fees and everything, court costs and the lawsuit and everything.” The women did not complain about paying attorneys because gaining benefits was contingent on their attorneys’ services. As Kathy stated, “First, they (employer) wouldn’t, I tried to do things on my own with them, you know, communicating with them. And it got to the point where they said, well, you have to get an attorney.” Karen made this clear when she stated, “Well, they made a big deal of it. That’s when I had to hire a lawyer because they weren’t going to pay.”

As an alternative or supplement to payment, some women were told they would get medical care for their workplace injuries for the rest of their lives. The WCDP controlled the diagnosis and treatments, and the adjuster controlled the payment for what constituted a medical need related to the initial injury. Hence, the actual benefits were seldom realized. Esther, who lost her leg when hit by a car, stated, “The hospital kept everything. I only got a little bit of money [\$20,000.00], everything went to the hospital.” If a third party is at fault in a work-related injury, all insurance reimbursement from the third party goes to the WC insurance company that pays the hospital for the injuries. The WC insurance company is legally compensated fully for its loss, while the worker is not reimbursed with full salary.

Aftermath of Workplace Injuries: Aging After Injury

There were moments, perhaps epiphanies, when the majority of the women perceived that their functional limitation, pain, and mental distress had reached a critical point that signaled the end of their employment. These critical points, medically factual or not, were narrative springboards documenting the women’s reasons for departure from the workplace. They foretold a trajectory in which the women were forced to choose between their jobs and their health. This critical point of departure was most telling for women like Maria, who left her job 3 months prior to qualifying for retirement because of pain and job stress. She simply could not work for one day more. This did not coincide with a sudden injury. Instead, her injury was gradual and cumulative, combining with age to trigger her work departure. This left Maria to manage the costs associated with functional limitation and unemployment through a shift of responsibility from the private sector employer to SS/DI and eventually Medicaid/Medicare. The two themes describing the women’s later years include “the Damage was Done”, and “It wasn’t fair and it wasn’t personal”.

The damage was done—The frustration and anger described by the women at the time of their injuries diminished into a sense of futility in later years. This was especially so for those who were told by their WCDP they had no injuries. For instance, Camilla went to a private-pay doctor when her back pain intensified in later years, with increasing levels of functional limitation. She said that her private-pay doctor looked at her old x-rays and said that “it shows that you already had damage. It showed already in that x-ray.” She responded with a sense of betrayal, “When they told me that I was fine that there was nothing wrong; I could keep on working. And of course that was a doctor from the company. But when they got those same x-rays over there. The doctor (private-pay) over there said, ‘No, you already had damage there on your [pause]. We could prove that with the first x-rays.’ But there was no point. My damage was already done.”

The women who were provided care through WC were not without functional limitation in later life; good and bad outcomes occurred, regardless. For instance, Georgia stated that her back pain continued to worsen over time. Although she had stopped receiving WC benefits,

she continued to need care: “So, I went to see a doctor and the doctor that checked me did x-rays. Well, I don’t have good news for you. He said, I can give you therapy but it’s not going to help you. You have a real bad back. Your back is completely, you know, ruptured. So, he said, you’re going to need surgery and he said you need to, from now on; you need to stay out of work. I damaged my back so bad because I let it go.” Her WCDP had denied damage at the time of her injury; later in her life, her private-pay physician stated that she needed surgery due to her earlier injuries. On the contrary, JoEllen had received WC care: She had back surgery that resulted in paralysis from the waist down at the age of 60. Afterward, she was placed in a nursing home for 3 years for which Medicaid covered the cost. She said, “Especially when you go to your chart at the nursing home and it says the doctor says, “dismissal-unlikely”, I go, “unlikely”? I’m not going to stay here for the rest of my life! No. Not me. There’s too many other things I like to do.”

It wasn’t fair and it wasn’t personal—After their injuries, the women went through a process of adjustment. Psychological distress after a trauma is not uncommon, but it is unique to injured workers due to workplace liability issues, the need for RTW, and the added WC process (Hensel, Bender, Bacchioni, Pelletier, & Dewa, 2010). There were women who felt betrayed by their employers and the system. Toni stated, “Oh my God. It was like they took my life away. From doing everything, to after surgery, I could not do nothing. I mean it was like they took my life out of me. Like it was totally disabled. It was like a big shock. I couldn’t cope with it. I was mad and I could see that I couldn’t move.” The injuries had a severe effect on the women’s sense of hope for the future. It was not that all the women wanted to work; all the women wanted to be free of functional limitation and pain.

The women who tried to work after their injuries and worsening impairments reported difficulties. They were told it was not personal; it was business. Jocelyn, who had polio since childhood, applied for a job as a teacher’s assistant after a previous workplace injury that worsened her functional limitation to the point of her needing a wheelchair. She did not receive the position despite having ample education, experience, and what she perceived to be a positive phone interview. Jocelyn filed a complaint with the Equal Employment and Opportunity Commission and won. Of the experience she said,

So we settled it before we even got to mediation. That’s how they knew they were wrong. But you know there was no apology. There was—no we will implement the law—the civil rights legislation as it’s written. We’ll go ahead and make sure this doesn’t happen again. Nothing of that. No admission that they did anything wrong. All they did was paid me.

Discussion

This work supports the theoretical model used to guide the analysis (Lipscomb, et al, 2006). The women’s work was perceived to have exposed them to injuries and illnesses that had long-term health, economic and quality of life sequelae. Further, the policies in place influenced their ability to access care and benefits, which also influenced the progression to poor outcomes in later life. For instance, the analysis showed that the participants viewed their injuries in terms broader than those with which WC injuries are defined under the law. WC benefits were provided only for legally defined, sudden workplace injuries. The women were not initially aware that distinctions were made regarding the type of injuries that qualified for benefits. Further, the women also experienced sudden injuries that were gradual and less clearly defined, injuries that were due to cumulative stress and strain, and injuries that were experienced on top of pre-existing functional limitation. The injuries limited their function and long-term health. However, because the injuries were objectively

difficult to define and treat under current WC policies, the women had few benefits, poor health, and diminished quality of life. This also had an effect on their families.

Examining changes in WC policy in Australia, Cameron (1994) argued that women's claims for compensation were rejected at the discretion of medical practitioners, rehabilitation administrators, and trade unionists, not due to the law or policy itself. It seemed that the law developed unevenly in the context of the social, economic, and political lives of the people. According to Guthrie and Jansz (2006), the issues of gender inequality in Australia's WC system come from the industrial environment. Women tend to work at different industries or "in gender-segregated circumstances," which provides women with smaller payments and leaves them without equal "industrial bargaining power." Such factors have caused difficulties in the processes of treatment and compensation for women, and subsequently their RTW rates are low (Guthrie & Jansz, 2006).

This study also adds to Lipscomb and colleague's (2006) theoretical work by emphasizing the impact of cultural beliefs on the progression from work to long to outcomes after exposure and injury. The women in the present study described how their views of their injuries and functional limitations were eschewed by adjusters, doctors, employers, and families. If people foster the cultural belief that injury resulting in functional limitation can be a means of obtaining unearned compensation through insurance, an adversarial culture with more deserving as opposed to less deserving people emerges. Women are held to notions of responsibility, ability and independence while being denied resources to maintain these values in the context of injury. Further, the healthcare system, under the control of the WC system, was viewed as an extension of the workplace, not two separate systems, which had an impact on access to care after work place injury.

According to Bourdieu, "humans will endlessly attempt to optimize their capital accumulation strategies: that strategic game-playing governs human action." (Adkins & Skeggs, 2004, p. 14). This begs two questions: What capital were the women trying to maximize during their interactions with the WC system? And did the women have the skill and knowledge necessary to play the political and economic games that would impact the rest of their lives? These women had diminished economic capital in the workforce and perceived their emotional capital (Adkins & Skeggs, 2004) to be threatened by claiming WC injury; ultimately, this drove the women out of the workforce taking with them any long-term perceived pathway for the accumulation of economic or social capital. Texas is a right to work state; this means that workers have the right by law not to join a union in their work place. The women in this study stated they were not members of a union nor had they voiced contacting anyone for assistance with their work environments, such as the Occupational Safety and Health Administration.

Knowledge and skill gained from within the informal rules of society influenced the women's belief system: what the women viewed as significant problems and their perceived ability to address any problems (Bourdieu, 1977; Lipscomb et al., 2006). For example, women were reluctant to question their WCDP due to his or her perceived connection with their employer. The healthcare and workforce fields were overlapping, leaving the women with modest economic, social or emotional capital. If the women had requested a new WCDP, the WC adjuster would have chosen a new WCDP for a mandatory medical examination to settle the dispute. Unless harmful to the individual, the injured employees can be expected to drive up to 75 miles for an examination (TDI, 2012). Such factors contribute to an environment that is not conducive to filing complaints or requesting changes, especially among low-wage workers with multiple family responsibilities. Any system that increases tension and requires burdensome time away from the family is likely to coerce women into accepting poor care ending in loss of emotional and social capital. The

provision of medical care based upon the opinion of a WC physician and a WC adjuster, not injured women, creates a culture where the women are physical objects evaluated for financial gain or loss.

Nationally, employment has been less statistically fruitful for Latinas than for their NHW counterparts. NHW women have experienced an average unemployment rate of 7.7% while Latinas have experienced 12.3% (U.S. Department of Labor, 2010a). Latinas also earn less; currently, they are compensated at 60% of men's average weekly earnings, whereas NHW women are compensated at 80% (Solis, 2012). While 42% of NHW women are primarily employed in management, professional, and related occupations, 33% of Latinas are employed in service occupations (U.S. Department of Labor, 2010b); in these service occupations, the highest number of occupational injuries for women occur (U.S. Department of Labor, 2008). It is through the creation and reproduction of life-style that an employer bears responsibility for a particular group being sorted into a particular job (Bourdieu, 1984). If a lifestyle develops from the employment of MA women in strenuous jobs that may result in injury, but for which they do not seek compensation, then the employer is responsible for the co-creation of any economic or health disparity resulting from this selection. As seen in Tables 2 and 3, injuries and rates of injuries within specific industries among women in 2010 begin to form patterns. If Latinas form a lifestyle pattern of taking jobs and leaving those jobs after injuries without benefit it reinforces a cultural disadvantage and health disparity.

The following limitations to the present study should be mentioned. The interviews were retrospective accounts of events. Further, mobility impairment was chosen as the type of functional limitation to study, in order to provide a more homogeneous sample. A study of upper body functional limitation might be fruitful. Given that carpal tunnel syndrome is a leading cause of injury, the experience that women with carpal tunnel syndrome have in gaining care might be informative. The present study was also limited to the experience of MA and NHW women. The experiences of other groups of women might be different. Men's experiences should be studied as well.

In conclusion, supporting women with functional limitation after workplace injury is needed; employment is the primary pathway to maintaining social and economic capital with age. The incidence of workplace injury among all groups has remained statistically unchanged over the past year with the median number of days off work due to injury remaining stable at eight days for the past four years (U.S. Department of Labor, 2012). While the rate of injury and fatality overall in the U.S. work force remained stable or diminished in the non-Hispanic White population, the incidence of injury and fatality increased from 1996 to 2004 in the Hispanic population (Richardson, 2005). One of the highest risk job categories continues to include nursing aides, orderlies and attendants who had an incident injury rate of 444 cases per 10,000 full time workers in 2011; registered nurses had an incident injury rate of 136 cases per 10,000 full time workers in 2011 (U.S. Department of Labor, 2012). Given the continued high rate of injury within jobs traditionally held by women, and more so by Hispanic women, there is a high likelihood that these women will continue to face circumstances where employment and healthcare collide to impact function with age, which incorporates aging with, and aging into, disability for women. Efforts to improve the care and benefits received would encompass assistance for both aging and disability groups in the community.

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Table 1

Description of Sample of Women with Work-Related Injuries

Women with Mobility Impairment Reporting Work Place injuries	
Variable	Mean, Range or Percentile
Age when permanently lost function	Mean=50, Std dev=15.8 (range 1 to 75)
Years of Education	Mean=13, Std dev=4.2 (range 1–21)
Married	39%
Fulltime Employment	29%
Seeking Employment	11%
Income less than \$10,000.00	32%
Owens Home	61%
Not Insured	9%
Mexican American	52%
Non-Hispanic White	48%
Current Age	Mean=65, Std dev=6.2 (Range 55 to 75)
Age began first job	Mean =11, Std dev= 5.5 (Range 5 to 44)
Years residing in the United States	Mean 62, Std dev=11.4 (Range 3 to 75)

Table 2

Number of nonfatal occupational injuries and illnesses involving days away from work by selected worker characteristic and major private industry sector, 2010. (U.S. Department of Labor, 2010b)

Occupation	Number of injuries in women leading to time off from work
Private Industry	365,610
Total Goods Producing	32,280
Natural Resources and Mining	3,050
Construction	2,140
Manufacturing	27,090
Services Industry	333,320
Trade, Transportation, and Utilities	83,680
Information	5,110
Financial Activities	13,200
Professional and Business Services	28,240
Education and Health Services	149,740
Leisure and Hospitality	45,040
Other Services	8,300

Table 3

Incidence rates for nonfatal occupational injuries and illnesses involving days away from work per 10, 000 full-time workers 2010. (U.S. Department of Labor, 2010b)

Nature of injury, illness	Incidence rate in women
Total private state and local government sectors (1,238, 490 cases)	105.7
Sprains, strains	42.6
Fractures	7.5
Cut, Lacerations, punctures	4.7
Cuts, Lacerations	4.2
Punctures	0.5
Bruises, Contusions	11.2
Heat Burns	1.5
Chemical Burns	0.3
Amputations	0.1
Carpal Tunnel Syndrome	1.4
Tendonitis	0.7